Pavillon

A Center for the Treatment of
Alcoholism and other Drug Addictions

In order to appropriately address any issue concerning the cost and reimbursement of the type of care a patient would receive at a substance abuse treatment facility such as Pavillon, it may be beneficial for legislators to know about the care that Pavillon provides. Pavillon is a residential and outpatient provider of treatment for substance use disorders. The residential program located in Mill Spring, North Carolina, offers treatment for adults 18 and older who are in need of treatment for alcohol and other drug addictions, and other related disorders.

Pavillon provides comprehensive, individualized treatment of addiction (alcoholism, drug abuse and other addictive disorders) and its related medical, psychological, psychiatric, spiritual and related problems. Pavillon's treatment model centers on the 12 step recovery process, motivational enhancement and cognitive behavioral interventions. Our mission is to promote healing and recovery to individuals and families who suffer from this disease.

Pavillon offers both hospital-based and non-hospital based medical detoxification, as well as our Primary Treatment program. Our Medical Director is board-certified in Internal Medicine and is also an ASAM and ABAM diplomate. We offer 24-hour, 7-day a week nursing care. We are a dual-diagnosis facility, capable of treating both substance and mental health disorders with our highly trained medical, psychiatric, psychological, counseling and spiritual staff. Pavillon offers a comprehensive series of therapeutic activities, including, but not limited to individual and group therapy, individualized treatment and continuing care planning, Openness Groups and Honesty Groups, art and equine therapy, and training in alternative relaxation techniques, such as yoga and tai chi.

Being very invested in the concept of whole-family treatment, Pavillon offers a quality Family Program and Children's Program to provide education and support for family members affected by addiction. We also offer Intensive Outpatient services and an Extended Care program for professionals.

Pavillon is situated on a beautiful 140-acre campus in the Western North Carolina foothills, with large semi-private rooms (with bath) overlooking our waterfall and lake. We have a walking trail and a fully equipped fitness room. We offer chef-prepared meals in a large dining room with an adjoining patio area.

Pavillon's interest in the well-being of our patients is not just limited to a patient's time in treatment. We also provide follow-up with patients at one, three, six, nine and twelve month intervals to determine if the patient is still abstaining from substance usage. Pavillon alumni meet together in Alumni Support Groups and Aftercare sessions.

Through all of our programs and services, the underlying theme is continuum of care, for our patients and for their families.

The following pages are the comments I have asked Betsy L. Beach, Insurance and Medical Records Coordinator to submit on Pavillon's behalf.

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The comments below are from Betsy L. Beach, Insurance and Medical Records Coordinator at Pavillon, located in Mill Spring, NC. Betsy holds a BA in Economics, is certified as a JCAHO accredited coding/billing specialist and has been with Pavillon three years. Betsy describes many of the flaws in the current system of providing insurance coverage for care of those recovering from substance abuse and mental health issues.

- Behavioral health medical necessity guidelines for mental health and substance abuse DO vary from plan to plan dependent upon the behavioral health entity that conducts the pre-authorizations and utilization reviews for the plan. For example, one major behavioral health entity considers partial hospitalization a higher level of care than residential treatment, whereas ALL of the other behavioral health entities that Pavillon works with consider partial a lower level of care than residential. New legislation should bring ALL behavioral health entities in sync with each other in terms of how the levels of care within behavioral health are viewed.

  Additionally, behavioral health entities vary with the utilization of AXIS versus ASAM criteria. Uniformity is certainly needed among these entities.

- Medical necessity criteria as it exists currently, actually discriminates against the somewhat healthy patient who recognizes that s/he has a problem, and who acts responsibly and seeks treatment immediately. Unless the patient has failed at a lower level of care, had something other than outpatient providers, or had suicidal or homicidal ideation or has some type of co-morbidity issue or any combination of the aforementioned, this patient likely will not qualify for any behavioral health authorization or any potential insurance reimbursement. The sad truth of the behavioral health care system today is that the sicker the patient, the better chance the patient has of authorization and insurance reimbursement. This needs to change in order to give each patient the care needed at a given time – perhaps this given time is early in addiction before s/he has had a serious auto accident, a bad fall or even hurt someone else.

- In behavioral health, progress and change is a slower process than hospital stay progress. And yet behavioral health care entities' Care Managers conducting pre-authorizations and utilization reviews often authorize in two and three day increments, and if SIGNIFICANT change does not occur within that time frame, continuing authorization is usually denied. Patients dealing with behavioral health issues are thus again discriminated against when the entire healing process is a very different one from a hospital stay healing progress.

- In behavioral health today, it is as though Care Managers look for any reason they can find to deny authorization, rather than focusing on the positive progress a patient is making. Utilization reviews thus become a time of presenting as bleak a picture of patient progress as possible to ensure continuing authorization of treatment for the patient. Behavioral health entities should view patient progress more positively. It's as though patients are penalized for making clinical progress in terms of behavioral health issues and this should not be.

- When a patient presents to a medical doctor, they can pay their co-payment amount and be quite assured that their insurance will take care of the rest. In mental health and substance abuse treatment the patient really has no idea what, if anything, their insurance will pay, due to the entire medical necessity structure. Disclaimers routinely quoted by benefits personnel include a statement like "Verification of benefits does not guarantee claim payment. Payment will be determined when the claim is received for processing." If a patient indeed has a behavioral health benefit on their insurance plan, they should NOT have to be subjected to additional worry and concern over whether or not they will receive any financial assistance from their insurance plan. The issues which have prompted their entry into treatment are significant cause for worry and concern and should not be compounded by behavioral health being considered the "red-headed step-child" benefit on an insurance plan. Additionally, a patient's potential insurance reimbursement for behavioral health should not be adversely affected by rigid medical necessity guidelines which "punish" a patient for healing and being healthier.

- Many insurance policies' limitations on the types of facilities covered and the kinds of clinicians who are allowed to provide treatment often serve to limit a person's ability to access mental health and substance abuse treatment.

- It is very common to see mental health and substance abuse benefits with a day-limit per calendar year, or a low-dollar benefit period and/or lifetime maximum. There are often excessive deductible and out-of-pocket amounts that may further prohibit a person from pursuing treatment for these disorders. In addition, "allowed amounts" or "usual and customary rates" upon which benefit payment is based are often significantly lower than the industry standard, making the patient's responsibility much greater.

- Parity needs to be imposed even within specific levels of care and their respective medical necessity criteria. For example, persons who admit with cocaine dependence are routinely denied inpatient detoxification services due to the fact that withdrawal from this substances does not pose the physical risk associated with other drugs and withdrawal. As one Care Manager recently put it, "They're not going to die from withdrawal; they just feel like they are."

- Mental health and substance abuse providers are often caught between two evils when it comes to being either in-network with an insurance plan, or out-of-network. Many times a lack of any type of out-of-network benefit acts to prevent patients from seeking providers of specialized services who may not even exist within the confines of their in-network providers. Out-of-network providers suffer a SIGNIFICANT decrease in co-insurance percentages, and oftentimes are subjected to higher deductible and out-of-pocket amounts. While the reasons a provider may choose to either be in-network or out-of-network vary, oftentimes the right to determine a provider's fee for service, and the right to collect the balance of that fee over and above what insurance pays figure in to the decision. In-network providers suffer as well, as they are told what they can charge, and are denied the right to balance-bill the patient. Additionally, insurance companies can, and do, change the rate for what is considered "usual and customary" and in-network providers have no say in the matter. Additionally, there is one major insurance plan in this country that is known to "punish" out-of-network providers by refusing to send any claim payment, under any circumstance, to an out-of-network provider.

- There are alternative accreditations for mental health and substance abuse providers (for example, CARF accreditation for substance abuse treatment facilities), different from, for example, the JCAHO accreditations that many hospitals have. These alternative accreditations are comparable accreditations for the specialty being practiced. However, not being JCAHO accredited has occasionally been the reason given for not authorizing behavioral health treatment. This needs to be addressed and corrected.

- It is important that parity extend to all levels of care, including detoxification, inpatient rehabilitation, residential, partial hospitalization, intensive outpatient, etc.

- Parity should extend to court-ordered mental health and substance abuse treatment if medical necessity criteria are met.

- The federal government should create a website, toll-free telephone number, and outreach campaign to educate consumers about the new parity law and record and promptly correct any problems consumers may have in accessing services.

- In reading about the upcoming parity legislation, I realize that small employers are exempt from providing this parity of coverage for mental health and substance abuse. However, considering the fact that prescriptions for mental health conditions are the number one selling non-generic medications in the US today (3-30-09 Forbes Magazine), and according to the National Institute of Mental Health, an estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder, perhaps small employers should be encouraged to think carefully about providing mental health/substance abuse parity for their employees.