**Commentary on Koons et al.’s (2013) “Negotiating for Improved Reimbursement for Dialectical Behavior Therapy: A Successful Project”**

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This paper provides a commentary of Koons, O’Rourke, Carter, and Erhardt (this issue), which takes an inspiring first step in bridging research and clinical practice. We encourage the field to take the following from this paper: (a) evidence-based treatment (EBT) can work in real-world settings; (b) publishable research can be accomplished in a purely clinical environment; (c) some insurance companies are willing to pay more for EBTs; and (d) getting sufficient pay for more time-consuming work has potential to help patients.

Koons et al. found the crucial synthesis for all clinicians: In a purely clinical setting, research demonstrated that people got better and the providers were paid more for their work.

**Keywords**: dialectical behavior therapy; reimbursement; evidence-based treatment

**Abstract**

Dialectical behavior therapy (DBT), an evidence-based treatment (EBT) approach for chronically suicidal individuals suffering from borderline personality disorder (BPD), was originally developed in a research setting (Linehan, 1993). The treatment, though shown to be cost-effective in terms of preventing hospitalizations (Amner, 2012), is labor-intensive to learn and to deliver. The attempt to implement this approach in nonacademic clinical practices proves to be challenging in regards to both cost of delivering the treatment itself as well as training and maintaining staff adherence. Koons, O’Rourke, Carter, and Erhardt (2013–this issue), authored by two DBT teams (led by a nationally recognized DBT trainer) that function within private practice settings, attempt to model the effective negotiation of increased fees for the provision of DBT as well as evaluating DBT outcomes in their practice.

EBTs are crucial to the successful management of mental disorders, and not all treatments are created equal. There is ample evidence demonstrating that different treatments have different rates of success for different diagnoses (Butler, Chapman, Forman, & Beck, 2006; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Öst, 2008). Many insurance companies, however, seem to fail to acknowledge these data. In most states the reimbursed rate for a 50-minute “eclectic” psychotherapy session is the same as an EBT session of the same duration. Though the EBT may cost more to deliver, it is likely more cost-effective in the long run (Gabbard, Lazar, Hornberger, & Spiegel, 1997). The level of training required to effectively provide an EBT such as DBT may also pose a barrier to providers or to a system. Administrators are hesitant to implement DBT in their facilities because of concern over sufficient personnel for training and implementation and the necessity of ongoing training due to personnel turnover (Herschell et al., 2009).

One potential side effect of insurance companies’ failure to reimburse at a higher rate for DBT treatment is potential burnout and frustration of the treatment’s providers. This became an issue in our own center where we provide several EBTs for eating disorders (cognitive behavioral therapy [CBT], family-based therapy [FBT], and DBT). In adherence to the EBT, our DBT therapists provide phone coaching and attend consultation team yet are paid the same by insurers as providers who are administering EBTs that do not require these additional components. Being paid the same amount for working with more difficult patients and spending more unreimbursed time doing it has led, in some situations, to burnout and staff turnover.

Another potential side effect of insurance companies’ failure to reimburse at a higher rate for DBT is that it may dissuade agencies from adopting DBT. Agencies that are trying to remain profitable in the current health care environment may bristle at the notion of the consultation
We have had many patients come to our center stating they received nonadherent DBT. Specifically, we have found many examples of a patient’s failure to understand that the treatment they received was nonadherent DBT. Specifically, we have met patients from a nearby program that “provides DBT” in the form of an 8-week DBT skills group taught by a therapist without a consultation team, with no DBT training outside of having read Linehan’s manual, and in which no DBT individual therapy or phone coaching is offered. Having insurance companies reimburse DBT at a higher level when provided by clinicians with appropriate training and expertise will serve our patients well. Until we are able to inform insurance companies about how to establish these standards, patients will face this inconsistency in available providers.

Koons et al. (2013–this issue) should also be lauded for describing a structure for research to occur in a practice setting and for that research to both substantiate the request to increase payment and to inform treatment itself. Koons et al. describe having received insurance company grants and using the money to set up a database. We have experienced firsthand the problems related to collecting data in private practice. Several issues that have been challenging include: clinical staff do not prioritize data collection over other duties, data management itself, establishing funding for research positions, and issues with IRB involvement. One solution to these problems that we have found involves our clinical practice partnering with an academic researcher. The academicians are likely to have access to students and funds that will help with the management of data as well as experience in presenting at conferences and writing for academic journals, something with which many clinicians do not have adequate experience. While research and clinical practice have been perceived as ends of a dialectic—we believe that finding a synthesis that incorporates both will result in the best patient care.

Finally, Koons et al. (2013–this issue) should be lauded for practicing what they preach: DBT. Koons et al. applied DBT strategies in their negotiations with insurance companies. In their process of negotiation, Koons et al. likely effectively used their GIVE skills while highlighting and linking what they had to offer (i.e., a treatment shown to decrease hospitalizations) to what the insurance companies wanted (reductions in hospitalization, thereby decreasing costs). Koons et al. tended to the relationship with the insurance company by taking insurance company referrals to the DBT programs and choosing research measures they believed would be interesting to insurers. Koons et al. showed that not only can research be used to support requests for increased reimbursement rates, it can (and should) be used to change clinical practice. Koons et al. used the data from their study and “checked the facts” to change their clinical practice—specifically, considering the data they collected on noncompleters and choosing to focus more on the commitment phase of their patients.

Koons et al. (2013–this issue) took an inspiring first step in bridging research and clinical practice in their study. We encourage the field to take the following from this paper: (a) evidence-based treatment can work in real-world settings; (b) publishable research can be accomplished in a purely clinical environment; (c) some insurance companies are willing to pay more for EBTs; and (d) getting sufficient pay for more time-consuming work has potential to help patients. Koons et al. found the crucial synthesis for all clinicians: In a purely clinical setting, research demonstrated that people got better and the providers were paid more for their work! Maybe dreams really do come true.

References


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