

# Addressing the Emotional Problems of Children and Their Families: The Role of Reimbursement

## **INSURANCE PAYERS ARE WILLING TO REIMBURSE FOR THE TIME IT TAKES TO UNDERSTAND THESE ISSUES. REIMBURSEMENT IS REASONABLE.**

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### **Abstract**

Addressing the emotional problems of children and their families has traditionally been a difficult task. Providers for these patients face a number of financial, emotional, and perceptual barriers in their efforts to care for children and their families. This article focuses on reimbursement issues in addressing some of these barriers. By looking at reimbursement issues from a different perspective, providers may be able to find the time and space to hear illness stories and more actively participate in a therapeutic role for patients and their parents.

### **Introduction**

Pediatricians and others could play a much more important role in the prevention, or, at least, the earlier recognition of the emotional problems of children and their families. They don't. Why don't they?

There are several reasons. One reason is they feel they haven't been adequately trained to do so. (Why they haven't been is a story for another day.) They could become better if they provided parents (or their patients) with the time for parents to be their teachers, and just listened, thoughtfully, to their stories. (An old teacher of mine once said, "Listen to the patient – he's telling you the diagnosis!")

Another reason is that patients sometimes make us uncomfortable when they share their problems with us. It may remind us of hard-to-confront and painful experiences in our own lives. And then there are those who are skeptical that we have the capacity to help patients change the direction of their lives. That, too, would require a separate article.

I believe we can overcome those obstacles. I have written about an approach to doing so in a website located at [www.CEHL.org](http://www.CEHL.org). My purpose in writing this article is to discuss how we can go about finding the time to listen to our patients, even in an era of managed care.

*How can we find the time to do so?*

It isn't complicated. If in your periodic exam, patients (or parents) indicate that they are concerned about some emotional issue (or one that might be disguised as a physical problem), invite them to come back at a time of day when you have time to listen to them, uninterrupted by the phone or other patients waiting to be seen.

*Suppose they don't want to come back?*

That is their choice. They may be engaging in what is sometimes called, "a flight into health." "The problem isn't that bad." That's ok. At least you offered them the opportunity. They know the next time they raise some issue, you have indicated your availability to meet with them. The result may be that they will finally address the problem, on their own; they may think it over and decide to see "a real therapist;" or they might reconsider their decision and take you up on your suggestion and decide to talk it over with you, the next time you ask.

*Are all patients ready for help at the same time?*

We've just discussed that. Patients (and parents) vary in their "psychological mindedness." We need to work with parents where they're at. For some, it may be the issue of stigma. They might think that by talking they must be "crazy." They might have had a relative with mental illness and they're afraid of identifying themselves with that relative. Or they may be ashamed of sharing their concern. Or they may not think it would be "manly" to do so or they may be fearful of being (even if, constructively) dependent. Those are issues for the physician to be aware of. Timing is everything!

*How would you code or bill for reimbursement for such a visit?*

Just make it an "E and M" code. This is not "psychotherapy." You code just as you would for any long or comprehensive "30", "45", or "60" minute encounter, as if you are dealing with a comprehensive or complicated problem, e.g. a child with asthma or dehydration or sepsis. If you spent the time and you can document having done so, it will be accepted by most payers.

*What diagnosis do you use?*

When I first started practice, I was told you should use different diagnoses each time. Otherwise, "the payers will become suspicious." But, against that idea is the reality that patients (or parents) worry about the implications of your using a mental health diagnosis, even though you only engaged them, in simple exploration, trying to ascertain the reason for a problem. They worry it might affect subsequent insurability or the possibility of not getting a job.

I decided, long ago, to use the simplest, least stigmatizing diagnosis I could identify. I use the diagnosis of "adjustment disorder" of childhood (or adolescence or of adult life.) Every normal person in his or her life warrants that diagnosis, some time. Again, your responsibility is to document what you have done, so you can back up having spent the time (and billing a payer for doing so.)

Presumably, you are not doing long-term therapy. In a way, what you are providing is "crisis intervention." (If you do this once, and adequately, it may be the only time you will need to do so, in the course of taking that patient's history.)

*What do you do if you meet only with the parents and not the child; "who is the patient?"*

That's a great question. Of course, if you are a pediatrician, the parent is not your patient. So, you bill as if your patient is the child, even if you only met with the parents and took the history from them. Oftentimes, in taking the history from them, they will share with you current or historical issues about the family system, (e.g. "he reminds me of my father, who was an alcoholic.")

In the course of sharing such "secrets," parents begin to reassess with whom they may have identified their child and, hopefully, share with you feelings they may have experienced with that identified figure. In the course of talking about experience, they may be able to see their child more realistically and develop better boundaries with their child. What you and they have done is to help them reconsider "who is the real patient?"

### Summary

I have been surprised by physicians' reluctance to invite patients (or parents) to return and discuss an emotional concern in greater detail. Patients are waiting for you to ask them what they think is wrong. I have found that payers are willing to reimburse for the time it takes to understand these issues. Reimbursement is reasonable. It won't be what you could earn if you saw six patients in that hour, for minor problems. But the fee is reasonable and you don't have to do this regularly, just when you and the patient are motivated.

Of course, the challenge is "what do I ask" that would take up an hour of time? What to ask is discussed in the aforementioned website. The real question is "are you interested, can you listen to them empathically and with respect, can you help patients to feel like they are teaching you about life (which they are)?"

Physicians feel like every visit has to be like you were being asked to diagnose "meningitis." Some things take time to understand. If you are willing to take the time, you will ultimately learn the whole story.

One last point – we aren't taking care of "patients" as much as taking care of "family systems." If we view the family as our real patient, we can justify taking time by the understanding we acquire and our ability to gain insights about a family problem that may go back three generations in time.