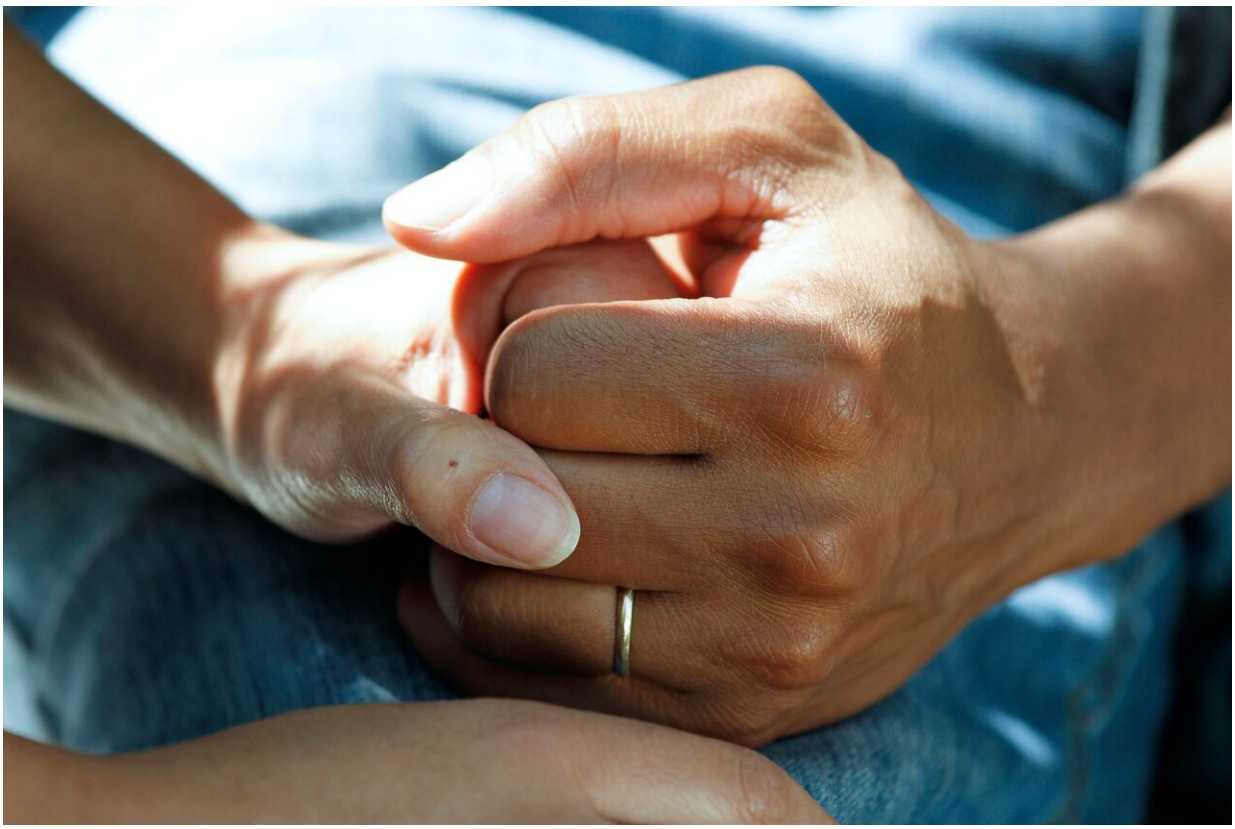
Patients seek mental health care from their doctor but find health plans standing in the way

June 13 2022, by Aneri Pattani



Credit: Unsplash/CC0 Public Domain

When a longtime patient visited Dr. William Sawyer's office after recovering from COVID, the conversation quickly turned from the

coronavirus to anxiety and ADHD.

Sawyer—who has run a family medicine practice in the Cincinnati area for more than three decades—said he spent 30 minutes asking questions about the patient's exercise and sleep habits, counseling him on breathing exercises, and writing a prescription for attention-deficit/hyperactivity disorder medication.

At the end of the visit, Sawyer submitted a claim to the patient's insurance using one code for obesity, one for rosacea—a common skin condition—one for anxiety, and one for ADHD.

Several weeks later, the insurer sent him a letter saying it wouldn't pay for the visit. "The services billed are for the treatment of a behavioral health condition," the letter said, and under the patient's health plan, those benefits are covered by a separate company. Sawyer would have to submit the claim to it.

But Sawyer was not in that company's network. So even though he was in-network for the patient's physical care, the claim for the recent visit wouldn't be fully covered, Sawyer said. And it would get passed on to the patient.

As mental health concerns have risen over the past decade—and reached new heights during the pandemic—there's a push for primary care doctors to provide mental health care. Research shows primary care physicians can treat patients with mild to moderate depression just as well as psychiatrists—which could help address the nationwide shortage of mental health providers. Primary care doctors are also more likely to reach patients in rural areas and other underserved communities, and they're trusted by Americans across political and geographic divides.

But the way many insurance plans cover mental health doesn't

necessarily support integrating it with physical care.

In the 1980s, many insurers began adopting what are known as behavioral health carve-outs. Under this model, health plans contract with another company to provide mental health benefits to their members. Policy experts say the goal was to rein in costs and allow companies with expertise in mental health to manage those benefits.

Over time, though, concerns arose that the model separates physical and mental health care, forcing patients to navigate two sets of rules and two networks of providers and to deal with two times the complexity.

Patients typically don't even know whether their insurance plan has a carve-out until a problem comes up. In some cases, the main insurance plan may deny a claim, saying it's related to mental health, while the behavioral health company also denies it, saying it's physical.

"It's the patients who end up with the short end of the stick," said Jennifer Snow, head of government relations and policy for the National Alliance on Mental Illness, an advocacy group. Patients don't receive the holistic care that's most likely to help them, and they might end up with an out-of-pocket bill, she said.

There's little data to show how frequently this scenario—either patients receiving such bills or primary care doctors going unpaid for mental health services—happens. But Dr. Sterling Ransone Jr., president of the American Academy of Family Physicians, said he has been receiving "more and more reports" about it since the pandemic began.

Even before COVID, studies suggest, primary care physicians handled nearly 40% of all visits for depression or anxiety and prescribed half of all antidepressants and anti-anxiety medications.

Now with the added mental stress of a two-year pandemic, "we are seeing more visits to our offices with concerns of anxiety, depression, and more," Ransone said.

That means doctors are submitting more claims with mental health codes, which creates more opportunities for denials. Physicians can appeal these denials or try to collect payment from the carve-out plan. But in a recent email discussion among family physicians, which was later shared with KHN, those running their own practices with little administrative support said the time spent on paperwork and phone calls to appeal denials cost more than the ultimate reimbursement.

Dr. Peter Liepmann, a family physician in California, told KHN that at one point he stopped using psychiatric diagnosis codes in claims altogether. If he saw a patient with depression, he coded it as fatigue. Anxiety was coded as palpitations. That was the only way to get paid, he said.

In Ohio, Sawyer and his staff decided to appeal to the insurer, Anthem, rather than pass the bill on to the patient. In calls and emails, they asked Anthem why the claim for treating obesity, rosacea, anxiety, and ADHD was denied. About two weeks later, Anthem agreed to reimburse Sawyer for the visit. The company didn't provide an explanation for the change, Sawyer said, leaving him to wonder whether it'll happen again. If it does, he's not sure the $87 reimbursement is worth the hassle.

"Everyone around the country is talking about integrating physical and mental health," Sawyer said. "But if we're not paid to do it, we can't do it."

Anthem spokesperson Eric Lail said in a statement to KHN that the company regularly works with clinicians who provide mental and physical health care on submitting accurate codes and getting

appropriately reimbursed. Providers with concerns can follow the standard appeals process, he wrote.

Kate Berry, senior vice president of clinical affairs at AHIP, a trade group for insurers, said many insurers are working on ways to support patients receiving mental health care in primary care offices—for example, coaching physicians on how to use standardized screening tools and explaining the proper billing codes to use for integrated care.

"But not every primary care provider is ready to take this on," she said.

A 2021 report from the Bipartisan Policy Center, a think tank in Washington, D.C., found that some primary care doctors do combine mental and physical health care in their practices but that "many lack the training, financial resources, guidance, and staff" to do so.

Richard Frank, a co-chair of the task force that issued the report and director of the University of Southern California-Brookings Schaeffer Initiative on Health Policy, put it this way: "Lots of primary care doctors don't like treating depression." They may feel it's outside the scope of their expertise or takes too much time.

One study focused on older patients found that some primary care doctors change the subject when patients bring up anxiety or depression and that a typical mental health discussion lasts just two minutes.

Doctors point to a lack of payment as the problem, Frank said, but they're "exaggerating how often this happens." During the past decade, billing codes have been created to allow primary care doctors to charge for integrated physical and mental health services, he said.

Yet the split persists.

One solution might be for insurance companies or employers to end behavioral health carve-outs and provide all benefits through one company. But policy experts say the change could result in narrow networks, which might force patients to go out of network for care and pay out-of-pocket anyway.

Dr. Madhukar Trivedi, a psychiatry professor at the University of Texas Southwestern Medical Center who often trains primary care doctors to treat depression, said integrated care boils down to "a chicken-and-egg problem." Doctors say they'll provide mental health care if insurers pay for it, and insurers say they'll pay for it if doctors provide appropriate care.

Patients, again, lose out.

"Most of them don't want to be shipped off to specialists," Trivedi said. So when they can't get mental health care from their primary doctor, they often don't get it at all. Some people wait until they hit a crisis point and end up in the emergency room—a rising concern for children and teens especially.

"Everything gets delayed," Trivedi said. "That's why there are more crises, more suicides. There's a price to not getting diagnosed or getting adequate treatment early."