

OFFICE OF PATIENTS' RIGHTS

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To: All Patients' Rights Advocates

From: Office of Patients' Rights

Re: Voluntary vs. Involuntary Services in a Managed-Care Environment

Date: June 26, 2001

California's statutes and regulations firmly establish a patient's right to receive voluntary mental health services. (*Welfare & Institutions Code* §§ 5003, 5151, 5250(e))

Put simply, once the physician determines that an individual, as a result of a mental disorder, is a danger to self or other, or unable to provide for basic needs, he/she also must determine whether the individual is willing and able to accept voluntary treatment prior to initiating an involuntary hold.

Confusion has arisen around the provision of voluntary services because some managed care providers "suspend" the "medical necessity" determination and permit payment when individuals are placed on involuntary psychiatric holds. Increasingly, advocates report that physicians are placing individuals who seek voluntary treatment on involuntary holds either as a shortcut to ensure payment authorization or out of a real fear that their patients will be inappropriately denied necessary treatment. This memorandum discusses the standards for obtaining voluntary inpatient services in a managed-care environment and how advocates can monitor compliance with these requirements.

How is medical necessity for voluntary inpatient services established?

The regulations adopted by the state Department of Mental Health on inpatient admissions expressly provide for a non-emergency admission and for continued reimbursement at an acute inpatient level even when the patient does not meet the 5150 standard of danger to self or others nor grave disability. The Medi-Cal mental health managed care regulation on "Medical Necessity Criteria for

Reimbursement of Psychiatric Inpatient Hospital Services” provides for admission to inpatient hospital services when the patient “has symptoms or behavior that ...represent a recent, significant deterioration in ability to function” or “require admission for ...other treatment that can reasonably be provided only if the patient is hospitalized.” (*Cal. Code of Regulations, Title 9, § 1820.205(a) (2)*)

The same regulation provides that “continued stay services in a psychiatric inpatient hospital” shall be reimbursed when there is a “need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the psychiatric inpatient hospital.” (*Cal. Code of Regs, tit. 9, § 1820.205(b)(4)*)

Finally, the regulation concludes that “an acute patient shall be considered stable when no deterioration of the patient’s condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.” (*Cal. Code of Regs., tit. 9, § 1820.205(c)*)

More generally, Welfare & Institutions Code §14201(e)(i) provides that mental health services recommended by a doctor or other mental health providers must be provided to help with the “maximum reduction of physical or mental disability and restoration of an individual to best possible functional level.” Additional information about medical necessity may be obtained from a Department of Mental Health Policy Letter: www.dmh.cahwnet.gov/dmhdocs/docs/notices01/01-01.pdf.

Emergency Inpatient Services in Another County

Sometimes questions arise as to whether a client can receive inpatient services in a county that is different than where they typically live. The county where the client lives must authorize his/her services. (*Cal. Code of Regs., tit. 9, §§ 1810.405(a), 1850.405(e)*) Generally, the MHP can limit a client to its contract providers, which are usually in the county. Even if the client is out of county, the MHP can make the client come back to see a contract provider. However, there are two exceptions:

If the client has an “urgent condition,” the MHP must give authorization to a local provide in the county where the client needs services if a contract provider is not “reasonable available...especially in terms of timeliness of service.” (*Cal. Code of Regs., tit. 9, § 1830.220(b)(3)*)

If a client is placed out of county by a conservator, then the MHP must authorize a local provider in the county where the client is placed based on his/her needs, “the geographic availability of providers and community standards for the availability of providers” in the county where the client is placed. (*Cal. Code of Regs., tit. 9, § 1830.220(b)(4)*)

Thus, inpatient hospital services should be available for a client in another county, at least when the client meets the 5150 criteria or when the client meets the medical necessity standard for voluntary hospitalization and the client’s condition is likely to deteriorate deeming a transfer of the patient from the out-of-county hospital to an in-county facility.

Obtaining Community Services Following Release From an Involuntary or Voluntary Hospitalization

A common complaint from clients is that it is difficult to get services from a mental health plan following hospitalization. The hospital must prepare an “aftercare plan” for the client that includes “referrals to providers of medical and mental health services.” (*Welf. & Inst. Code §§ 5622(a), 5768.5(a)*) The county MHP must be part of this planning process. As part of the referral process, the hospital must tell the client about all “aftercare services which support adjustment to community living following hospital treatment.” (*Welf. & Inst. Code § 5008(d)*)

The hospital must make sure that the referral is effective and that the other agency or provider accepts the client. (*Welf. & Inst. Code § 5008(d)*) This means that the hospital and the MHP must make sure that the client has a follow-up appointment with a clinic for more medication or counseling when it is needed.

What can advocates do?

Advocates may want to provide training to mental health professionals and service providers emphasizing the following. This may be a good training to do in conjunction with mental health staff responsible for monitoring managed care services.

Mental health clients have a statutory right to treatment in the least restrictive setting, and there is a clear public policy preference for voluntary treatment.

An individual's status as a voluntary or involuntary patient is not necessarily an indicator of the severity of that individual's condition or their need for treatment. Managed care plans can authorize voluntary hospital services.

The definition of medical necessity for voluntary inpatient services.

Hospital and managed-care plan's obligation to develop meaningful aftercare plans prior to discharge.

Advocates may want to review the Mental Health Managed Care Plan to insure:

The definition of medical necessity for voluntary inpatient services is consistent with Department of Mental Health guidelines.

The Plan has procedures for providing out-of-county services when required by state law.

There is a clear procedure by which the Managed Care plan staff participate and assist the facility in coordinating the aftercare plan.

Advocates may want to monitor facility records to determine:

The number of voluntary vs. involuntary hospitalizations.

The criteria noted in clients' charts for providing voluntary services and the consistency of this criteria with the managed care medical necessity criteria.

Facility policies/procedures compliance with the medical necessity standards.