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I believe the Compliance Institute (CI) is the most effective compliance conference in the world; however, that is not why I would go to the annual meeting of my profession.

I would go to sip orange juice in the morning and meet someone new who happens to have the same issues I do.

I would go for that first break in the morning to run into that person I had always wanted to meet and be reminded that we are in a great profession with a wonderful mission.

I would go to have lunch and listen in on the conversations and realize my problems are their problems.

I would go to drink a beer at the reception and listen to Al Josephs, John Steiner and Kelly Nueske tell funny stories that make me forget my challenges for the moment.

I would go to skip a session, sit in the lobby with a colleague, and solve a private difficult problem I have.

I would go to the CI to go to dinner with an old friend.

I would go to the annual meeting of my profession so I could come back reenergized, confident, and proud to be a member of this profession.

That's why I would go!

Roy Snell, CEO HCCA

Roy Snell

Core issues and regulatory compliance in behavioral health

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Behavioral health as a specialized field has historically struggled with regulatory compliance issues, because of its subjective nature and flawed diagnostic system that separated it from the rest of medicine.

According to Fisk and Thomas,[1] the most common problems with behavioral health regulatory compliance have to do with documentation, billing and coding, treatment plans, and medical necessity. They also suggested that providers can assess their compliance efforts by asking themselves a series of questions about self-improvement, and most important, by assessing the quality of the care they provide. In addition, they recommended that sound research and outcomes-based practice are the best ways to improve outcomes in behavioral health treatment and will be the most effective methods for aligning practice with regulations.

However, is it possible to accomplish true quality of care with outcomes-based practice when the psychiatric field is saturated with uncertainty and consumed with a defective diagnostic system that contaminates the whole process?

Meanwhile, psychiatry continues to lack a single test that would validate the theories behind its alleged disorders.

The 1973 famous Rosenhan study[2] illustrated this issue. The study provided the courts with evidence that is severely damaging to the belief that psychiatrists can, in fact, distinguish between "the sane" and "the insane," "the normal" and "the abnormal."

Rosenhan basically takes the view that psychiatric diagnoses are in the minds of the observers (that is, the psychiatrist or the mental health worker) and are not valid summaries of characteristics displayed by those observed.

These problems in behavioral health present us with the following ethical dilemmas and compliance questions:

- How can we ensure medical necessity, accuracy in billing, and adequate treatment planning when the launching premise (the diagnosis) is erratic?
- How can providers ensure quality and efficacy of treatment when insurance billing (e.g., Medicare and Medicaid) is based on predetermined inclusive diagnoses that reflect the severity of the psychopathology?
- Do the stringent and limited insurance requirements set the stage for upcoding and billing inaccuracy?
- How can patients be assured of the quality of their treatment, when the etiology of their alleged illnesses are only presumed and not known?
- Can uncertainty be correctly coded?
- Do most people compartmentalize their behaviors and tailor their ethics to the situation at hand, in order to justify their conduct?
- Can ethics be situational and negotiable? As a compliance officer, executive, provider, and as a person, can you be half ethical?

Core issues and regulatory compliance:

Issue 1: Screenings and early prevention

Our obsession with prevention is not a new idea. Prevention in mental health is a costly and cumbersome mission to accomplish. Early mental health intervention is plagued with multiple obstacles, ranging from erratic screening tools and poor diagnostic systems, to a fragmented and chaotic multidisciplinary approach.

However, the continuous rise in health care costs, in addition to other corporate economic needs, has created a political climate conducive to the advocacy for early mental health intervention. Catching the illness early on could save the corporate health system millions of dollars and could also save many lives and alleviate suffering. At the same time, it could generate for this same health system billions of dollars due to early intervention, screening, diagnostics, medications, and various treatments.

Although it is extremely important to be proactive in a reactive psychiatric world, the process of early intervention can be intricate and could become extremely detrimental to the patient. For example, under the guise of deterring suicide, early screening has been promoted nationally by many agencies, both governmental (e.g., the New Freedom Commission on Mental Health) and nongovernmental, as a key tool for the detection of early pathology (defined as any disturbance in mood, anxiety, sleep, attention, eating, development, education, etc.). This screening process, like the Columbia University Teenscreen, is definitely problematic, troubling, ominous, and, in some cases, unethical. It tends to create a new caste system, in which minors are branded, classified, and placed in a specific mental health category that will haunt them for the rest of their lives. These screening tools are usually generic and subjective, lack reliability, and carry the ability to find symptoms in any screened minor, regardless

of age. This leads to erratic results and many false positives. As a result, many children and adolescents are automatically misdiagnosed and referred anyway for psychiatric treatment.[3]

Ironically, the US Preventive Services Task Force (USPSTF) found no evidence that screening for suicide risk reduces suicide attempts or mortality. [4] The report stated that there is limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk. The USPSTF found insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality.

These concerns in screening and early prevention introduce these regulatory compliance questions:

- Can a general screening of the population be justified as a billable service?
- Do preemptive behavioral health screenings constitute a medical necessity?
- Should the whole population be referred for psychological treatment and medicine as a preventative measure?
- Are these screenings conducive to unethical upcoding and overpathologizing to justify billing?
- Does early mental health intervention pave the way for pathologizing and medicating everyone to promote $3.00 pills?

Issue 2: The medicalizing of behavior

The other problem for behavioral health is the medicalizing of behavior to sell $3.00 pills. If a mental condition is proven to be of medical etiology, it ceases to be a psychological/psychiatric one. Patients should be referred to internists, neurologists, and endocrinologists to help them correct these chemical imbalances in the brain. Unfortunately, and up to this day, we still do not have a single test that would confirm the presumed monoamine hypothesis, which alleges that deficiency or superabundance of neurotransmitters in the brain such as serotonin, norepinephrine, and dopamine are a cause of mental illness, i.e., depression). In addition, operating on the premise that psychological disorders are medical illnesses will actually contaminate any outcomes-based practice, because the original hypothesis is tainted with doubt and uncertainty.

Subsequently, hiding negative drug research outcomes by the pharmaceutical companies, as well as using psychometrics to manipulate these results through hired research companies that are willing to tweak results in favor of the new drug, is a potential compliance hurdle.

Unfortunately, the Food and Drug Administration (FDA) became unable to manage any ethical and regulatory compliance issues since the inception of the Prescription Drug Users' Free Act (PDUFA) in 1992. This effective watchdog organization was transformed by Congress into a semi-privatized impotent agency that receives money from the pharmaceutical companies (e.g., $500,000 per drug) to hire reviewers, who in return will speed up the process of approval of new drugs.

This massive conflict of interest combined with the medicalizing of behavior raises the following compliance questions:

- Is the current DSM coding system considered a medical or a psychological one?
- How can the behavioral health provider distinguish between a psychological symptom and a medical condition when the tools of detection are non-existent?
- Could an unproven hypothesis be treated as a real and billable disorder?
- Does the speeding up of the drug approval process affect the quality of care?
- Are the governing federal agencies as the nation's "CEO" held accountable to the same compliance standards as everyone else?
- Does absolute power exclude accountability and ethics?

Issue 3: The DSM diagnostic system

Another major concern that constitutes the most significant problem for behavioral health regulatory compliance is the diagnostic classification process that is built on the diagnostic bible of the American Psychiatric Association (APA), the Diagnostic and Statistical Manual for Mental Disorders (DSM). This manual, which defines disorders from personality problems to drug addiction, is not based on any empirical evidence or statistical data as the title suggests, but on a consensual system among psychiatrists with strong connections to the corporate world. Unfortunately, this manual is an opprobrium, which is designed to find pathology in every human being. It is unequivocally problematic for the mental health intervention process.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, also known as DSM-IV-TR, includes all of the allegedly existing mental health disorders. The coding system utilized by the DSM-IV-TR attempts to correspond with codes from the International Classification of Diseases, commonly referred to as the ICD. Early versions of the DSM did not correlate with ICD codes, because updates of the publications for the ICD and the DSM are not simultaneous, therefore, some distinctions in the coding systems may still be present.

A smoking-gun study by Cosgrove, Krimsky, Vijayaraghavan, and Schneider[5] demonstrated that 95 (56%) of 170 psychiatrists who contributed to the DSM had one or more financial associations with companies in the pharmaceutical industry. One hundred percent (100%) of the members of the panels on mood disorders, schizophrenia, and other psychotic disorders had financial ties to drug companies. The results of this study could explain the recent surge of bipolar disorder diagnoses in

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lieu of the previous popular and trendy diagnosis of attention-deficit hyperactivity disorder. Ironically, the number of disorders listed in the DSM has exploded from 112 in 1952 to about 374 in 1994, an increase of almost 70%. No field has ever been so prolific in finding and generating disorders![3]

Despite the wide publicity that this study has received, the US Department of Health and Human Services ignored it, knowing well that these APA psychiatrists might have been involved in a major ethical violation that impacts everyone in the field, and affects the safety and the overall quality of care in behavioral health.

The problems with the DSM make the criteria for diagnosis at best nebulous, subjective, and unreliable. Almost anyone can be defined as mentally ill. These inherent issues in the diagnostic system obfuscate the symptoms of mental health, create an atmosphere of confusion and uncertainty, as well as a diagnostic cocktail where every patient can have nine to ten different diagnoses depending on the practitioner's point view and bias.

These issues in the DSM manual raise these additional regulatory compliance questions:

- How can the behavioral health provider conduct an accurate assessment and treatment, when the baseline of symptoms is unknown, and the diagnoses of the same patient among clinicians are perpetually inconsistent?
- How can providers ensure quality of care and compliance when the DSM diagnostic system is based on the marketing of new drugs, politics, and diagnostic trends?
- Can marketing stultify ethics and triumph over science?
- Is the DSM designed to find pathology in everyone?

Change

When profits and productivity, rather than ethics and quality, are the central themes in an agency's culture, the end results would obviously be upcoding, billing inaccuracies, poor treatment planning, and poor quality of care. Change must come simultaneously from the top-down and from the bottom-up. A national change of culture must be promoted by the top in order for the bottom to be encouraged, empowered, and enhanced. Trust and cooperation must supersede fear and retaliation in order for true change to be born, and for regulatory compliance to be effective.

What should be done now to induce a required change in a disparate behavioral health industry?

Improving quality of care in behavioral health

It is essential that ethics are emphasized and prioritized over billing. Ethical behavior must be incorporated and instilled in the workplace. The ethical person will be more conscientious, and will make an additional effort to ensure that he or she has sufficient evidence to make a diagnosis. A diagnosis should not be made just for billing purposes.

Executives have the power to induce change in the culture of their agencies. Therefore, they must increase the competence of their employees; model responsibility, transparency, and accountability; encourage passionate, respectful, and ethical engagement; and ensure the synchronicity of their services to reduce errors and improve quality of care.

The behavior health industry must also work on enhancing the disorder-specific diagnostic skills, and choose a more efficient and consistent diagnostic system than the DSM, in order to reduce upcoding as well as to increase accurate diagnosis among various clinicians. As a start, switching to the ICD-9-CM from the DSM might help create more diagnostic consistency and reduce unnecessary work and translation errors.

Practitioners should recognize warning signs of exacerbated symptoms and intervene accordingly. Their plan of care should establish the linkage between evolution of treatment results and care plan modification. Agencies must implement effective risk assessment, and utilize the latest research and evidenced-based practices. Executives must encourage the development of cultural competencies regarding behavioral health, and educate their employees in psycho-social implications of mental illness, improve crisis intervention skills, and develop a goal-specific training curriculum.

The following are recommendations by Fisk and Thomas[1] that might contribute to improvement in quality of care.

General recommendations

- Use the current environment as a catalyst for quality; examine honestly and deeply the quality of treatment.
- Investigate and implement evidence-based practices wherever possible and reasonable.
- Abandon the destructive notion that the area of behavioral health should be perceived as "different" and therefore should be isolated.
- Learn how other clinical areas in the system are handling compliance and share ideas.
- Recognize that treatment plans are helpful; use them to direct treatment and to demonstrate that treatment's efficacy.
- Use electronic medical records.
- Educate, educate, educate everyone—including billing, clinical, and management staff—about regulations, payer expectations, compliance, and quality
- Perform internal quality audits.
- Spread the word that compliance is not optional

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- Take political action against unreasonable or counter-therapeutic regulations.

Improving documentation

- A chart entry must describe the service as well as justify it.
- The progress note documentation must be legible and must include the following information:
  - The date and duration of the session
  - A description of the nature of the treatment service
  - The patient's response to the therapeutic intervention
  - A plan
- Progress notes, for example, are expected to contain recommendations for revisions in the treatment plan and an assessment of the patient's response to treatment and progress in meeting the goals set forth in the original treatment plan.
- The medical record specifies the psychiatric components of the record.
- The content requirements for admission documentation are spelled out, as are the expectations for the treatment plan and progress notes.
- Improving billing and coding
- Improved communication between billing departments and the rest of the health care system.
- An accurate Charge Description Master.
- Access only to appropriate codes for the level of the provider (e.g., codes for evaluation and management are not provided to practitioners who are not qualified to use them).
- Clinical documentation justifies the code billed, including medical necessity.
- Edits that ensure that only payer-qualified clinicians are providing the services billed.
- Accurate diagnoses recorded on claims.
- An efficient process flow from service rendered to bill submitted for payment.
- Formal, regular communication and feedback loops between billing and clinical areas.
- Education for billers that improves their ability to discriminate among clinical services, and education for clinicians that underscores the critical nature of their documentation and coding choices.

Improving treatment based on medical necessity

- Prompt providers to examine the concept of medical necessity and to question their own notions of treatment.
- Determine the treatment's real value.
- Ensure that the treatment truly is for the benefit of the patient and will have a positive impact upon that person's well-being.

Improving treatment planning

- Begin with accurate, precise diagnostics and a clear description of symptoms and presenting problems.
- Include behavioral goals that are concrete, realistic, measurable, and meaningful to the patient.
- Make sure the plan is individualized to the patient.
- Update the treatment plan whenever a change is reasonable or whenever the current treatment has not proven to be effective.

Conclusion

In an increasingly regulatory world, ethics and compliance are no longer optional. Regulatory compliance is entangled with quality of care.

Behavioral health has many hurdles to overcome; therefore, self-accountability must become a norm in order to advance the field in the right direction. Compliance issues must be taken seriously as a means for self-improvement and progress. Fear of punishment and penalties should not be the main incentive to implement an effective compliance program.

In summary, the strategic components that would deter or reduce a prospective compliance conflict in behavioral health would entail the following:

- Establishing an honest relationship with payers.
- Implementing prevention and detection strategies.
- Admitting mistakes and implementing self-correction, education, and ongoing training for employees, as well as risk management, and transparency.

The behavioral health executives have to set the stage for their agencies by deciding whether to practice Machiavelli's ethics (i.e., the end justifies the means, and an effective leader must retain power at any cost) or Cicero's ethics (i.e., wrong doing for the sake of gain is never to be tolerated), and whether they want quality of care or status quo. ■

1 1 Fisk, Anne and Thomas, Mary Beth: Regulatory Compliance Issues in Behavioral Health. Journal for Healthcare Quality, 2003;(133). National Association for Health Care Quality. Available online at http://www.nahq.org/journal/ce/article.html?article_id=163

2 Ziskin, Jay and Faust, David: Coping with Psychiatric and Psychological Testimony, 4th Edition. 1988, Law and Psychology Press, pp. 828-829.

3 Skaff, Richard: "A Fundamental Manual for Early Mental Health Intervention." Contemporary Psychology: APA Review of Books, September 27, 2006. (Mental Health in Early Intervention: Achieving Unity in Principles and practice. Gilbert M. Foley and Jane D. Hochman, Eds.)

4 U.S. Preventive Services Task Force: Screening for suicide risk: Recommendation statement, May 2004. www.ahrp.org/infomail/04/05/21.php.

5 Cosgrove, Lisa; Krimsky, Sheldon; Vijayaraghavan, Manisha; and Shneider, Lisa: Financial ties between DSM-IV panel members and the pharmaceutical industry. Journal of Psychotherapy and Psychosomatics, 2006;75(3):154-160.