

Ethics Course 4D, cont.

'Additional Ethical Issues When Working With Insurance Companies or State Contractors – Theirs and Yours'.



This lesson addresses additional ethics-related issues which occur in managed systems of care – with thoughts about assessment of the professional's ethical response and responsibility.



FREQUENT QUESTION: Do HMOs and MCOs just cruise through their contracts – getting out of one responsibility after another? Providing little care to persons who are really sick? Typically, the answer to that is NO. The feds and the State regulators will not allow it if they become aware of a pattern of short-changing the enrollees, through unreasonable withholding of care that the company is contracted to provide.

Additionally, if the HMO habitually allows patients to deteriorate from lack of effective interventions, the resulting cost of providing expensive inpatient treatment EVENTUALLY 'does them in', financially.

HOWEVER, oftentimes a managed care company or a healthcare contract manager may DELAY approval of treatment – or may even increase DENIALS or reductions in Level of Care for a short period of time – typically toward the end of the fiscal month or quarter. Why? Because spending less money near the end of a fiscal timeframe improves the ‘bottom line’ of their financial statements for that month or quarter, i.e., they appear to be in better financial shape on that report, with lower commitments to “pay”.




It's called “CASH FLOW CONTROL”.

See “benching”, next page.

Benching . . . a form of “cash flow control”.



 **BENCHING** is a **DELAY** in giving a decision to a provider about whether a patient can be admitted to a particular service – leaving providers and patients feeling ‘left out in the cold’ until an answer is given. This practice most often is seen when a request is made to admit to inpatient treatment or to another expensive services such as detox or partial hospitalization. Though not a rampant trend, regulators tend to watch such practices closely.

Benching . . .



Q: Where does the ETHICAL dilemma come in, for providers? A: Providers may need to speak up about this issue, as an advocate for their client, if they perceive that the client's safety is at risk because of the delay or denial of care . . . even though fear of reprisal might tell them to be silent. We recommend approaching the managed care or insurance company FIRST – with an eye to negotiation and cooperative solutions.

For example, if admission to inpatient treatment is delayed, will the MCO approve admission to a day treatment program or to an Intensive Outpatient Program (IOP), and ACT (Assertive Community Treatment) team, or a 23-hour non-medical observation unit? We are talking about *Alternative Services* here.

Benching . . .

But if such alternative services clearly will not keep your 'acute' client safe, then the *ethical professional* may decide to proceed to a formal, rapid-action Appeals Process which challenges a Care Management decision in acute situations. Such appeals are typically most effective if a psychiatrist or other involved physician can become actively involved, communicating directly with the HMO's or MCO's Medical Director [often referred to as a "doc-to-doc review"].



And finally, if it is clear that 'benching' is becoming a TREND with a particular HMO or other MCO – with no success through direct negotiation with the company – ethical action might include bringing the issue to the fore in a Provider Advocacy Committee or other oversight entity for discussion and review.

Caveats to the Foregoing . . .

That being said (related to ETHICAL RESPONSIBILITY of providers to pursue appropriate care), we must also bear in mind the NECESSARY CHANGES that limited health care funds and new contract arrangements have brought to the behavioral health field. To be successful in this system, the provider may need to rise to the occasion – learning NEW WAYS to DELIVER treatment. And these new approaches can be even BETTER for our clients. To recognize this is important, and supports our ETHICAL responsibility to ensure the welfare of our clients.



We are all familiar with the exciting changes in treatment of adults with Severe Mental Illness (SMI): IOP and ACT Teams with Intensive Case Management are now utilized rather than long term inpatient treatment.⁷

Almost certainly, the managed care company will LIMIT how long individuals remain in the expensive levels of care (such as detox and inpatient). How does it limit this? The MCO may 'STEP THEM DOWN' to a lower level of care (i.e., less intensive and less expensive) sooner than the provider – *in the past* – would have done so. Is this really 'bad'? It's NOT necessarily bad, depending upon the condition of the client at the point of discharge, and whether there are good alternative services available (such as IOP). Is it ETHICAL? Yes.



For CD-AOD clients, 28-day residential programs are almost non-existent. CD-IOP following detox is the typical 'step-down' move.

Another area where alternative services are now used almost exclusively by insurance companies: Adolescents – who *in the past* would have been admitted for weeks or months to a Residential Treatment Center – are now admitted to Intensive Home-Based or Community- Based Services, or to Intensive Outpatient Programs (IOP). Providers are encouraged to be supportive of such treatment alternatives.



IS THIS ETHICAL? Yes. Like the other examples we have given here, these alternatives should be given a try with any adolescent who needs non-inpatient intensive services. These alternatives have proven to be generally more effective than residential treatment, which removes the child from the environment.

- **BUT REMEMBER: Is the managed care 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 managed care 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 managed care 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, or will need to refer the individual to a provider who can deliver the services.**



You have an ethical responsibility to fully disclose the limits of treatment to your client – up front!

The treatment provider must educate the client at the beginning of the treatment process about the fact that there will likely be limits placed on what services are available, and the amount of services that can be provided.

Sometimes there are OTHER PROGRAMS OR FUNDING SOURCES available that can provide exactly what the client desires and needs in the way of treatment, but not always. The client should be aware of this from the outset.



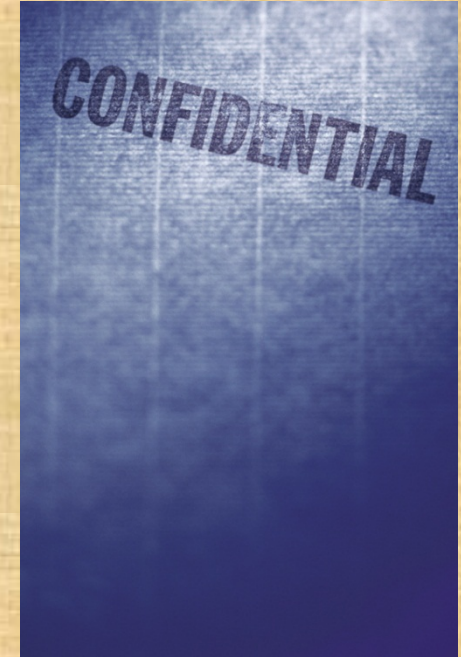
The bottom line here is this: In cases in which the client needs continued services, if the treatment provider decides that he or she cannot continue to provide services on a pro bono basis (i.e., without charge), the provider is responsible for making a referral to an agency or individual who can perform services that are as close to what the client needs as possible, at a price the client can afford. Whenever possible, providers should attempt to secure the client's signed agreement with a decision to terminate and the reasons for doing so.

But Also Remember the Concerns of NAMI . . .

Recall from Lesson 1, the concerns of the National Alliance for the Mentally Ill (NAMI): NAMI has expressed the thought that health insurers' corporate emphasis upon *profit* may result in harm to the delivery system. For example, one comment made in the 2006 report is that "too often . . . people's needs are sacrificed in favor of private profit incentives."

If you, as an ethical professional, feel that your client's welfare is placed in danger by a Care Management decision, you should proceed to APPEAL the decision as described in earlier slides.

The HMO-MCO's Emphasis Upon the Effectiveness of Your Client's Treatment . . .



**Is it legitimate, or
is it an invasion of
your client's
privacy? Is it
ethical?**

Scrutiny of 'effectiveness of treatment' . . . is it just a move to harass providers or to dump providers who prove to be too "expensive"? Is it invasive of client privacy?



***Looking
for
quality!***

Oftentimes, providers come to feel that the managed care company or other such contractor is being unethical and over-zealous when they place the provider's 'EFFECTIVENESS' under scrutiny. But is this truly the case? Are they being hyper-critical? Invasive? Are they being UNETHICAL in their scrutiny of the provider's activity and the outcome of a client's treatment? Overstepping the bounds of a client's privacy? Of YOUR privacy? These questions oftentimes plague providers who deal with insurance payors.

Unethically Invasive? Not Necessarily.

As we indicated with regard to the need for explicit documentation of client treatment, there is more to 'Quality Management' functions than simple invasiveness of the client's privacy. It's not necessarily unethical prying.

In this day and age of limited funds and shrinking state and federal health care budgets, *"doing good"* as we have always thought about it is no longer enough.

And under the new health care direction, we no longer have 'forever' for treatment to work.

Managed Care is a 'short-term intervention' mindset, due to the need to control costs. The clock is ticking from the first session.

'Short-term' not only means briefer treatment – it also means that treatment episodes should not be repeated over and over.





This is obviously problematic for Mental Health and Substance Abuse Treatment providers, because the nature of our clients' illness is oftentimes RECIDIVISTIC. And obviously, managed care companies do know this.

Despite their desire for ever-briefer treatment, the companies are responsible for ultimately keeping all enrollees under their care safe and stabilized.

THEREFORE, what they seek to do, is to demand that only quality ('effective') outcomes be supported and funded.



It's Nationally Driven

Payors and funders – whether public or private – are no longer willing to continue support of MH and SA/CD services based upon faith or tradition. One early example from the Federal Substance Abuse and Mental Health Services Administration, which persists to this day:

"State substance abuse agencies can make a strong case for federal and state funding of their programs simply by showing that they are effective . . . This is not the time to say that we don't know anything."

Nelba Chavez, Ph.D.
SAMHSA

Yes, there's a new emphasis upon outcomes, and it may look a lot like Apple or Google – or Amazon! Is this really ethical? Yes it is. And it's consistent with our ethical standards to provide effective treatment within our Professional Scope of Practice.

We need outcomes data just like Big Business . . . which tells us . . .

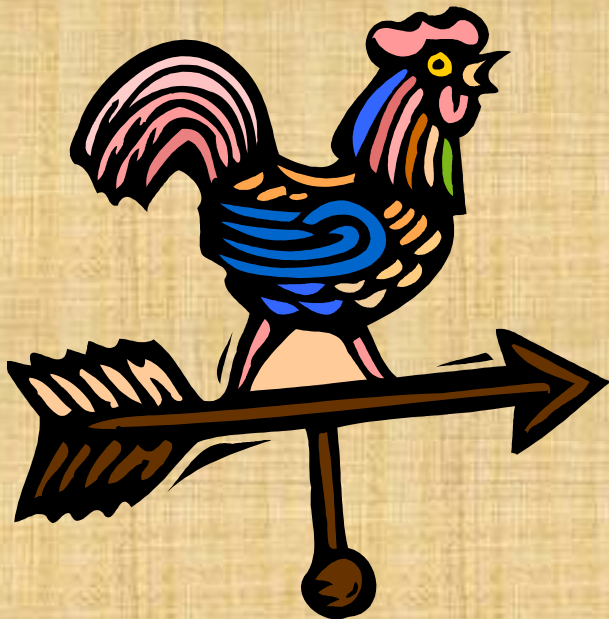
- **Did it work? If so, how well?**
- **Did our customers like it?**
- **Was it what they needed and wanted to buy?**
- **Will they want to buy more when its needed?**



As part of our ethical practices, we must use outcomes measurements to . . .

- **Change programs and approaches that don't work (i.e., those with poor outcomes)**
- **Promote those that do work (i.e., those with good outcomes)**
- **Alert us if program cuts or modifications are hurting rather than helping – and our ETHICS demand that we SPEAK UP if the funding modifications are hurting our clients.**
- **Document cost savings and success, which shields MH and CD services from budget cuts in State and local and HMO budgets.**

Outcomes can be a part of our 'ethical practices weather vane'



- Outcomes measurement keeps us on track, signals the need for a shift in the client's treatment (at the client level, AND at the program level)
- It tells us when we are "doing the right thing" for our clients – when we are being effective.
- It puts things in perspective, for us and the clients

And so yes, scrutiny of 'effectiveness of treatment' is indeed ethical. In fact, it is **UNETHICAL** to provide services when we are 'unable to assist' the client.

Providers are ethically bound to NOT initiate services OR CONTINUE TO PROVIDE services when the services are NOT BENEFICIAL to the client. (Possible exception is when services are court ordered.)

When the provider is unable to effectively assist the client, he or she should refer the individual to an agency or practitioner who may be BETTER ABLE TO PROVIDE beneficial services²³

**Even if the client refuses a referral,
providers should not provide
services which they believe are NOT
BENEFITING the client.**



Unless ordered by a court of law, conventionally accepted professional ethics require termination of services when . . .

- **it is reasonably clear that the client is no longer benefiting from services,**
 - **services are no longer needed,**
- **clients have not fulfilled agreed upon arrangements (e.g. payment of fees, arriving at sessions without using alcohol or other drugs),**
 - **services no longer meet the needs and interests of the client, or**
- **there are agency or institutional or insurance coverage restrictions on continuing current services.**

Bottom line, we must always act in the
BEST INTEREST OF THE CLIENT.
It's a basic ethical requirement.

Specifically, no action may be taken that is in – or in support of – the self-interest or gratification of the provider or someone other than the client (e.g., the agency, a parent, or client's intimate partner).

And that includes continuation of treatment that is not effective. For example, the provider cannot recommend longer or more intensive treatment which will make more money or to support goals of one's agency or practice, when such treatment is NOT JUSTIFIED or ineffective.

**. . . always act in the BEST INTEREST OF
THE CLIENT.**

As with many ethics issues, we are not necessarily talking about LAWS here – but rather about the need to make ‘ethical judgments’ . . . including judgments about what will support the BEST INTEREST of the client.

And that includes the necessity to carefully EVALUATE whether or not continuation of treatment is LIKELY TO BE EFFECTIVE.

The MCOs are ALSO focused upon effectiveness of treatment – and it's ethical for them to do so.

- **Of course, we can't say that HMOs or other such contractors are simply engaging in 'treatment ethics' when they focus upon Quality of Care. Rather, they MUST ensure that money is spent ONLY on services known to be effective, SO THAT there is 'effective treatment available for the entire client population' with a typically limited pot of funds.**
- **Consequently, community programs and providers who have demonstrated that they have good treatment outcomes are important to health care contractors – and to the community and to the consumers themselves.**

Ensuring Good Outcomes Is Healthy for All Concerned. And It's Part of Our Ethical Responsibility to Work Toward Effectiveness of Treatment.

- **If you or your organization have worked hard to ensure good outcomes – and if you express an interest in working with the HMO or other healthcare contractor to measure and track the treatment outcomes of consumers in your care – your clients will benefit.**
- **Your requests for treatment for individual clients will move much more smoothly toward approval, because the quality of your work is well known. Your clients will benefit from the confidence that the contractor has in your treatment process . . . even if the 'vetting' process seemed rather painful at the outset.**



And What Is The State's and the Managed Care Company's Ethical Responsibility, When Managed Care Comes to Public Healthcare Programs? They Have the Responsibility to Educate the Providers – Well In Advance!

With a shift to 'managed care' in a Medicaid, SSI, AOD or other health care program, States and Healthcare Management Companies are ETHICALLY BOUND to ensure that these things happen:

- **Intensive training of providers on managed systems of care – the rules, the goals, the procedures for approval of treatment, the Medical Necessity criteria, and more.**
- **Consideration of a pilot program in the state, to test out the viability of the rates paid to providers, the procedures, the Medical Necessity Criteria, and the total amount of money devoted to the healthcare conversion. *With or without such a pilot*, program adjustments – in keeping with responsible feedback from providers – should be actively considered.**

One final issue related to ethical practice:

We have spoken often in this course about the need for good ASSESSMENT of client's needs and issues, as part of ETHICAL PRACTICE. We feel compelled to make a couple of additional points here – about the MANNER in which we go about an initial biopsychosocial assessment, and subsequent update assessments. For indeed, whether or not we take extra care to 'do it right' – and to document our assessment findings accurately – impacts the ethics area known as 'Scope of Practice'.

. . . How we go about assessing the client's status and needs.

Many clinicians approach assessment and diagnosis in an expedient manner – oftentimes gathering just enough information in written format to confirm that there is a behavioral health problem, and that the client meets the criteria of the admitting agency or practice. There are good reasons for this, of which we are all familiar – including the pressure of too little time during any given day to accomplish myriad activities . . . the fact that we are required to gather so much data and complete so many forms which are in keeping with our contractors' requirements [which verge upon the voluminous and sometimes the ridiculous], etc..

Assessing 'on the fly' . . .

Furthermore (and here lies the trap), most of us who have been doing this type of work for awhile rest easily on the dual assumptions that (1) “we know it when we see it”, and that (2) “we therefore don’t need a standardized format” upon which to gather the data which is needed to arrive at accurate diagnosis(es). Based upon these two assumptions, we oftentimes ‘assess on the fly’ [meaning ‘without pre-planning and structure’ and ‘according to the needs of the moment’].



What we are missing here, is that in doing so (assessing on the fly, and failing to follow a standardized WRITTEN protocol) we leave ourselves in an untenable position from a legal and risk perspective. And even if no issues related to the case ever see the inside of a courtroom, there is truly a danger that we will 'miss something important', no matter how many years we have been in this business.



And in the process of 'missing' or overlooking some detail about the individual's history or functional status, there is unfortunately a risk that we will misdiagnose him or her, or that we will fail to include an important issue in the treatment plan, which may come back to haunt us. There is also a danger that we will see one particular diagnosis rise to the surface as being 'The One' – and ignore or fail to recognize or address another diagnostic issue.

All of this hits directly upon the ethics area of 'Scope of Practice' . . . which for most of us, requires us to diagnose, plan and DOCUMENT with accuracy.

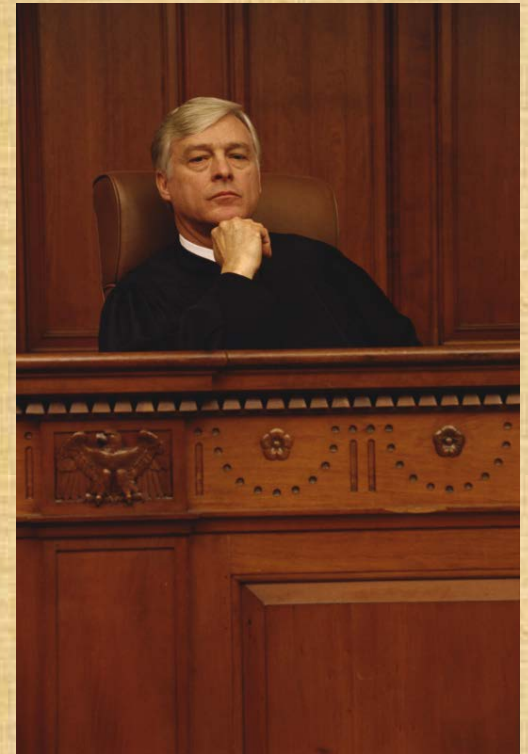
There's an ETHICAL need for a structured approach to assessment.

Our point relates to the ethical need to perform a 'formal, written assessment in a STRUCTURED format' – as part of ethical practice, i.e., as part of our Scope of Practice requirements . . . EVEN IF your ethics regulations don't specifically say "use a structured, written assessment protocol."

So have we made too big a leap here? No. Your rules of ethics related to Scope of Practice DO spell out or allude to the need for accuracy and professional competence in ASSESSING and DOCUMENTING the status and needs of your clients. And HOW we go about those activities do indeed reflect upon whether or not we are adhering to these precepts.

The need for a structured approach to assessment . . .

Our point relates to the critical nature of 'formal, written assessment in a STRUCTURED format'. We make this point because we know these issues to be real – based upon our years in local and State level administration, our experience auditing records under State mandate and also private consultation contracts, and our opportunity to see tragedy up close and personal within these contexts – both in and outside of a courtroom.



A thorough, DOCUMENTED CLINICAL ASSESSMENT of behavior, emotions, and functionality is a critical process, if we are to do effective Diagnosis, Treatment Planning and Treatment Intervention. This is true whether we are dealing with young or middle age adults, geriatric individuals, or children and adolescents. We need to explore the individual's historical and current issues, behavioral and social functioning, any medical issues which might be present and perhaps complicating matters, and mental status, in order to know how to approach the treatment process in a way that makes sense. Simply 'looking at obvious SYMPTOMS' and listening to the client's or his caretaker's REPORT of problems is NOT ENOUGH. And there can definitely be legal AND ETHICAL repercussions if we neglect to cover multiple vital areas.

Want an example?

OK. Let's say that a professional fails to EXPLORE and/or DOCUMENT a particular area of a client's problems, issues, and history during the ASSESSMENT. And say, the client later has an ADVERSE TREATMENT OUTCOME that can be associated with that area which was not pursued or documented during the assessment. What may the RESULT be, for the professional? He or she can be sued in a civil court of law – accused of failure to perform his or her Professional Responsibilities [which is one area of our ETHICAL STANDARDS]. And he or she subsequently may be found to be PROFESSIONALLY NEGLIGENT. This can be very costly to the professional in terms of monetary and other civil damages, and may even become a licensure review issue.

In summary . . .

There are MANY REASONS to document clinical findings and issues carefully and in detail within a client's clinical record. Some of these reasons relate to our ability to acquire and keep CONTRACTS with managed care companies or other health care contract administrators. Obviously, meeting the contractor's clinical expectations supports our ability to deliver treatment services to our clients.

Documenting what we do in a clear and detailed manner also relates to how well we can demonstrate our EFFECTIVENESS in the treatment of our clients – and enhances the QUALITY of care we deliver.

And finally, good documentation of what we do . . .

- 1. Supports our ETHICAL requirements of PROFESSIONAL RESPONSIBILITY and SCOPE OF PRACTICE, and**
- 2. Helps to ensure that our clients receive ACCURATE DIAGNOSIS AND GOOD TREATMENT, and**
- 3. PROTECTS us as clinicians from legal repercussions.**



**Where to find specific national ethics standards for each licensure designation?
Check our links!**

See our 'clickable' links to Ethics Standards published by the national organizations for each type of license, on the next two pages!

Internet Links to the Ethics Standards of Various National Organizations for Specific Licenses

Note: Public URL link can change without warning.

- **National Board of Certified Counselors (NBCC):**
<http://www.nbcc.org/assets/ethics/nbcc-codeofethics.pdf>
- **National Association of Alcoholism and Drug Abuse Counselors (NAADAC):** <http://www.naadac.org/membership/code-of-ethics>
- **American Psychological Association (APA):**
<http://www.apa.org/ethics/>
- **American Mental Health Counselor Association (AMHCA):**
[https://www.amhca.org/assets/news/AMHCA Code of Ethics 2010_w_pagination_cxd_51110.pdf](https://www.amhca.org/assets/news/AMHCA_Code_of_Ethics_2010_w_pagination_cxd_51110.pdf)

- **National Rehabilitation Counselor Association (NRCA):**
http://www.worksupport.com/documents/proed_codeofethics.pdf
- **American Counselor Association (ACA):**
<http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx>
- **American Association of Marriage and Family Therapists (AAMFT):**
http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx
- **American School Counselor Association (ASCA):**
<http://www.schoolcounselor.org/files/EthicalStandards2010.pdf>
- **National Association of Social Workers (NASW):**
<http://www.socialworkers.org/pubs/code/default.asp>

Congratulations!



You have completed the final lesson in this course! You must pass Quizzes 1, 2, and 3, and *must* complete our short Feedback Form for this course, to earn your certificate. You can then automatically receive your certificate on line (printable and savable to disk), downloaded to your screen.

NOTE: We have also provided instructions for emailing your certificate to yourself if you choose, on our CERTIFICATES web page. To go there, click [here](#) . . . or go to the ‘About Certificates’ page under the ‘Courses’ tab on the website menu bar, where you will find a link to ‘How to Email Your Certificate to Yourself’.

To reach the links for the quizzes and the feedback form, simply close this page, or you may return later to [My Home Page](#). Thanks for your business, and come back to see us again at *CEU By Net!*