Psychological Assessment in Managed Care

Chris E. Stout

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Preface

IN THE MANY BOOKS ON the "how-tos" of dealing with managed care, little is written for the specialty of testing and assessment. Most of this book deals with testing, assessment, and systems from a psychologist's perspective. However, other assessment concerns within managed care inevitably cross into the domain of other practitioners—primary care physicians, researchers, administrators, evaluators (vis-à-vis outcome instruments), psychiatrists, social workers, and various other users of screening instruments, surveys, and expeditious data-collecting tools.

This book neither criticizes nor champions the impact managed care has had on behavioral healthcare practice. Instead, it focuses on various means and methods of using testing and assessment activities to improve one's practice within a managed care environment.

The book's approach is pragmatic and utilitarian. It is designed, written, and meant to be used as a tool for reference, planning, and marketing.

Practice and Instruction Shifts

My academic/clinical experience partially led to this work's existence. In my own clinical practice, I have found it increasingly difficult to be able to provide psychodiagnostic consulting and assessment services within the constrictions of third-party payments and fourth-party reviewer limitations or prohibitions. Colleagues whose practices were

more specialized and were solely based on assessment services had even more difficulties. I have been teaching objective assessment techniques to doctoral-level graduate students within an APA-approved program. My lectures on how to select testing instruments, as a basis for possible referral, were beginning to be amended to include a discussion of methods of gaining preapprovals, justifying test selections to fourth-party reviewers for approval, and other such new "technical" activities resulting from managed care's impact. Students' questions concerning reimbursement levels were historically answered with a statement of a range of a few hundred dollars, based on reasonable and customary charges. The only "complication" to this straightforward billing procedure would be the occasional co-pay. Today, I punctuate lectures with variations on the theme ". . . but, within a managed care environment, . . . ". There is certainly nothing wrong with this per se, but although it is a practical reality in most clinicians' practices, it is often ignored in graduate instruction.

The Merit of Testing?

These and similar circumstances led to the genesis of this book, irrespective of the "academic support" of the value and merit of projective psychological testing techniques argued by Piotrowski (1984) and, more recently, by Watkins and his coauthors, that ". . . [projectives] are here to stay . . . and their place in clinical assessment practice now seems as strong as, if not stronger than, ever" (Watkins, Campbell, Nieberding, & Hallmark, 1995, p. 59). Earlier critiques (Pruitt, Smith, Thelen, & Lubin, 1985; Thelen, Varble, & Johnson, 1968) cast doubt on the longevity of the projective testing within clinical psychology. The current applied clinical atmosphere does not bode well for such testing and makes studies on the utilization of psychological testing difficult to generalize to managed care settings, if not moot. Whether one "likes" managed care or not, it is a reality now and it is likely to penetrate practices further. This is not a book to rally the troops nor an attempt to collectively bargain for assessment. I have not written a guerrilla manual on how to "work the

system" of managed care. This is a broad-based but direct and realistic collection of means, methods, and ideas on how to work to maintain, if not expand, the utility and role of a variety of types of assessments in a managed care environment, in order to provide better care to patients while demonstrating psychology's key utility.

Overview

This book canvases the various areas of psychological testing and other forms of patient data collection within the context of managed care. Chapter 1 reviews the basics and the evolution of managed care, and Chapter 2 examines the role and function of family practice physicians, primary care physicians, internists, and general practitioners as "screeners" for psychopathology and identifiers of patients in need of testing services. Often, individuals will present to these medical practitioners with vague physical complaints that are actually secondary to or symptomatic of psychological disorders. To deliver the most efficient and effective level of care, medical generalists must have screening tools and psychological consultation. Psychologists must train them in the "how tos" of conveying findings to the patient and/or the family, and managing the referral most appropriately. Instruments that would be helpful to these ends are discussed.

Medical patient populations that tend to be the domain of specialists are discussed in Chapter 3, along with various strategies for providing differential diagnosis in biological cases; disorders that mimic psychological malingering cases; neuropsychological problems; and other new directions for testing psychologists.

Facilities have been impacted by managed care to a marked degree. Cost containment and large cutbacks within various treatment venues are paradoxically countered by the ever-increasing performance expectations of patients, regulatory and accrediting bodies, and payors. Meeting these increased demands requires forward thinking as to the various economies afforded by expeditious testing methodologies, technologies, and protocols. Chapter 4 discusses a

variety of models that offer cost savings while maintaining the goal of enhanced quality of clinical care.

Outcomes management is the focus of Chapter 5. The instrumentation and methodology considerations described include the psychologist's role in assessment of treatment outcome, treatment follow-up, patient satisfaction, and level of functioning. Chapter 6 reviews and explains various quality issues and reporting mechanisms such as the HEDIS Report Card, the JCAHO Report Card, the Baldrige National Quality Award standards developed for healthcare and other related areas, and how assessment can play a key role. Risk management, clinical liability, and the changing complexion of managing these areas within managed care cases are articulated in Chapter 7. Risks are increased and more complex within managed care. Various case precedents are provided, along with strategies for mitigating the risks.

Chapter 8 examines medical cost-offset issues, and provides statistics that are helpful in educating physicians, employers, and payors as to the merit, value, and cost savings afforded by application of psychological service to medical healthcare needs.

The book concludes with an in-depth look at automated systems for psychologists, who are now more mobile than they have been in the past. Telecommunications, accessibility, computer assistance, and cellular and other technologies help psychologists to provide better care and to manage their professional practice more efficiently. These technologies are continually improving even as they diminish in cost. This final chapter identifies some seeds from which enhancements and advancements may eventually grow.

I hope this book will be useful as psychologists adapt to changing circumstances. The goal is to provide various new ideas that will aid in attaining improved levels of clinical assessment and care while still maintaining high-quality practice standards and solidifying psychology's key role in healthcare.

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SECTION I

THE BRAVE NEW WORLD

CHAPTER 1

Where Managed Care Came From, and What It Means to Testing Psychologists

The Use of Psychological Tests

PSYCHOLOGICAL TESTING has long been an important and unique clinical application of psychology (Garfield, 1974; Goldenberg, 1973; Watson, 1953). The types and models of psychological assessment have not fundamentally changed over the past few decades (Sundberg, 1961; Watkins, Campbell, Nieberding, & Hallmark, 1995). The American Psychological Association's Clinical Division 12 (1993) views psychological testing activities as a key to defining clinical psychology. Piotrowski and his associates (Piotrowski & Keller, 1984; Piotrowski & Zalewiski, 1993) gathered strong evidence that psychological assessment, in its myriad forms, continues to be a prime component of graduate programs across the country. Watkins et al. (1995, p. 55) studied the contemporary private-practice activities of clinical psychologists and found:

- 90% conduct personality testing.
- 60% conduct intellectual assessment.
- 15% conduct vocational or career assessment.
- 13% conduct ability or aptitude testing.

Considering that the balance of their professional time must be spent on clinical psychology activities such as research, teaching, supervision, consultation, and administration, it is evident that personality

testing is second only to psychotherapy (96%) as an activity of practitioners. These findings apply across a variety of clinical settings—private practice, clinics, hospitals, and medical schools (Watkins et al., p. 58), and they highlight the importance and broad scope of psychological testing in clinical practice today.

The managed care reimbursement structures have had a marked impact on the prevalence of psychological testing. *Psychotherapy Finances*, a monthly newsletter devoted to practice aspects of behavioral healthcare providers, noted in a recent survey (Fee, Practice, and Managed Care Survey, 1995) that the number of psychologists who are providing testing services has now declined by approximately 10%. The decrease is likely amplified in an even greater decline in the testing evaluations conducted. This compounded result is of marked concern to psychology's role in behavioral healthcare.

Practice Impacts

Managed care has had a dramatic influence, both positive and negative, in the practice of behavioral healthcare. Clinicians, consultants, professional groups, and hospital administrators have argued against many managed care procedures. But, despite an initial dislike of managed care, it must be dealt with directly and proactively. Psychologists should work effectively within managed care for the best benefit of their patients while conducting their practice with the highest possible level of professionalism.

Managed Care's Evolution

HEALTH MAINTENANCE ORGANIZATIONS

Managed care, in its initial phases, was identified with health maintenance organizations (HMOs). This model provides enrollees with a variety of healthcare services, including behavioral healthcare, for a

set payment amount per month. Often, HMOs are regulated by state insurance commissions. The most common practice models within HMOs are:

- *Staff Model*

  Clinicians are paid employees of the HMO.

  Care is provided at clinic sites that are owned and operated by the HMO.

- *Group Model*

  Clinicians are in a large private practice—or an Independent Practice Association (IPA) or Group Practice without Walls (GPWW)—that has broad geographic coverage through its various offices.

  Clinicians are *not* HMO employees (contrary to the Staff Model).

  Office sites are owned and operated by practice owners, not by the HMO.

  In some instances, a degree of exclusivity is provided to large group practices that receive the majority of referrals ("anchor groups").

- *Network Model*

  Similar to the Group Model, but uses a number of smaller practices to service clients, instead of a few large, anchor groups or IPAs/GPWWs.

FIRST GENERATION OF MANAGED CARE—SERVICE LIMITATIONS

The first generation of managed care consisted of rather unsophisticated service reduction. Payors paid for fewer days in inpatient and residential facilities. In addition, there was a limitation on the number of outpatient sessions. Psychological assessment was also limited. Frequently, psychological testing or assessment was simply not covered by a patient's insurance agreement. Along with service reduction, there was a reduction of the fees paid.

Psychologists' Payment Dilemmas

Testing psychologists found themselves in a variety of dilemmas with managed care cases. In some instances, regardless of what test was administered in the battery, they would be paid a flat fee. However, some managed care companies would pay for only certain types of tests; other companies would not pay at all. If a utilization reviewer or case manager felt that psychological testing was not indicated (even if testing was a covered benefit), then testing would not be approved, even after it had been ordered by the doctor in charge of the case. A variety of payment schemes have been effected, other than limiting the amount paid for a full battery or for select tests. Psychological testing within the managed care environment is sometimes paid for, at a reduced hourly rate, for an unlimited number of hours.

Payment Examples

The most frequent methods of pricing and payment are:

- *Flat Rate* (or *Fee for Battery*). A testing battery is paid for, if approved within a policy's benefit structure, at a total set fee, regardless of the number and types of tests administered or the amount of time taken. There is usually an implicit (if not explicit) minimum expectation of an intelligence test, an objective personality measure, and an interview or screening device or two. Fee rates may range from $250 to $500, depending on the payor, the geographic region, and the minimal tests included.
- *Fee-for-Test.* Reimbursement is based on a predetermined selection of approved tests at approved fees. Usually, there is no option to bill for the additional time involved in interpretation or in writing the report. Thus, if an examiner wishes to administer the Wexler Adult Intelligence Test-Revised (WAIS-R) and Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2), and conduct a clinical interview (presuming all are approved), payment would be based on the total of the sum of each test's predetermined reimbursement level. Thus, if the managed care organization reimburses

$75.00 for WAIS-R, $50.00 for MMPI-2, and $100.00 for a clinical interview, the battery would yield $225.00.

- *Fee-for-Service.* Reimbursement is based on an hourly rate. For example, if 5 hours are billed for administration and scoring, the 5 hours are multiplied by the customary managed care rate for testing (usually, $70 per hour) to yield the total fee allowed (i.e., $350).

  Some plans may limit the total hours per battery (or per testing episode), even though testing may take longer. Other plans may not limit hours but may require preapproval and may possibly dictate which tests to be administered. (The preapproval process of the flat rate is similar; see below.)

  More generous plans may pay for the time it takes to write the report. Examiners must be aware of a possible requirement for using different Current Procedural Terminology (CPT) coding in such instances (e.g., CPT 90887: Results Interpretation, or CPT 90889: Preparation of Report). When examiners bill for their services, it is very important to use the appropriate CPT code to avoid any risk of nonpayment or any question of insurance fraud. (Such risks are discussed in detail in Chapter 7.)
- *Inclusive/Per Diem/Capitated Rate.* Arrangements with facilities, group practices, or other types of provider entities may contract for a variety of services "bundled" together. If psychological testing is part of that bundle, it is unlikely that any "independent contractor" examiner would be referred to the case. These arrangements typically occur within hospitals or other systems of care. A staff psychologist who is on salary (or retainer, or some other similar employment arrangement) conducts the referred testing and bills no one. There is usually no preapproval or regulation/restriction as to test selection or battery composition. Such choices are within the discretion and clinical judgment of the assessor.

Summaries of Payment Models

Table 1.1 offers a comparative analysis of the various reimbursement models for psychological assessment under the current managed care options.

TABLE 1.1
A Sample Comparison of "Standard" Testing Battery Reimbursement Models

	Flat Rate Test/Activities Included		Fee for Test Test/Activities Included		Fee for Service* Test/Activities Included		Capitated Test/Activities Included	
Battery Components	Yes	Amount	Yes	Amount	Yes	Amount	Yes	Amount
Clinical interview	✓	N/A	✓	$ 75	✓	$ 70	✓	$0
Bender gestalt	✓	N/A			✓	20	✓	0
WAIS-R	✓	N/A	✓	75	✓	100	✓	0
MMPI-2	✓	N/A	✓	50	✓	50	✓	0
TAT	✓	N/A			✓	50	✓	0
Rorschach	✓	N/A					✓	0
Aphasia screen	✓	N/A			✓	25	✓	0
Score/Interpretation	✓	N/A					✓	0
Report write-up	✓	N/A					✓	0
Total paid		$300		$225		$315		$0**

* Amount based on fraction of $70/hour.
** Psychologist is paid per member, per month (PMPM), not per discrete clinical activity.

Concerns Involving Payment Decision Makers

This author attended a managed care conference in which a psychiatrist, who was a medical director of a managed care company, stated, "The day that I see a scientific research study that indicates that the Rorschach is a valid and a reliable tool for assessing an individual's level of psychopathology is the day that I will pay for one." This statement highlights several unreconciled issues:

1. Individuals without training in psychological testing, psychometric procedures, or statistical analysis may make determinations as to what type of testing is or is not appropriate.
2. There is definitely a consistent bias within the managed care industry toward objective tests and away from projective types of tests.
3. Broadly, psychology needs to demonstrate (from both psychometric and fiscal perspectives) the merit of such assessment in improving the quality of care and clinical efficiency, and adding cost-effective value. More specifically, it is incumbent on testing psychologists to structure a test battery that best