Keys to Overcoming Mental and Behavioral Health Billing Challenges

NCDS
Medical Billing

Table of Contents

Introduction

19.86% of adults experience a mental illness, equivalent to nearly **50 million** Americans. With the prevalence of various forms of mental illness, mental health services provide crucial support to many of us.

Mental health providers typically enter the mental health space to help others. This purpose can be hindered by the challenges of mental and behavioral health billing. Time spent navigating challenging billing rules and regulations lead to lower provider profits and less time spent helping patients.

Many mental health practices receive less than **85%** of the money that they're owed. Read on to learn common mental and behavioral health billing challenges, and NCDS Medical Billing's top tips for practices to get paid in full.

Common Billing Issues for Mental and Behavioral Health Practices

Complicated Billing Processes

Mental and behavioral health has overall more complex and nuanced billing methods. There are two major reasons for this complexity: high treatment variance and pre-authorization.

High Variance in Treatments

At physical health doctors, most exams are pretty standard and similar. Doctors typically perform the same exams and tests for patients. These routine visits are a simple task to bill.

When it comes to mental and behavioral health treatments, there is a lot of variation. Between the variety of treatments, services, and levels, medical billing becomes more complicated. With mental health, treatment varies greatly on a patient-by-patient basis.

Many factors contribute to differences of mental health services:

- **Location of services**
- **Session length**
- **Patient age**
- **Prescriptions**
- **Type of therapeutic approach**

Because of these varying factors, mental health billing becomes very complicated. Standardized treatment in mental health is rare due to the highly personal nature of mental health.

Pre-Authorization

Typically, health insurance plans require some form of pre-authorization. Patients cannot receive coverage for mental health services until this pre-authorization is received.

Pre-authorization slows down insurance billing, preventing providers from getting paid for services and from patients receiving a necessary treatment.

Insurance Ineligibility

Mental health is a form of medicine where patients are more likely to go out-of-network. Compared to physical health practices, for mental health services patients are much more likely to find a provider that is not covered by their insurance plan.

Because of this higher inclination towards out-of-network providers, many more patients come to practices that either are out-of-network or their insurance doesn't cover the services that they're in need of. This creates challenges when it comes to billing, as there is no insurer to guarantee payment.

Incorrect Patient Information

Accurate patient information is one of the easiest issues to fix in medical billing, but one of the most common challenges. If a patient's information is incorrect, it typically leads to a dreaded denial. Whether an incorrect address, incorrect spelling, or out of date insurance information, a claim will be denied if it's inaccurate.

Claims Denials

Denials are a burden on medical practices of all types. Denials get in the way of cash flow, and put a wrench in efficient revenue cycle management. What's even more challenging? Denials are inevitable. Even the strictest claims systems still get the occasional denial.

Claims can be denied for a host of reasons. Whether a claim lacked a necessary pre-authorization, insurance was out of date, a provider was out of network, a service was not approved, or patients' information was incorrect, there are a long list of reasons that claims can be denied.

At the end of the day, denials mean one thing: the practice has not yet been paid for services that have been provided.

Lack of Staff

Lack of resources is another challenge that mental healthcare providers struggle with when it comes to medical billing. Many medical practices often have an administrative team that handles billing and coding, while practitioners can put their focus on caring for patients.

Many medical practices often have an administrative team that handles billing and coding, while practitioners can put their focus on caring for patients.

However, many mental health practices have limited administrative support due to often being a small partnership or sole proprietorship.

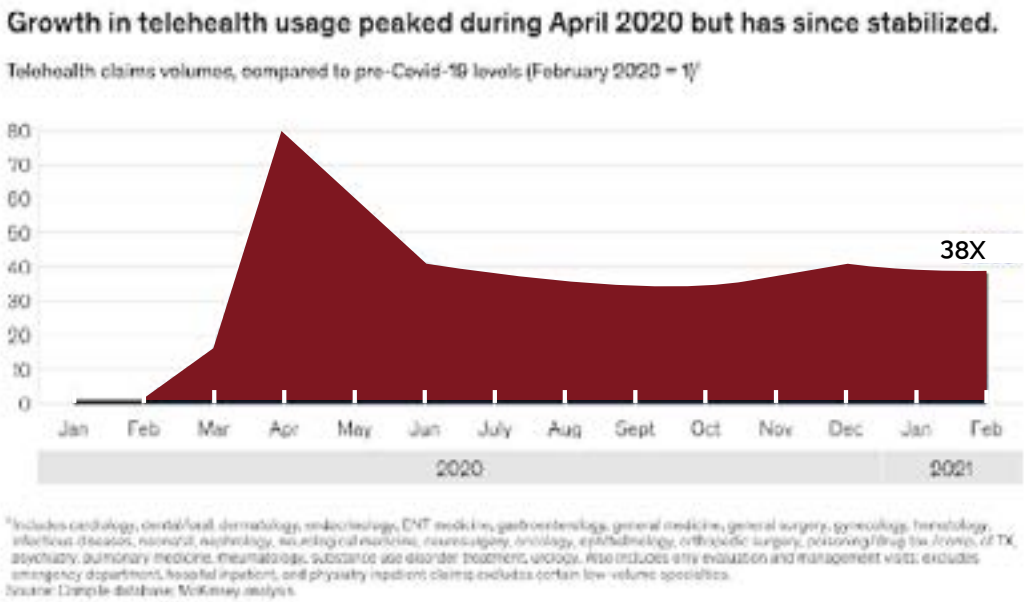
This limited support leads to a lack of help with medical billing, and a lack of dedicated team members to ensure medical billing is completed in a manner to meet all regulations. Practitioners then need to cover billing themselves, on top of managing patient care and schedules.

Solutions for Resolving Common Billing Issues for Mental and Behavioral Health Practices

Activate Credentialing and Insurance Enrollment

The need for mental and behavioral health services has been gradually increasing for years, but the COVID-19 pandemic sent it soaring. The World Health Organization identified that the COVID-19 pandemic triggered a **25%** increase in anxiety and depression across the globe.

The ability to provide services via telemedicine also increased availability and access to mental health services. As of 2021, telehealth showed that there was a **38x** increase in usage since pre-COVID-19.



Telehealth claims as a result of the COVID-19 pandemic found by McKinsey

The increased access and vast opportunity presented by telemedicine combined with the increased need for mental health providers vastly overhauled much of mental health services in a few ways:

- **New Providers:**
  - Many new providers entered the field
- **Insurance Acceptance Increase:**
  - Some existing providers were encouraged to move from cash-based practices to becoming practices that now accept insurance plans
- **Practice Consolidation:**
  - Many single and small group practices expanded to combine or build into larger multi-provider, multi-level entities

These changes have been great to support the growing need for care, however, the proper insurance contracting, tax structuring and set up needs to be inplace to allow for maximum reimbursement and longevity.

Credentialing Process and Importance

Credentialing with providers consists of both credentialing and contracting. During credentialing, insurance companies confirm credentials and verify that a practice meets the requirements they have for participating in their network.

During contracting, the insurance company shares an agreement that lays out what the participation terms are for in-network claim reimbursement. This participating provider agreement is necessary to receive in-network reimbursement.

Without credentialing and contracting, there is no guarantee that a claim will be processed with an insurance company.

Insurance Reimbursement Variance

Reimbursements are not all created equal. Reimbursement varies significantly based on many different factors, and different credentials and licenses often have large variance across states and insurance companies/plans.

To reduce any surprises about the differences in reimbursement, the following are important to being compliant for proper reimbursement:

- **Location of services**
- **Session length**
- **Patient age**
- **Prescriptions**
- **Type of therapeutic approach**

To reduce any surprises about the differences in reimbursement, the following are important to being compliant for proper reimbursement:

- **Strong understanding of what is and isn't billable**
- **Determine what supervision requirements are**
- **Knowledge of compliance factors for proper reimbursement**
  - Know state compliance needs
  - Know plan and insurer compliance needs
  - Understand how the specific credentials/licenses at hand effect reimbursement

Confirm Insurance Eligibility and Verification of Benefits

Mental health visits are **five times more likely** to be out of network than primary or specialty care.
Prior to beginning treatment with a patient, having the full picture of a patient's coverage and knowing and understanding any payment limitations is essential.

To confirm insurance eligibility and benefits included, the following two fundamental steps are recommended:

1. As a best practice, all practices should confirm that the patient at hand has provided accurate coverage information, and that the policy provided is active.
2. After the carrier has been confirmed, providers should look at the benefits included in the policy. Things to check for include determining total reimbursable visits per year, identifying if prior authorization is required, or if the plan is high deductible and will force the patient to pay the balance out of pocket. The key to confirming insurance eligibility and gauging the full picture of a patient's benefits is to gather all the information necessary to determine a game plan for how the patient's care will be paid for.

Determining and creating this payment plan right off the bat eliminates any surprises and reduces payment related stress for both the patient and provider.

Determine Telemedicine Guidelines and Billing

As mentioned previously, telemedicine is growing, and is predicted to continue to do so.

According to a new report from Growth Plus Reports, the telemedicine market is expected to hit **$324.38 billion** by 2030, with a compound annual growth rate of **18.9%** between 2022 and 2030.

Psychiatric care and counseling practices are a driving factor in this huge expansion into telemedicine. The surrounding insurance regulations are continually evolving to accommodate patients and providers with additional coverage guidelines and policies.

Practices will need to stay informed and closely monitor the news and updates carriers are distributing to know the latest standards to avoid claim denials and know specific benefits for telemedicine services. With regularly changing insurance regulations, keeping close to these policies will keep practices maintaining a healthy cash flow.

Identify Specialty Specific Sub-Contracted and Carve-Out Insurance Plans

The detailed and sensitive nature of the mental and behavioral health specialty leads insurance carriers to often outsource coverage for these claims to expert health plans that focus solely on these types of services.

Many insurance providers use carve-outs to mitigate legal and financial risk. Benefit providers share that **20-40%** can be saved on prescription drug spend alone by using carve-outs, creating incentive for insurance providers to use this tactic.

Carve-out insurance plans are common in mental and behavioral health plans, and allows insurers to isolate specific risks as well as minimize the financial risks for themselves. Carve-outs can be as large as to cover the majority of a plan, or be as small as a single benefit such as addiction services.

This piecemeal outsourcing method can add additional layers of complication to the medical billing process for a few reasons:

1. These third parties often require claims to go to a mailing address totally different from where the main carrier claims are sent.
2. Third parties typically have different or limited electronic channels for processing, which further impedes the billing process.
3. Third parties may have specific benefits, restricted coverage or additional prior authorization procedures that differ from the overarching insurance carrier.

It's important to know when these types of carve-out plans come into play. Sometimes all claims for a carrier managed by the sub-contracted plan and other agreements are for specific types or claims or conditions.

Practices that have done their due diligence with the eligibility and verification of benefits process should be able to work these issues out ahead of time.

Know the Differences for Billing Medicare, Medicaid and Commercial Insurance Plans

On top of the nuances within all the various commercial insurance plans, there are distinct differences between how private and government payers process claims.

The different types of payers allow different Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes based on different provider types.

Licensure and credentialing requirements often vary not only between plan types but from state to state depending on local laws and regulations adding yet another layer to the divergence in coverage between these main groups of insurance.

Even when allowing the same coding, there is often a need for a specific modifier that Medicare will require one way, Medicaid another and multiple variation between commercial plans that establish their own policies and others that match some version of Medicare or Medicaid guidelines.

There will be constraints and alternatives in how different types of services are provided between plan types for E/M (Evaluation and Management), counseling, medication management, etc and even unique ways to handle billing for couples, family or group therapy sessions as well as specific terms for EAP (Employee Assistance Program) billing.

Overall, there are major billing differences and nuances between payer types, provider types, coding processes, locations, Medicare, Medicaid, and other unique situations depending on the patient at hand.

Keeping a close eye on the varying policies and coding and staying informed on the latest policy updates for each unique patient's payment plan keeps mental and behavioral health practices a step ahead.

Create a Denial Management Process

Denials lead to decreased cash flow and additional costs incurred for practices.

According to a Healthcare Information and Management Systems Society survey, **76%** of healthcare leaders say that claim denials constitute the greatest challenge they face. Another study found that **9%** of hospital charges are denied initially - and a lack of clean claims leads to these denials.

In the mental and behavioral health space, there are additional challenges. Without a clean claims process upfront, denial management on the backend can become an overwhelming task.

Prevention is the best possible method, but denied claims are an inevitable part of even the most steadfast practice's clean claims routine. Even with a strong routine of registration, eligibility and verification of benefits that are in place to minimize claim rejections, practices need to be prepared to deal with the outliers that undoubtedly occur.

5 top tips to reduce denials include:

1. **Identify, analyze, and address common denial reasons**
2. **Review patient information**
3. **Determine prior authorization**
4. **Conduct quality checks on every claim before submission**
5. **Educate and train staff on billing practices**

Clean claims and denial management don't have to be difficult. Below are two resources to help improve mental and behavioral health provider revenue cycle management.

- Top Tips for Clean Claims
- Denial Management Guide

Ensure Patient Balance Follow Up and Payment

Many modern insurance plans require a portion of healthcare costs to be covered by the patients themselves. To complicate matters further, those receiving mental health care are much more likely to be seeing a provider out of network than other types of medical care.

A National Alliance on Mental Illness article found that about one in four respondents went out-of-network for a mental health prescriber or therapist, while only **one in 10** went out-of-network for a medical specialist

Patient payment is a particularly sensitive situation in the mental and behavioral health industry.

Patient Financial Challenges in the Mental and Behavioral Health Space:

- **Patients may be more sensitive to approach because of their mental state**
- **There may be monetary issues wrapped up into their reason for therapy**
- **Divided households cause confusion with financial responsibility**
- **General patient difficulty of understanding medical bills and determining what is owed and what is not**

Due to these challenges, creating a patient-centric, straightforward method for patients to provide their payments helps keep practices' cash flow healthy and patients paying in a way that works for them.

Top Tips for Encouraging Patient Payment in a Patient-Centric Manner:

- **Identify, analyze, and address common denial reasons**
  - Practices must take a special approach to patient collections and individualize patient outreach as much as possible. By individualizing outreach, providers can better understand and meet the needs of each patient and maximize their efforts.
- **Allow Convenient Payment Options**
  - Providing patients with as many convenient payment options as possible help make payment as stress-free and simple as possible. Offering payment methods such as cash, check and credit card are standard but providing a web payment system and other digital means is increasingly important in capturing open patient balances.
- **Offer Payment Plans**
  - Another valuable option for patients is offering payment plans and creating arrangements for patients to pay over time. Providing this flexibility is helpful, but a crucial piece of the success of payment plans is ensuring that the due diligence is done

Like much of the rest of the billing process, fully addressing and determining a payment plan during the registration process with information learned from benefit verification can set the proper expectations ahead of time.

Open communication about payment types prevents surprises for both patient and provider, and big potential loss on past due balances.

Get Ahead of Mental and Behavioral Health Billing Challenges

Mental and behavioral health billing has its roadblocks - but all roadblocks can be overcome.

NCDS Medical Billing offers services specific to mental and behavioral health practices. We can help you get the most out of your billing so you can focus on what's important - providing care for your patients.

Contact Us Today! to learn more about how we can help you overcome billing challenges and increase profitability