ACT

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HAZARDS OF MANAGED CARE FOR MENTAL HEALTH

The research suggests that there are numerous hazards to utilizing managed care, now being referred to in the mental and medical fields as "mangled care" or "damaged care." With managed care, there is a problem with the lack of confidentiality; potential conflict of interest because the therapist is working for the managed care company and the client; with the regulations concerning cost effective treatment taking precedence over the client's unique situation; continuity of treatment; control of care; and the one-size-fits-all approach in utilization review and treatment planning. Managed care policies compromise ethical practice for therapists and providing the best treatment possible for clients. Managed care organizations are cost-focused rather than person and treatment-focused.

Managed care operates under the philosophy of cost-effectiveness which compromises the highest quality of care. Managed care is more concerned about their profit than people's health. To qualify for insurance coverage, patients must be given a specific diagnosis, drawn from the Diagnostic and Statistical Manual of Mental Disorders, known as the DSM, published by the American Psychiatric Association. Since the level of coverage may depend on the diagnosis, therapists will sometimes assign a more serious condition when given two similar options—because the client needs the additional sessions. Some states, such as California and Massachusetts, allow certain psychiatric disorders to receive a higher benefit level, which is generally assigned to medical visits. As a result, the therapist may give someone the diagnosis of a more serious psychological disorder than was needed to secure authorization of additional sessions.

In such circumstances, counselors and therapist find themselves playing the diagnosis game. Insurance companies only cover a small portion of psychiatric conditions. The paradox is that if you have a mild diagnosis and are high functioning, your insurance company may deny coverage because they consider your condition to be mild and in their view does not warrant coverage.

On the other hand, if you are diagnosed with a psychological disorder that falls under the category of mental conditions that are categorized as severe or chronic, you may not be covered because your condition will require long-term treatment. If you have a serious condition such as Anorexia, Bipolar Disorder, Bulimia, Major Depression, Obsessive-Compulsive Disorder, Panic Disorder, Pervasive Developmental Disorder, Schizoaffective Disorder or Schizophrenia they may deny you coverage because you may require long-term treatment which they tend to be unwilling to pay for. Moreover, your diagnosis will be documented in your medical records and will follow you throughout your entire life. This is a frightening situation for parents who may seek counseling or therapeutic services for their children that require a diagnosis. When the child becomes an adult and may be dealing with the same concerns the insurance company may state that the condition is preexisting and deny coverage.

Also, if you are a high functioning individual and do not meet the criteria of any diagnosis or a mild diagnosis that is not covered by your insurance, therapists using your health insurance may engage in insurance fraud by diagnosing you with a condition that you do not meet without your knowledge to be reimbursed for their work. An exaggerated diagnosis can have negative implications as well. A diagnosis

of depression, for example, could make it difficult to get disability insurance. As previously mentioned, your diagnostic information becomes a permanent part of your medical records. Have you asked your counselor or therapist what your diagnosis is? Therapist's ethics are comprised by their desire to be compensated for their work because of this inherent conflict of interest.

To make matters worse, if you relapse and have a recurrent episode, your presenting concern may not be covered because now it is considered a preexisting condition. Consequently, only a small amount of diagnoses are covered that are not classified as mild or severe. If you are seeking counseling or therapy to improve an intimate relationship or any other family relationship, the insurance companies do not cover such care. In such a case, one of the partners or family members must be diagnosed in order to be seen. Here again, counselors and therapists are placed in an ethical conundrum because they have to falsify the truth to insurance companies and engage in a form of insurance fraud by suggesting that they are treating a condition rather than improving a relationship.

Even more disturbing, a client's insurance policy may include 20 sessions per year, however the insurance company may only approve 6 - 8 sessions for a depressed client, in case the individual relapses and experiences another depressive episode during the same year. What are the ramifications for such a client? A client is more likely to relapse because their treatment was prematurely terminated. To aggravate a difficult situation, the client is then denied future authorizations for sessions because of a preexisting condition.

To avoid diagnosis backlash, discuss the options before you begin therapy. Many practitioners are not inclined to put labels on their patients for a variety of therapeutic reasons but are forced to provide one before insurance companies will cover their services. Pay for your treatment out-of-pocket and the need for any diagnosis—and certainly for an inflated diagnosis—will disappear. The benefits of private pay therapy are confidentiality, individualized person-centered treatment without any limitations in coverage and declines in the quality of care.

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