

Working Paper:
Insurance Companies Need to Authorize and Pay for Longer Therapy Sessions
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The Advocacy Committee of the Massachusetts Psychological Association is calling for health insurance companies *to pay a higher rate for longer sessions than they pay for shorter sessions for the treatment of behavioral health disorders whenever clinical considerations justify the use of longer sessions*. This change in insurance companies' practices would remove a major barrier to the provision of effective medically necessary behavioral health treatment to people in Massachusetts.

The Center for Medicare Services (CMS) and insurance companies utilize a standard coding system for billing for medical and behavioral health conditions. This system allows for behavioral health treatment sessions covering a variety of session lengths. Medicare leaves it to the clinician's discretion to choose the session length that meets the client's needs, regardless of whether it is for 30, 45, or 60 minutes. With appropriate documentation, Medicare regulations also allow prolonged sessions lasting 90 minutes or more.

However, many insurance companies, including prominent companies that insure large numbers of people in Massachusetts, have designated 30 and 45 minutes as the standard session lengths for routine behavioral health services, even though clinical circumstances and research findings often dictate that treatment be delivered in longer sessions. Unlike Medicare, which reimburses providers for longer sessions, these insurers maintain policies that tightly restrict payment for longer sessions or eliminate payment for them entirely. When insurance companies restrict payment in this fashion they are blocking subscribers' access to clinically and medically necessary treatment.

The purpose of this paper is to provide information in support of realigning the payment practices of insurance companies so that they square with the treatment needs of individuals with behavioral health problems. Providers should be allowed to utilize longer sessions when warranted and receive adequate payment for devoting the time amounts that are actually needed for the delivery of medically necessary behavioral health treatment. Providers and insurers alike should have as their highest priority ensuring that enrollees have access to effective and medically necessary treatment. Current insurance company practices, however, often prevent this and need to change if access to effective medically necessary treatment is to occur.

One might argue that practices that prevent or tightly restrict the authorization of longer sessions are justified because of the need to constrain health care costs. However, given that the amount of money that is devoted to outpatient mental health treatment represents but a small fraction of overall medical spending in the United States, there is no justification for behavioral health treatment to be a target

of cost-cutting efforts that are deleterious to behavioral health clients by depriving them of access to effective treatment.

In this paper, we will first offer background information to explain how standard codes govern Medicare and insurance companies' authorization and billing practices. We will then describe the ways in which insurance companies, in contrast to Medicare, have placed barriers in the way of providers' use of sessions longer than 45 minutes for behavioral health treatment. We will then explain why *a significant change in insurers' practices is needed* by addressing two key points. The first point is that cheaper services are not necessarily effective services. The second point is that a wide variety of treatment modalities and circumstances for behavioral health disorders require treatment sessions that exceed 45 minutes in length and therefore, practices that limit insurance enrollees' access to longer sessions are contrary to sound clinical judgment and research findings and deprive consumers of medically necessary treatment. Specifically, we will present the rationale for longer sessions for:

- CBT and Exposure Therapy
- EMDR and other Trauma Therapies
- Collateral work with families
- Psychodynamic Psychotherapy
- Other circumstances reported by Massachusetts Psychological Association members.

Background

In January, 2013, Medicare and the insurance industry started using the American Medical Association's revised Current Procedural Terminology (CPT) codes for documenting and billing behavioral health assessment and intervention services. For individual psychotherapy, the codes covered 30, 45, and 60 minute sessions.

Because clinicians complained that the CPT manual failed to take into account the need for longer sessions, the code system was amended to account for 90 minute and longer sessions, by introducing an add-on code that can be used to document additional time blocks of 30 minutes. Periods are operationally defined as ranges of time. For example, the code 90834 for 45 minutes of individual psychotherapy applies to services lasting between 38 and 52 minutes.

Medicare regulations list codes for 30, 45, and 60 minutes and leave it to the behavioral health clinician to choose the session duration that best meets the client's needs. Medicare also allows for prolonged sessions such as 90 minutes with appropriate documentation of need in the client's record. As would be expected, Medicare pays a higher rate for longer sessions, commensurate with the longer session duration, with no prior authorization requirement. Some insurance companies, such as Optum/United Behavioral Health do pay for 60 minute sessions but require prior authorization for the longer sessions and largely restrict their use to a limited set of treatments and diagnoses.

Blue Cross/Blue Shield of Massachusetts doesn't pay at all for a 60 minute session and will reject claims using the CPT code 90837. Both Aetna Insurance and the Tufts Health Plan allow payment for a 60 minute session, but pays the same amount for a 60 minute session as for a 45 minute session, essentially penalizing providers who work with clients for a longer time period.

These policies need to change because insurance companies' practices dictate the length of sessions. Behavioral health treatment in the United States is largely delivered and paid for through an insurance-based system. Most people in the United States expect that insurance will cover behavioral health treatment and lack the resources to pay out of pocket for these services. For this reason, as a matter of necessity, most providers affiliate with one or more insurance companies and/or Medicare.

When a provider agrees to join an insurance panel's network, in the vast majority of cases, he or she is obligated to accept the insurance company's allowed amount as payment in full for the service. When an insurance company refuses to cover a type of service or limits payment, the provider has no practical or legal alternative to receive proper compensation and the insurance enrollee has no alternative way of obtaining the service. Although the client or clinician can appeal to the Massachusetts Office for Patient Protection, this procedure would be too cumbersome and time-consuming to use on a routine basis to counteract an insurance company's practice of denying or inadequately paying for longer sessions.

Cheaper Services are Not Necessarily Efficacious Services

The Medicaid program in Virginia recently altered its payment policies to reimburse behavioral health clinicians for 60-minute sessions. The Virginia Medicaid officials made this change in response to evidence that the 60-minute time period reflects the duration of treatment in many research studies involving randomized control trials, especially for anxiety disorders. The clinicians pointed out that choosing not to pay for 60 minute sessions and limiting payment to shorter sessions actually equates to refusing to cover treatment that has been demonstrated to be effective, while covering treatment with unclear or no demonstrated efficacy.

There are clear analogs in medicine and elsewhere that illustrate this point, e.g., a 2-day supply of antibiotics is cheaper than the standard 10-day supply, but we use the longer duration of treatment because of the scientific evidence that it's necessary and effective to do so. Likewise, chocolate is cheaper than any pharmacological treatment for psychiatric disorders, and may make people feel better briefly (especially when they like chocolate), but no one prescribes that as a treatment nor would insurance companies pay for it just because it's cheaper and temporarily makes someone feel a little better.

Review of Treatment Modalities and Circumstances That Require Longer Sessions

Cognitive Behavior Therapy (CBT) and Exposure Therapy

There is a broad clinical consensus that for a wide variety of presenting problems involving anxiety symptoms, some form of exposure to feared or emotionally upsetting stimuli is a key mechanism for treating behavioral health conditions.

For example, the American Academy of Child and Adolescent Psychiatry's Practice Parameters for the Treatment of Anxiety Disorders in Children and Adolescents (American Academy of Child and Adolescent Psychiatry, 2007) recommends the use of psychotherapy for treating anxiety disorders in this age group and notes "that exposure-based CBT has received the most empirical support for the treatment of anxiety disorders in youths(p.272)."

Exposure based therapies may combine a variety of different types of exposure such as in vivo exposure, imaginal exposure, and interoceptive exposure. Since the purpose of exposure treatment is to induce habituation to disturbing stimuli, multiple exposures are required before the desired outcome can occur. Premature cessation of a treatment session, before habituation has occurred, will actually reinforce withdrawal from the disturbing stimulus and perpetuate phobic symptoms. Thus, shorter sessions can actually be counter-productive and harmful to clients.

Not surprisingly, research has shown that for cognitive-behavioral treatment, sufficiency of treatment length is a critical "dosage" factor in treatment outcome. For example, a meta-analysis of studies of treatment for OCD conducted by Abramowitz and published in *Behavior Therapy* in 1996 found that "Length of sessions was the only variable that correlated significantly with effect sizes on measures of OCD. This relationship was found at both posttest, and at follow-up. Reductions in OCD symptoms were larger when individual therapy sessions lasted longer."

Exposure based therapy is indicated for many types of anxiety disorders and OCD. Therefore, it would be contrary to the delivery of clinically appropriate treatment for clients to face barriers to longer sessions for treatment of these disorders. UBH/Optum's guidelines for prior authorization of one-hour sessions, posted on their website, states that longer sessions may be approved for routine treatment when a member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder or Obsessive Compulsive Disorder and is being treated with Prolonged Exposure Therapy. However, other types of anxiety disorder are excluded from this.

For example, an individual who started experiencing severe anxiety symptoms during the first month following a mass incident such as the Marathon bombing or the Newtown shooting would not meet this guideline because Acute Stress Disorder (the category that covers traumatic reactions to events that occurred within the last month) is not included.

Other anxiety disorders for which exposure is the treatment of choice, such as simple phobia, agoraphobia, and social phobia, are also excluded, as a psychologist who is an MPA member recently found out. A UBH/Optum enrollee sought help from her for a blood/injection phobia. Because the client experienced intense physiological arousal symptoms in the presence of medical treatment, he had avoided seeing his PCP for 5 years.

The psychologist saw the man for two sessions. The first session included introductory psychoeducation, practicing muscle tension (crossed legs, clenching muscles, short/shallow breathing), CBT with imagery/exposure therapy and assignment of homework. The second session, which lasted one hour, consisted of exposure to tying his arm, simulated insertion of needle sticks, looking at phlebotomy pictures, and counteracting vasovagal responses bodily, all the day before his doctor's appointment. The man subsequently reported that as a result of these two sessions, he was able to overcome his phobia and participate, free of anxiety symptoms, in the medical appointment. However, the psychologist was not paid for the additional session time beyond 45 minutes. The psychologist went through several levels of time-consuming telephone conversations and appeals, which should have been unnecessary, to no avail.

These examples show that when bureaucratic guidelines narrowly define when extended sessions are permissible, invariably some individuals with behavioral health conditions will be left on the outside, unable to access medically necessary treatment. It should be noted that even though the UBH/Optum guidelines offer a little bit of room for exceptions on a case-by-case basis, in practice, clinicians cannot count on the people who interpret these guidelines to authorize medically necessary treatment and in any event, the time involved in making appeals is burdensome to the clinicians.

With regard to the length of exposure sessions, the implementation of the exposure activities often necessitates that the clinician spend time addressing client's anxiety and resistance to trying them. Working with this resistance is an integral part of treatment since a key component of the symptomatic presentation of anxiety disorders, as noted in operational definitions in the DSM and elsewhere, is habitual withdrawal from and avoidance of feared stimuli. Therefore, in addition to the actual exposure activities, therapists often need to devote time during sessions to working with the client to counter his/her well-developed tendency to withdraw and avoid these stimuli.

Financial considerations actually support allowing coverage of lengthier sessions so that enrollees can receive treatments for anxiety disorders and P.T.S.D. that have demonstrated efficacy. While inferior or ineffective treatments can be provided with lower costs per visit, the outcomes are likely to be poorer for patients who receive them, and medical costs are likely to be higher. For example, well-designed, controlled studies conducted by Marciniak, Lage and colleagues, published in 2004

and 2005 in the journal *Depression and Anxiety*, have found that anxiety disorders are associated with significantly higher non-psychiatric medical expenditures. Combined, anxiety disorders have been found to increase medical costs by an average of \$1,555 per person in Health Maintenance Organizations compared with people who do not have anxiety disorders; and PTSD is associated with an increase of \$3,940 per person.

Trauma Therapies, including EMDR

Trauma-based disorders are an important category of behavioral health disorders in which multiple symptoms of anxiety is often accompanied by other types of symptoms. Similar to other anxiety disorders, treatment often requires exposure to emotionally distressing stimuli. Work with children and adolescents who have experienced trauma generally requires sessions of up to 90 minutes because of the exposure work and the need for collateral work with parents. For example, in work with children and adolescents who have experienced trauma and grief, Judith Cohen and colleagues (Cohen, Mannarino, and Deblinger, 2006) outline in their book *Treating Trauma and Grief in Children and Adolescents*, an evidence-based cognitive behavioral therapy that requires 90 minute sessions to implement. In addition to work with the child or adolescent, Cohen spells out procedures for work with family members to help the young person in their family to grieve in a healthy fashion.

Eye Movement Desensitization and Reprocessing (EMDR) is a therapy that was developed to treat trauma. This therapy is designed to be delivered in 90 minutes sessions, because it 1) must be carried out carefully with vulnerable people who are prone to emotional dysregulation; 2) includes prolonged exposure to disturbing memories of past experiences and reprocessing of those memories; 3) includes working with the client to develop co-regulation and self-soothing through the therapeutic relationship and through techniques such as “resource development” visualization; and 4) requires that time be devoted to transferring emotional and cognitive changes experienced in relation to past memories forward to support coping with present day and future challenges.

Dozens of research studies have demonstrated the efficacy of EMDR therapy for treating post-traumatic stress disorder (for a recent listing of research studies and international treatment guideline endorsing EMDR, see Shapiro, 2012). For this reason, UBH allows for prior authorization of between 12 and 25 60 minute sessions for EMDR treatment of PTSD.

In this regard, UBH is ahead of other insurance companies that will not pay (or pay more than what they pay for 45 minutes) for longer sessions for PTSD treatment. However, trauma, the painful behavioral health impairing experience that EMDR is indicated for, is not synonymous with PTSD, which is a very narrowly defined syndrome.

The operational definition of PTSD in the DSM-IV includes the requirement that “the person has been exposed to a traumatic event in which...the person

experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.” The DSM-V (which corresponds to the ICD-10 CM) similarly requires “exposure to actual or threatened death, serious injury, or sexual violence”.

When people present with behavioral health disorders and impaired every day functioning, and careful history taking and other assessment techniques indicates that the person experienced traumatic events that were not life threatening, such as prolonged emotional abuse and denigration by a parent when she was a child, and the therapist identifies a connection between the trauma and present day difficulties, behavioral health providers trained in EMDR view this modality as a treatment approach of choice. Their reasoning is that the mechanisms of etiology, the types of symptoms, and the cognitive and emotional processes observed are very similar to those observed in people with PTSD. In order for these clinicians’ clients to receive and benefit from the treatment that the clinician’s clinical judgment and training deems most appropriate, providers need to be able to get compensated for the lengthier sessions that this treatment modality requires. Treatment in these cases must not be constrained by overly narrow reimbursement criteria tied to the narrow PTSD definition.

Collateral Work with Families

In many circumstances, for example, when the client receiving treatment is a child, adolescent, or individual with disabilities, the therapist needs to take additional time to work with family members. This results in the need for lengthier sessions. For example, the American Academy of Child and Adolescent Psychiatry’s Practice Parameters for the Treatment of Anxiety Disorders in Children and Adolescents (AACAP, 2007) recommends as a “clinical guideline” the use of collateral work with family members as a clinical guideline for treating pediatric anxiety disorders.

One of our MPA members described the time consuming, multi-modal nature of this work, including the family component, telegraphically, as follows:

“Exposure work with kids and teens with severely impairing OCD, selective mutism, school refusal, emetophobia, phobias of sounds and weather, other phobias, panic disorder with agoraphobia and anxiety disorders. Educating them about the disorder and CBT exposure treatment. Creating exposure hierarchies. Coaching their parents and schools in helping them climb the Bravery Ladder. Doing exposures in the office and in the building and neighborhood. Could not possibly get this done on 45 minute visits.”

Longer sessions are also needed when the clinician is working with children in a high conflict divorce situation. As one psychologist described the nature of the therapeutic work and concomitant time requirements, “you are working with kids caught in the middle and you have to meet with a parent in conjunction with working with a child around these issues. I meet with the child and then often with

the parents - and it gets even longer when the parents won't come into the room with each other.”

Psychodynamic Psychotherapy

A 2010 review article in *American Psychologist* (Shedlove, 2010) summarized evidence for the efficacy of psychodynamic psychotherapy and found, derived from several meta-analyses, positive outcomes from this type of therapy. The effect sizes are of a magnitude that is generally considered to be in the “large” range, including pre- and post- treatment comparisons and measures of long-term improvement. According to one of the leading researchers in this area, Allan Abbass (personal communication, 12/26/13), since these results are based, for the most part, on 60 minute sessions, they provide evidence for the efficacy of psychodynamic approaches to behavioral health treatment, when delivered in 60 minute sessions.

There is also further evidence, as summarized by Dr. Abbass, that psychodynamic treatments, including those under 40 sessions, are effective in complex cases with personality disorders and depression: in these settings treatment sessions are often extended beyond the typical one hour to accommodate this complexity.

Psychodynamic treatment trials of therapy, extending up to 3 hours in a single session at the start of therapy, have their own treatment effects and appear superior to standard assessments. There is extensive and growing evidence of cost offset of these brief treatments generally and also when applied to populations with high rates of disability.

These research findings now present overwhelming evidence that psychodynamic psychotherapy is as effective as cognitive behavioral therapy and maybe more broadly applied. In order to align coverage and reimbursement practices with research findings, insurance companies need to allow and reimburse providers appropriately for 60 minute sessions and extended sessions when warranted for complex populations.

Other Circumstances that Necessitate Longer Sessions

Members of MPA have brought to our attention a number of situations, modalities, and circumstances, in which longer sessions are clinically indicated.

Treatment of Depression in Children and Adolescents: The well-researched Taking ACTION program for treatment of child and adolescent depression (Stark, Schnoebelen, Simpson, Hargrave, & Glen, 2007; Stark, Streusand, Krumholz, & Patel, 2010) is designed to be delivered in 90 minute sessions. Evidence for the program’s efficacy is based on 90 minutes sessions.

Presentation and Discussion of Test Results: Often families will travel some distance for psychological or neuropsychological testing, and cannot attend multiple sessions for reviewing and discussing test results with the clinician who did the assessment. Often, at least an hour is needed to review test findings and recommendations with

a family and address their questions. It would cost the insurance company less if the clinician billed for one 60-minute session as opposed to two 45-minute sessions

Dialectical Behavioral Therapy: This CBT procedure, which includes behavioral rehearsal and practice for transfer of skills outside the session, is designed for 90 minute sessions. This is true of the adult treatment program developed by Marsha Linehan and the modified treatment protocol for adolescents developed by Jill Rathus and Alex Miller (Wagner, Rathus, & Miller, 2006). Studies that document the efficacy of DBT are based on 90-minute sessions.

Therapy for People with Disabilities: For example, therapeutic work with clients with expressive language difficulties and very slow processing speeds requires extra session time.

Behavioral and Multi-Modal Child and Adolescent Therapy: Parent-Child Interaction Therapy (PCIT; McNeil & Hembree-Kigin, 2010), the well-researched behavioral treatment program for young children with externalizing behavior problems, was designed for sessions of one to two hours in length. Some research studies demonstrating the effectiveness of PCIT relied on one hour sessions. There is no evidence for the effectiveness of PCIT when delivered in 45-minute sessions.

According to the American Academy of Child and Adolescent Psychiatry, (AACAP, 2007, p.) “Child-focused CBT is not effective for all children with anxiety disorders, and about 20% to 50% may continue to meet criteria for an anxiety disorder after treatment (Barrett et al., 1996; Kendall, 1994; Kendall et al., 1997)... (Therefore), given limitations in the translation of CBT to community practice, a broad array of psychosocial interventions and multimodal treatments need to be flexibly considered so that individual children and families receive the most comprehensive treatment available to them. (p. 274)”

Family therapy in high conflict situations: “The more people in the room, the more time that may be needed, especially earlier sessions when you often open up issues and get emotion aroused. Often more time is needed to explore each person's views and then bring the emotional level down so people can leave with some calm and hope.”

Conclusion

In conclusion, there are a large variety of circumstances in which proper, effective, medically necessary outpatient treatment for behavioral health disorders requires sessions longer than 45 minutes. For people to have access to these treatments, insurers need to pay for them. Since behavioral health treatment addresses complex disorders of emotional and behavioral processes, clinicians also need to have the flexibility to utilize longer sessions when clinical circumstances call for it. Such practices as restricting payment to briefer sessions, restricting authorization for longer sessions to a narrow set of diagnoses or circumstances, allowing longer sessions but paying for them at the same rate as shorter sessions, and imposing

cumbersome, time-consuming, and vague authorization requirements, pose unreasonable and crippling barriers to treatment. Since insurers are the gatekeepers for behavioral health treatment for the vast majority of Americans, an end to these practices would unblock access to necessary behavioral health treatment for large numbers of people.

Insurance companies cite “evidence basis” for restricting longer sessions, using this justification to limit clinicians’ options for treatment. As we have demonstrated, most of the evidence for the efficacy of behavioral health treatments comes from research studies that utilized sessions of one hour or longer. For many conditions, there is little or no evidence that shorter sessions are beneficial.

Massachusetts Psychological Association members have found, moreover, that whenever insurers impose a limitation on the diagnosis or circumstances in which longer sessions can be used, many people who need treatment are excluded. This is highlighted in the example of an insurance company that authorizes payment for the treatment of people with panic disorders through longer sessions but will only pay for a 45 minute session to treat a person with simple phobia, even though both disorders require the same extended length treatment.

Instead of placing excessively tight restrictions on access to longer sessions, insurers should apply more expansive criteria that allow for clinical judgment. Even in circumstances in which research evidence is thin, behavioral health clinicians should be allowed to use clinical judgment in utilizing procedures that have shown efficacy with one population when they are working with a case that has similar, but not identical characteristics.

Research protocols, by necessity, require narrow limits to specifying the population under investigation. Clinical practitioners, by necessity, need to be able to be more expansive in adapting treatments that have shown efficacy in research studies involving a narrowly defined population to the exigencies of real life circumstances that may not exactly fit the research paradigm. This is true of behavioral healthcare no less than it is true of medical treatment. Such flexibility, therefore, should be allowed as long as research findings do not contraindicate the use of a particular treatment modality or procedure.

None of this is intended to dismiss insurers’ reasonable concerns for financial responsibility or concern that appropriate treatments are delivered. If 45-minute sessions (officially representing a range of between 38 and 53 minutes) and the level of payment associated with them are to be considered the “standard” session length and payment, we accept that clinicians may be required to provide a justification and/or documentation of the reason for longer sessions. However, we insist that any procedures for the approval of such sessions must not be time consuming or pose an undue burden to the providers.

The reimbursement rates that insurance companies pay psychologists do not take into account their expenditure of large amounts of time filling out documentation, participating in phone queues, and/or making appeals to insurance company representatives or to the Massachusetts Office of Patient Protection. These requirements have the effect of blocking individuals' access to treatment, in keeping with the well-known behavioral principle of "response for effort", in which the imposition of laborious task requirements suppresses the occurrence of a behavior. Therefore, we expect that any requirement for documentation and justification will be reasonable and governed by the minimum time and effort necessary to accomplish its purpose.

In summary, the Massachusetts Psychological Association Advocacy Committee has written this paper to bring to the attention of practitioners, insurers, legislators, and state regulators the need for changes in insurance companies' practices to allow individuals with behavioral health disorders to receive treatment in sessions longer than 45 minutes, when dictated by clinical circumstances. Specifically, we are calling for the following changes:

1) Insurers should pay accordingly for extended length treatment sessions for behavioral health disorders whenever clinical circumstances warrant it as judged by the clinician.

2) Insurers should allow clinicians the flexibility to implement longer session lengths regardless of specific diagnosis or treatment modality, provided that they document a justification for why time beyond 45 minutes is needed and as long as research findings do not contraindicate the use of a particular treatment modality or procedure.

3) Any authorization and/or documentation requirements should be designed so that they are not time consuming or impose an undue burden on the providers.

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