

When Insurance and State Contracts Are Paying For Treatment – The Ethics of Treatment Documentation in Today's World



Health Insurance Companies and State Behavioral Health Contracts Are Now Paying for Very Specific Things. The Criteria for Treatment Eligibility Are Becoming Tighter! So How Do You Document the Treatment, When You May Disagree With the Criteria That Are Used for Approval? And Are There OTHER Ethical Issues? YES.

a.k.a. 'Ethically Obtain Approval for Your Client's Treatment Through What You Write!'

This is a new behavioral healthcare environment, which has changed a lot of things! The new health plans often require that providers deliver treatment under a 'CARE MANAGEMENT' system – administered by an insurance company or by a State agency or appointed administrator. The Health Care Reform movement will bring new players into the process.

This course focuses upon the 'ETHICS OF DOCUMENTATION' in clients' treatment records . . . when an insurance company or other Health Plan Manager (administrator) is paying for the treatment.

THE FOCUS OF THIS COURSE



And the concept of MEDICAL NECESSITY is key!

What kind of insurance company or contract manager?

- **'Insurance companies'** include Health Maintenance Organizations (HMOs) and other Managed Care Companies (MCOs and BHOs) who manage State- or Federal-funded health plans like Medicaid, Medicare, and the Affordable Care Act plans . . . *as well as* private health insurance plans including 'commercial insurance'.
- **'Appointed administrators'** include special contract managers who may not be an 'insurance company', but they (like insurance companies) oversee the provider network and the authorization of treatment, as well as payment of claims to providers. Sometimes a large Community Mental Health Center or Hospital District may serve in this role.





OVERVIEW: So where's the **ETHICAL** issue here? Providers can no longer deliver treatment 'at will'. We must play a form of 'Mother May I?' with the insurance company who is paying for the treatment. This process is called '**CARE MANAGEMENT**'. It's the **AUTHORIZATION** process, and it restricts **WHO** can get **WHAT** treatment, and for **HOW LONG**.

These new restrictions on treatment oftentimes conflict sharply with health care professionals' **ETHICAL BELIEFS** about what their clients actually need.



Furthermore, the type of DOCUMENTATION which we place in a client's treatment record MUST support the AUTHORIZATION which we have received, if we agree to accept the authorization.

Meaning? We must be very specific about the client's diagnosis, details of his functioning, his need for treatment, and the treatment which we have provided to him, as well as his response to the treatment – whether it 'looks good' or not.

This much detail may be very different from what we are accustomed to . . . perhaps different than we have been trained to do. And it may seem UNETHICAL to provide this level of information in a client's record.

Bottom line: Doing this type of documentation typically presents some ETHICAL challenges for most providers.

- **For example: Many providers question the ETHICS of emphasizing the individual's 'illness' or 'symptoms' or 'problems' or 'weaknesses' – particularly in writing, in a client's treatment record. But if you DON'T document these things, it's a PROBLEM, if the insurance company is paying for the treatment. Why?**

Because healthcare insurers are PURCHASING 'problem and disease management' – not 'strengths identification' (although we UTILIZE strengths of our clients in everything that we do). Authorization (i.e., approval to deliver treatment) depends upon whether or not the treatment we are requesting is MEDICALLY NECESSARY, or not. Is the client 'sick enough' and will he benefit from the treatment?



Medically Necessary? Ethical Issues?

 The key ethical issues are prompted by this fact: The insurance carrier – not the provider – decides which treatment will be delivered to your clients, based upon what the carrier decides is **MEDICALLY NECESSARY**.

Quick overview: Individuals who don't have major mental health or addiction problems MAY NOT be 'AUTHORIZED' for ongoing treatment, if they have public (e.g., Medicaid) or even private health insurance. In other words, only those for whom behavioral health treatment is deemed to be MEDICALLY NECESSARY are authorized for treatment, beyond the initial assessment and a few outpatient sessions. More to come on this, soon.



This can be a shock to our ethical perceptions about 'what's right' and 'what is needed'.

- **Yes, there are new requirements here – like requesting APPROVAL TO TREAT our clients (sort of like playing *‘Mother May I?’* with the MCO). And then there are new expectations for DOCUMENTING THAT TREATMENT in the client’s record.**

These expectations may require revisiting our ‘traditional ETHICS’ in several areas. QUESTION: Can we make these accommodations, and still retain our ethical boundaries? We believe that you CAN – particularly if you have a good understanding about why the companies who are paying the bills ‘do what they do’. Understanding sometimes PROMOTES ETHICAL ACCOMMODATION.

Bottom line: Fine-tuning the documentation of WHAT we do and HOW and WHY we do it – and documenting the OUTCOME of what we do – are the new watchwords. ‘Doing good’ is no longer enough.

If we are going to do business in the healthcare field today, we must learn how to ETHICALLY ACCOMMODATE what is expected by those who are paying for the treatment.



Good documentation will support the APPROVAL of your request for authorization to provide treatment – and it is also a skill which can PROTECT YOU FROM 'RECOUPMENT'.

Recoupment is the 'taking back' of claims payments by the insurance company AFTER they have paid you, because of problems that they find in your clients' treatment records when they audit them.

Summary of the ETHICAL ISSUES: Why are so many of us put into a quandary about what to do, when we start treating and documenting services provided to clients under contract with an MCO or a private insurance carrier? Here's why:

- **It's a MEDICAL MODEL – and we may not agree with the 'medical' approach to things. After all, we are counselors and social workers and therapists.**
- **What the insurance company says that the client needs may not be what we think is needed to effectively treat him. And we feel that it is UNETHICAL to not give him what he needs.**
- **We may have been trained to focus upon STRENGTHS – not weaknesses. And we have been taught to NOT put judgments and opinions in writing, and to play down such medical things as DIAGNOSIS. We may feel that to do otherwise is UNETHICAL.**

But unfortunately, if we are going to serve our clients in a practice or program that is not 'private pay', we are more than likely stuck with a new way of doing things – such as how we document treatment. How do we do this, and keep our ETHICS intact? That is what this course discusses. So let's go forward and look at details.



Like It or Not, It's 'Disease Management' – Not Social Service

- **'Managed' systems of health care are 'Medical Model' – and we must adapt what we write in charts, according to our contractors' philosophy. That philosophy is becoming increasingly 'medical' in orientation – which poses ETHICAL CONCERNS for many.**
- **'Medical' means TREATMENT – not simply social service or support. Health plans pay for TREATMENT which TARGETS DYSFUNCTION.**
- **When delivering health plan services to individuals with behavioral health diagnoses, we must think 'clinical' and 'treatment' and 'remediation of dysfunction' when we DOCUMENT the treatment and the need for it – which may be a major shift for many professionals.**

We must crank up the 'treatment' perspective. We must make clinical-sounding statements (not just social service talk) in everything we write. This may well violate an individual's ETHICAL beliefs about how we should approach the work we do with our clients.

**Does this mean what it sounds like?
Are those who are paying for the treatment (the insurance companies) trying to change how we have 'always done' treatment – and how we DOCUMENT it? Well . . . yes.**



Why are things changing? Could it have something to do with how health care is now funded – with new GOALS, perhaps? YES!



One of the primary goals of 'managed health care' is to CONTROL THE RISING COST of healthcare, a.k.a. COST CONTAINMENT.

This means that who gets treatment – and how much of what type of treatment they get – had to change. BUT are there any good things here? YES!

Managed health care also . . .

- **Focuses upon the REASON for services and how much the client NEEDS the services – wants to avoid inappropriate care.**
- **Offers consumers a broader choice of providers, in most cases**
- **Seeks to improve QUALITY of care**
- **Promotes INNOVATION in delivery of services – particularly in Medicaid plans**
- **Seeks to improve outcomes for consumers (doing 'good' is not enough)**

But what – exactly – does ‘reducing the cost of health care’ have to do with these new expectations for providers?

 An MCO or other such health insurance manager is typically ‘at risk’ of LOSING A GREAT DEAL OF MONEY when it contracts with the State or with the Board of a publicly traded or private company to manage health services (including Medicaid). Thus it must do what it can to REDUCE HOW MUCH MONEY IS SPENT ON TREATMENT. In other words, these health insurance carriers must PRIORITIZE *who* gets treatment, and *what* they get, and for *how long!*



There’s no treatment unless it is Medically Necessary!

Therefore, 'MEDICALLY NECESSITY'!

For the health insurance carrier (Managed Care company), 'NOT losing money on the contract' *depends upon* an assumption that ONLY those who have a need for **MEDICALLY NECESSARY** treatment **WILL GET SERVICES**. In this case, however, they are **NOT** looking at a **PHYSICAL** need for services. They are looking for the degree (or severity) of the client's mental and behavioral **DYSFUNCTION**.



They are also looking for evidence that the individual will **BENEFIT** from treatment. If he fails to **BENEFIT** from treatment, then approval for 'more' may be withdrawn – or the type of services which have been approved may change.

And all of this must be DOCUMENTED in the client's treatment record! The MCO expects to see it when they audit a client's record. After all, they have PAID you, based upon this information.

Well, OK – but do these new documentation approaches actually collide with the provider's professional ethics or personal beliefs about what is 'appropriate' to write in a client's chart?



Maybe! And it's because of the nature of CARE MANAGEMENT and MEDICAL NECESSITY.

The MCO's expectations for documentation may be a turn-off to private practitioners and program staff, for various reasons.

- **For example – as indicated elsewhere – providers who have been trained in 'strength based' models may question the ETHICS of emphasizing the individual's 'illness' or 'symptoms' or 'problems' or 'weaknesses' – particularly in writing, in a client's treatment record. We may want to emphasize 'strengths', and say little about the severity of his problems. But this won't work when an insurance company is paying. Why?**

Because healthcare insurers are PURCHASING 'problem and disease management' – not 'strengths identification' (although we UTILIZE strengths of our clients in everything that we do).



They will also take a close look at the accuracy of the mental health or addiction **DIAGNOSIS – although diagnosis alone is *not enough*. The client's **FUNCTIONALITY** must also be taken into consideration.**

And in addition to looking at the **FUNCTIONALITY, they are looking at the likelihood that the individual will **BENEFIT** from additional treatment. And they want to see **ALL** of this backed up, **IN WRITING!****



**What's a primary issue here?
Although much of the current
mental health and addiction
philosophy would AGREE that
mental illness and addiction
are a DISEASE PROCESS,
writing about it in this way in
clients' treatment records is
an entirely different matter.
Many Counselors and Social
Workers will need to (re)train
to WRITE in a way that is
'clinical' and 'diagnostic', and
oriented toward 'disease
management'.**



**This is especially true for
those addiction counselors
whose philosophy comes
from a highly didactic,
teaching and educational
model. And also true for
mental health professionals
who come from a 'strength
based' model – where we
tend to downplay 'deficits'
and 'problems' and
'diagnosis'.**

Unfortunately, therefore, the DOCUMENTATION expectations may collide with the provider's historical ETHICS or personal BELIEFS about what is 'appropriate' to write in a client's chart. Many of us believe that too much detail violates a client's confidentiality.

- **The new documentation expectations may actually be irksome to many providers, regardless of whether they provide MH or CD treatment. The shift may even be impossible for others. If philosophical bias prohibits a provider from adapting to the new expectations of 'managed health care', he or she may choose to simply not participate, leaving the field altogether or shifting who they serve.**



To put it simply . . . if you can't clearly explain (verbally and in the client's record) the reasons WHY the client has a MEDICALLY NECESSARY need for the services – and if you don't address HOW you deliver the services – you will not be paid for what you do. You will either be denied authorization 'up front', or claims payments can be taken back when the insurer comes to audit the treatment records. In either of those cases, clients may lose services.

Aside from submission of request forms, you may need to explain to the Care Manager verbally and/or in writing – up front – which of the client's issues are so serious as to be 'MEDICAL NECESSARY', and WHY you are requesting a PARTICULAR type of treatment, and for HOW LONG you wish to provide that treatment. AND then all of this must be reflected in writing in the client's chart or treatment record.

What's the best way for a provider to cope with the 'Medical Necessity' concept?



Part of being successful as a provider under a managed health insurance plan involves UNDERSTANDING what YOUR health insurance company means by '. . . the patient has a NEED FOR MEDICALLY NECESSARY TREATMENT'. Some are more rigid than others about how they define this need for treatment – especially if funds for behavioral health are stretched thin.

Remember that health insurers make these AUTHORIZATION DECISIONS through an APPROVAL process called CARE MANAGEMENT or UTILIZATION REVIEW. So what's their 'thinking process' here?



Understanding How MCOs Think.

If you do not understand how the 'MEDICAL NECESSITY' criteria are applied to the consumers in your care, getting approval from the health insurer to deliver care to your clients will be frustrating and confusing. The issue boils down to, essentially, . . . 'Well, how sick IS he – and how much of what kind of treatment is really NECESSARY?'

When dealing with Behavioral Health (Mental Health, Substance Abuse, Chemical Dependency, or Dual Diagnoses), we are NOT talking about being 'physically sick' as in pneumonia or appendicitis. We are talking about mental and behavioral functionality, and safety for self and others. These things can be somewhat subjective, and so it's best to be ultra-clear!

 They look at whether the individual is expected to **BENEFIT** from the treatment (based upon how he has **RESPONDED** and **COOPERATED** thus far, and his past **HISTORY**, and his **DIAGNOSIS**),

More on how they make Care Management decisions!

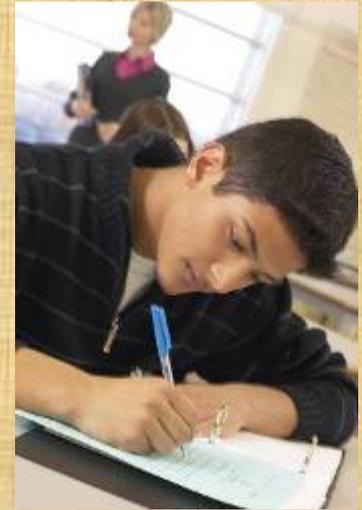
 . . . and whether the treatment is considered to be '**NECESSARY**' to recovery, based upon how **IMPAIRED** the individual is, and the '**PREVAILING STANDARDS** of care' for his condition ,

 . . . and whether sufficient **PROGRESS** is being made to justify the continued expenditure of funds at this level of care. If insufficient progress is being made, then the treatment plan and the level of care will have to change!

Communicating Your Client's Condition – While Retaining Your Ethics!



If you have difficulty *communicating* the nature and severity of your client's condition (in writing and verbally) – and if you have trouble with the ETHICS of spelling out the client's DYSFUNCTION in graphic terms – you will have trouble obtaining authorization for services. That's especially true under a health insurance plan where the health insurer is 'at risk' of losing money. You must be clear, clear, clear when you talk to the health insurance company about what is needed.





Documenting may be difficult for some practitioners because it has to be so SPECIFIC. Many of us were trained to 'say as little as possible' in the client's chart, avoiding 'judgment statements' or similar comments which you might later need to explain in court if called to testify on a matter related to the case.

Also remember that MCOs place a great deal of emphasis on whether (or not) the client will BENEFIT FROM additional treatment. For both CD clients and for Seriously Mentally Ill (SMI) clients, this can be a difficult point; your documentation needs to communicate clearly why and how he will benefit from additional CD or MH treatment, despite repeated RELAPSES. [This is an important ETHICAL ISSUE, because 'relapse' is an expected occurrence with persons who have severe and persistent mental illness, and with those who have a long term addictive history.]



 Remember that MCOs make their 'Care Management' decisions (a.k.a. 'Utilization Review') based upon whether or not they believe that treatment is '**MEDICALLY NECESSARY**' for stabilization and improvement, and whether the treatment is believed to be **ESSENTIAL** for persons with the patient's particular **DIAGNOSIS** . Also, is treatment having a **POSITIVE IMPACT** up on his condition?

For MH clients, MCOs DO NOT look simply at whether or not it would be 'helpful' or 'nice' or 'ethical' for the individual to have a certain type of treatment, or whether the patient simply 'wants it'. And they DO NOT base decisions upon a plea that 'we have always done it this way.' Many of the 'old ways' have been discarded or radically modified, in this day of 'short funds' and more rigorous management of treatment. This makes many of us ethically uncomfortable.



For the addiction (CD) client, health insurers DO NOT look simply at whether or not he or she is having an alcohol or drug related crisis, or whether or not he has experienced a recent relapse, in order to say 'OK' to a treatment request. And they most certainly DO NOT base decisions upon a plea that 'we have always done it this way,' or that '28 day programs are part of our tradition.' In fact, if the client has had multiple relapses to use of alcohol or drugs, they may begin to question whether additional treatment beyond detox and basic services is really justified – particularly during any given year.



A CD Issue Related to Care Management Decisions

Special Note: Standardized Level of Care protocols (such as those typically used by Insurance Companies and MCOs in their Care Management process) are believed by many to result in 'questionable clinical outcomes' for Chemically Dependent consumers. Reason: These 'Care Management' protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery.



A CD Issue Related to Care Management Decisions . . .

What to do here? For your most relapse-prone clients – especially those who are recycling in and out of detox frequently – ask for a ‘Case Rate’, where you can make treatment decisions more freely – where you ‘hold the cards’. (More about that in the second half of this course.)

Philosophical and Ethical Conflicts About Documentation in AOD Services

And do these documentation requirements collide with the AOD provider's professional ethics or own beliefs about what is 'appropriate' to WRITE in a client's chart? Just as with Mental Health providers, the answer is maybe – or perhaps with AOD, it's 'likely'.



Although most CD philosophy AGREES that this is a DISEASE PROCESS, writing about it in this way is an entirely different matter. Many CD Counselors will need to (re)train to WRITE in a way that is 'clinical' and 'diagnostic', and oriented toward 'disease management'.



This is especially true for those CD Counselors whose philosophy comes from a highly didactic, teaching and educational model – which speaks directly to their professional ethics.

In plain language, what is the impact upon AOD services – which have inherent ETHICAL issues attached?

- 1. Necessary Shifts in Program Design and Treatment Approach – *'But we have strong traditions in the CD field, about what works and what doesn't.'***

The issue here, is that the CD treatment community is being required by Managed Care to abandon or to seriously modify many of its most cherished and historical treatment practices and options.

- 2. HMO Credentialing – *'Are you qualified?'***

The issue here is that Managed Care wants more licensed providers than CD treatment providers typically have on hand.

- 3. Documentation of Treatment – *'But in your progress note, did you make it clear that?'***

The issue here is that all providers (both Mental Health and CD Treatment providers) are being required to document in a way that is foreign to many of us – and which feels UNETHICAL.

In the second lesson, we'll talk more about the four (4) CORE CONCEPTS that drive the final decision regarding 'MEDICAL NECESSITY' of treatment. We'll talk about HOW TO ASSESS whether or not the client meets the criteria, BEFORE you approach the insurance carrier to request "more". There are definitely ethical approaches to working within those CORE CONCEPTS.



Bottom line, the health insurance company's decisions may contradict a provider's own PROFESSIONAL BELIEFS and ETHICS about 'how much' of 'what' is NEEDED by the client at any given point in time. For example, the health insurance company will probably limit how long an individual remains in detox or inpatient or day treatment – which the provider may feel is unethical.

- **The health insurer may 'step them down' to a lower level of care (less intensive and less expensive) long before the provider (in the past) would have done so.**



But is this really 'bad'? Is it UNETHICAL? Not necessarily. It may simply be 'different' than what we have done in the past. More on this later.



- **All of this may be irksome to some – and too far removed from their traditional view of ‘what’s ETHICAL – regardless of whether they provide MH or CD treatment. It may even be impossible for others. If philosophical and ethical precepts prohibit adaptation to managed systems of care, some individuals may choose to not participate. Or may need to leave.**

Are We Providers the ONLY Group Who Is Concerned About the Impact of Care Management Upon Treatment? No.

With the coming of Managed Care to several states, a decade ago the National Alliance for the Mentally Ill (NAMI) expressed concerns that the emphasis would be placed upon the element of COST CONTROLS instead of upon the element of CARE. And of course, the State legislatures typically ARE most concerned about the element of COST, as their primary reason for implementing a managed care model.

NAMI's concerns were first clearly expressed in 'Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness.' An example is this statement (and similar statements since then) in their 2006 *Report Cards of the States*:: "Managed care models sometimes turn into *managed cost models*."

Concerns of NAMI . . .

And further, NAMI has reflected the thought that managed care companies' corporate emphasis upon *profit* could result in harm to the delivery system [and this would apply to Mental Health and to CD-AOD.]

For example, one comment made in the 2006 report is that too often " people's needs are sacrificed in favor of private profit incentives." That concern has not changed to this day, in terms of how NAMI and many other behavioral health advocates see the potential problems.

However, the Principles of the Affordable Care Act Have the Support of NAMI.

Says NAMI on its website:

“The Patient Protection and Accountable Care Act (ACA) addresses many of the challenges people have in getting and keeping health care coverage. [There are] . . . key provisions of the law that offer meaningful benefits to individuals living with mental illness and their families.

NAMI identifies the following ‘Patient Protection’ provisions of the ACA as particularly positive for persons with mental health and addiction disorders:

- Pre-existing Medical Conditions – care cannot be denied based upon such.**
- Extension of Dependent Coverage**
- Prohibits lifetime limits**
- Prohibits annual limits for certain types of plans**

IMPORTANT SIDE NOTE: Is the health insurance company telling you that you CANNOT provide the services which you believe the client needs? NO. A provider is *always* free to deliver any service to a patient according to the provider's own professional judgment or organizational philosophy. HOWEVER – if the health insurance company does not feel that the services are **MEDICALLY NECESSARY and **ESSENTIAL** for the stabilization of the patient (or if the health plan simply does not cover a certain service or limits how much can be provided), then you **WILL NOT BE PAID** by the health insurance company to provide the service. You will have to do it for free ('pro bono'), or will have to use other funds to cover the cost.**

WORK FOR FREE? This is perhaps the most difficult decision that a provider must make when working within a health insurance plan: Do you provide a service for FREE, after the health insurer says 'STOP'? Or do you terminate services because there are no funds to cover the cost?

This decision is perhaps becoming easier for treatment providers, in this day of shrinking health care funds. We are used to the dilemma. And patients are also becoming accustomed to the fact that there may be limits placed on what services are available, or the amount of services that can be provided. Sometimes there are other programs or funding opportunities available to pick up the slack – but not always.



Again . . . Why Is the Care Management Process So 'Picky'?

WHY are the insurance companies so 'picky' about who gets care, and 'how much' of 'what'?

Remember that in public sector healthcare programs such as Medicaid, funds are generally short all the way around – much more so than in commercial private insurance plans.

 **The funds available to the health insurance company are quite LIMITED, while the need of the enrollees is GREAT. Obviously, the use of the limited funds by YOU, the provider, must be carefully MONITORED by the health insurer.**

They are going to take a CLOSE look at what you did with their money.

This means that the health insurance company will be taking a VERY close look at whether providers have ACCURATELY reflected the seriousness of the consumer's condition when requesting services . . . and then, was treatment delivered EFFECTIVELY? And does the billing you submitted correspond with the treatment that is DOCUMENTED in the consumer's record? If not, there will be problems!

But then . . . aren't these SAME expectations part of our licensure ETHICS and basic requirements? YES, of course they are. And so perhaps these new expectations are more in line with traditional ETHICS than we first thought!

Congratulations!



You have completed the 1st of 3 'lessons' in Ethics Course 4D. You may complete the short quiz for this lesson either now or later. To reach the links for the quizzes and the lessons, simply *close this page (i.e., exit this presentation)*. You will be returned to 'My Home Page'.

From there, just click through, starting with the LINK to this course, and you will see your list of Study Guides and Quizzes displayed. Or you may return at any time to the site – sign in – and click through to your course or quiz.

You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a quiz, and you may retake it immediately. We require 75% correct to pass.

So either take the quiz now, or you may resume the course – your choice!