Overview (Part 1)

- EMTALA vs. Involuntary detention
  - The regulatory binds over psychiatric services
  - Assessing EMTALA risks for emergency patients with psychiatric conditions
  - The 24-hour hold – is it a practical alternative?
- Does EMTALA help address 5150 imponderables?
- MEDI-CAL ED payment – all pain and little gain
- Improving your mental health well-being
- Open discussion and Q and A
Overview (Part 2)

The EMTALA obligations and the LPS obligations have nothing to do with each other

+ The EMTALA obligations and Medi-Cal payment for an emergency psychiatric condition are opaque and incongruent

= What Could Possibly Go Wrong?
Disclaimer No. 1

• This presentation is intended to provide information regarding psychiatric detention laws and involuntary holds.
• The presentation does not constitute legal advice, or its application to the delivery of emergency health care services.
• Attendees should consult with their own legal counsel and/or risk management for advice and guidance.
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How Bad Can This Be???

- Patient presents to a non-designated hospital ED; determined to have an psychiatric EMC -- suicidal ideation with a specific plan
- ED physician and county staff agree that patient requires inpatient psychiatric placement -- County places a 5150 on the patient
- Neither the hospital or County can find acute inpatient psychiatric placement – hospital admits patient to inpatient bed
- County makes daily visits to assess patient, and writes a 5150 multiple times to cover the stay
- After two weeks, physician and County agree that patient can be discharged
- What are the LPS and EMTALA issues; who pays for the stay?
EMTALA and Psychiatric Services in the ED

Overview –

• Basic Concepts of EMTALA vs. 5150
• Risks of an EMTALA violation
• 1799.111 holds
EMTALA v. 5150 Hold

- Involuntary detention is a state process
- A 5150 is means to facilitate access of a person to evaluation and treatment of a mental disorder
- **A 5150 is not a clinical determination**
- EMTALA overrides conflicting state law, except more stringent state laws that do not conflict with EMTALA
- Nothing in EMTALA addresses involuntary holds —
- CMS guidance – EMTALA obligations override state or local treatment networks and processes
Psychiatric EMC v. 5150 Hold

Similarities, but not congruence -

• Psychiatric EMC is based on a **clinical judgment** of an ED physician or other qualified professional designated by the medical staff.

• A 5150 hold is based on **probable cause** by a peace officer or a county-authorized professional as a legal mechanism to take a person involuntarily to a designated facility for an assessment of a behavioral health condition.
Psychiatric EMC v. 5150 Hold (cont.)

**Similarities, but not congruence** -

- A psychiatric EMC may not meet the probable cause standard for a 5150 hold
- A 5150 hold does not always mean that a person has a psychiatric EMC
- A determination that a patient’s psychiatric EMC is stabilized does not itself alter the status of a 5150 involuntary hold
- Documentation must be clear as to whether the ED physician has determined if the psychiatric EMC is stabilized
Stabilization — Psychiatric Emergency Condition

When is a psychiatric emergency condition stabilized?

- **EMTALA regulations**: when no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient to another medical facility.

- **Interpretive Guidelines**: psychiatric patient is “stable” when he/she is protected and prevented from injuring or harming himself/herself or others.

- This is a **clinical** decision!!!
Assessing EMTALA Risks for Psychiatric Emergency Medical Services
EMTALA Risks for Psychiatric EMCs

- Triage and medical screening of patients with psychiatric complaints or conditions
- Further evaluation and monitoring of psychiatric patients
- Security/elopement of psychiatric patients
- Transfer of psychiatric patients
- Acceptance of emergency psychiatric patients
  - Requests for insurance information
  - Discharge of psychiatric patients without transfer
CMS 2567: “__ of 48 sampled patients who presented to the ED with psychiatric emergencies, including suicidal ideations and altered level of consciousness:

(a) were not initially assessed and placed at the appropriate level of acuity

(b) were delayed in receiving an MSE to determine whether an emergent medical condition existed.”
CMS 2567 --
“… the facility failed to ensure that two... patients who presented to the ... ED ... with psychiatric diagnoses (including suicidal and homicidal ideations or an altered level of consciousness) received ongoing assessments and monitoring to ensure stabilization of an emergent condition ... These failures resulted in the potential for the undetected deterioration of an emergency medical condition which would place patients at risk for harm, including elopement.”
Question: must an EMTALA psych patient transfer be hospital to hospital?

CMS Response (see CHA EMTALA Manual, App. V):

- An appropriate transfer under EMTALA does not require in all cases that the receiving facility must be a hospital
- A transfer to a CSU or other non-hospital facility is not automatically a violation of EMTALA
Question: must an EMTALA psych patient transfer be hospital to hospital?


- An appropriate transfer under EMTALA does not require in all cases that the receiving facility must be a hospital
- A transfer to a CSU or other non-hospital facility is not automatically a violation of EMTALA
Transfer (cont.)

However …

- The sending physician must have a reasonable clinical confidence that the CSU has the capability to stabilize the patient’s behavioral emergency.

- If the sending physician does not have the clinical confidence that the CSU can stabilize the condition, the physician should arrange a transfer to a level of care higher than the CSU.

Note: a CSU is not subject to EMTALA unless operated under a hospital provider number.
Transfer (cont.)

2567s issued to hospitals that transferred a psychiatric patient to a CSU, who

• was subsequently transferred back to the sending hospital; and

• subsequently transferred to a psychiatric facility for admission

• “[P]otential for delay in stabilizing care if they are required to be transferred to an inpatient psychiatric hospital after 24 hours.”
Strategies -

• CSUs can be a resource for placing ED psychiatric patients, but …
  • Skepticism from some CDPH surveyors as to sending ED patients to an ambulatory facility

• A transfer agreement with the CSU is helpful -
  • Know the CSU’s admitting criteria and service limitations
  • Consider how to work together to serve patients

• Documentation of the patient’s condition and suitability for CSU placement is critical
  • Be selective as to who is a candidate for a CSU transfer
Discharge

CMS 2567 -

“…the hospital failed to comply with …[EMTALA] when Patient 1 was diagnosed with a psychiatric emergency medical condition and the hospital did not fully implement the stabilizing measures as determined by the mental health crisis worker …The stabilizing measures identified by …[the crisis worker] were located in Patient 1’s home town and Patient 1 was discharged without a means to get to her home, a distance of [___] miles from the hospital.”
Can You Ever Win?

- Patient on 5150 comes to a designated hospital ED in police custody; tased after assaulting a former spouse
- Patient is non-cooperative and disruptive
- ED physician, with psychiatrist consult, determines that patient is high on meth, but no mental disorder
- Plan – release the 5150 hold and discharge to police
- Patient is escorted by police off the property
- Patient assaults former spouse later that day, is arrested, convicted and sentenced to prison
- Patient complains of an EMTALA violation
The 1799.111 Hold

Is it a Practical Alternative?
Disclaimer No. 2

§1799.111 is an orphan law in the family of involuntary hold laws and immunities tucked away in the State emergency medical systems law

• It has nothing to do with LPS or Licensing
• Legal interpretations of §1799.111 —
• There is no state agency or county department that has authority to interpret §1799.111
• There are no cases interpreting or applying §1799.111
• There are no Attorney General opinions interpreting or applying §1799.111
The 1799.111 Hold — Who Can Use It?

**24-Hour Hold**
- An ED physician
- Other licensed professional staff in a non-designated hospital

**72-Hour Hold**
- Peace officer
- Attending staff of a designated facility
- County-designated mobile crisis team member
- Other county-designated professional persons
• Must be an acute or psychiatric hospital that is **NOT** a county-designated LPS facility
• Applies to the licensed professional staff, or physician providing emergency services, in any department of the hospital
• No civil or criminal liability -
  • for detaining a person if statutory conditions are met (see Appendix A); or
  • for the actions of a detained person after release from the detention at the hospital if statutory conditions are met (see Appendix A)
The hospitals must comply with all state laws and regulations relating to seclusion and restraint, and psychiatric medications for psychiatric patients.

The detained person retains his/her legal rights regarding consent for medical treatment.

The person must be credited for time detained if he/she placed on a subsequent 5150 hold.
Resources: CHA Mental Health Manual, Ch. 3

Documentation:
- Form 12-12 in the CHA Mental Health Manual for documentation of a 1799.111 hold

Minors: Can a physician apply a 1799.111 hold for a minor?
1799.111 — Advantages?

- No County involvement in the process
- Does not require the paperwork on an application for a 5150
  - But must document the patient record
- Lacks the stigma and record of a 5150 hold
1799.111 — Advantages?

- Provides treatment alternative and flexibility to the ED physician based on patient condition
- Person can be released without County involvement
- May help in obtaining authorization for post-stabilization services?
- Immunities
1799.111 – Disadvantages?

- What happens if the 24-hour period expires and no transfer?
  - Is there legal authority to continue detention of person?
  - Can county-authorized personnel write a 5150?
  - Are you required to release/discharge the person (what are the EMTALA consequences?)
If you find placement, can you transfer a person under a 1799.111 hold to a designated facility if the person refuses to consent to the transfer?

Will CDPH/CMS treat a 1799.111 hold different than a 5150 hold for EMTALA purposes?

If a patient arrives on a 5150 hold placed by law enforcement, and the custodial officer leaves the hospital:

Is the 5150 hold still valid?

Can you treat the 5150 as lapsed?

Can you convert the patient to a 1799.111 hold?
Does EMTALA Help Address 5150 Imponderables?
Question 1.

Does a 5150 remain in place in a non-LPS designated ED if the detaining authority has left the ED?

Answer:

- Is there any law addressing this question?
- Does LPS provide any help here?
Does EMTALA Help Address 5150 Imponderables?

Los Angeles County

Answer:

• DMH has no authority to require detention or permit release.

• Consult your legal counsel regarding the legal obligations and statutory authority for continuing or releasing detention.

Source: Los Angeles Department of Mental Health; FAQs regarding changes in LAC DMH procedures related to WIC 5150 detention, Questions 6 and 8, September 28, 2015
Does EMTALA Help Address 5150 Imponderables?

Orange County

• A 5150 hold on a person in a non-designated facility “remains in place only so long as a Designated Individual remains in the facility.” (this may include a designated trainer)

• If a Designated Individual leaves the facility, there is no hold, but the hospital may consider a 1799.111, but …

• “[T]he patient will need to be placed onto an involuntary hold to transport to the Designated Facility if the client remains unwilling to accept treatment.”

Source: Orange County Behavioral Health Services; November 14, 2016 Letter to Orange County Hospitals
Does EMTALA Help Address 5150 Imponderables?

Question 1.
Does EMTALA provide any guidance to whether a 5150 hold remains in place in a non-LPS designated ED if the detaining authority has left the ED?

Answer:
EMTALA does not recognize or address involuntary holds. It imposes an obligation to provide further examination and stabilization within hospital capability, until the EMC is stabilized, or the patient is transferred or admitted.
Does EMTALA Help Address 5150 Imponderables?

Question 2.
If a 5150 remains in place in a non-LPS designated ED if the detaining authority has left the ED, who has the authority to enforce the hold?

Answer:
• Is there any law addressing this question?
• Is there any legal protection (i.e., immunities) for enforcing the hold by a non-county designated professional?
• Does EMTALA or LPS help?
Los Angeles County

Answer:

DMH has no authority to require the staff of a non-designated facility to continue involuntarily detention of an individual that the DMH staff (or any other entity) has detained under WIC 5150, after the staff who originally initiated the WIC 5150 detention has left the facility. The non-LPS designated facility may wish to consult with its legal counsel regarding its legal obligation and statutory authority for continuing such detention.

Source: Los Angeles Department of Mental Health; FAQs regarding changes in LAC DMH procedures related to WIC 5150 detention, Question 10, September 28, 2015
Does EMTALA Help Address 5150 Imponderables?

**Question 2.**
Does EMTALA provide any guidance as to enforcement of a 5150 hold if the detaining authority has left the ED?

**Answer:**

- EMTALA does not address involuntary holds. It imposes an obligation to provide further examination and stabilization within hospital capability, until the EMC is stabilized, or the patient is transferred or admitted.
- However, any enforcement of a hold must comply with the laws governing restraints and seclusion.
Does EMTALA Help Address 5150 Imponderables?

Question 3.
If a 5150 remains in place in a non-LPS designated ED, when did the 72-hour clock start and when does the 72-hour clock end?

Answer:
• Is there any law addressing this question?
• Is there any help from EMTALA or LPS?
Does EMTALA Help Address 5150 Imponderables?

The Clock according to Los Angeles County

Answer:

DMH considers the 72 hour involuntary evaluation and treatment admission associated with WIC 5150 detention to start when the individual is involuntarily detained in an LPS designated facility, as indicated by the time noted on the admission to that Facility.

DMH considers WIC 5150 application to be valid for purposes of admission to an LPS designated facility, unless or until a period of more than 72 hours of custody for mental health assessment, evaluation, and crisis intervention has occurred.

Source: Los Angeles Department of Mental Health; FAQs regarding changes in LAC DMH procedures related to WIC 5150 detention, Questions 1 and 5, September 28, 2015
Does EMTALA Help Address 5150 Imponderables?

The Clock According to North Coast EMS Agency

The law has two conflicting statements as to when the clock starts – one statement is found at WIC 5150 and the other (conflicting) statement is found at WIC 5151. Reasonable minds differ on this topic and until it is resolved by the legislature or a court, no one particular view is “correct.” It may be interpreted that the 5150 clock starts when the 5150 document is written or at the time of admittance to the psychiatric facility.

Source: http://www.northcoastems.com/plansspecialty-care/5150-holds/section-3-faqs/72-hour-clock-starts/
Does EMTALA Help Address 5150 Imponderables?

The Clock According to North Coast EMS Agency

- **Humboldt County**: the 72 hour clock starts at the time the 5150 application is written.
- **Del Norte County**: the 72 hour countdown does not officially begin until the individual is admitted to a designated facility.
- **Lake County**: the Behavioral Health Director’s interpretation is that the clock does not start until the individual is in a psychiatric facility, however, those facilities used often disagree and count the entire time since the 5150 application was signed and dated.

Does EMTALA Help Address 5150 Imponderables?

**Question 3.**

If a 5150 remains in place in a non-LPS designated ED, when did the 72-hour clock start and when does the 72-hour clock end?

**Answer:**

- Is there any law addressing this question?
- Is there any help from EMTALA or LPS?
Question 3.
Does EMTALA provide any guidance to the duration of the 72-hour clock?

Answer:
• EMTALA does not recognize or address involuntary holds or any time limit on detention.
• It imposes an obligation to provide further examination and stabilization within hospital capability, until the EMC is stabilized, the patient is transferred to another facility or the patient is admitted as an inpatient to the hospital.
Medi-Cal ED Payment for Emergency Psychiatric Services

All Pain, Little Gain
Disclaimer No. 3

• Medi-Cal payment for emergency and post-stabilization psychiatric services is complex and perilous territory

• The slides are only an overview – you need to know more information

• **Good news** – CHA has published a white paper that gives you more information
  • Give a copy to your reimbursement team!
What Do You Need to Know?

EMTALA  Medi-Cal
What Do You Need to Know? (cont.)

- EMTALA obligations vs. Financial Obligations
- Who are the Players?
  - County Mental Health Plans (“MHPs”)
  - Medi-Cal Plans (“MCPs”)
- Who Covers Mental Health Services?
  - In and out of network emergency services
  - Post-stabilization services
- Is there Coordination between MHPs and MCPs?
EMTALA v. Medi-Cal Payment
A Short Course (Part I)

Basic Facts!

- Do not assume that following EMTALA rules is the gateway to reimbursement
- Do not assume that involuntary holds are the gateway to reimbursement
- Do assume that MHPs inhabit an alternative universe, with its own terms and rules
- Do assume the MCPs are not ready to help
EMTALA v. Medi-Cal Payment
A Short Course (Part I) (cont.)

Start with Defined Terms

- **Operational Terms** -
  - EMTALA – Emergency Medical Condition
  - Licensing – Psychiatric Emergency Medical Condition

- **Payment Terms** --
  - Medicaid – Emergency Medical Condition
  - Medi-Cal MHP – Emergency Psychiatric Condition

**Warning** - they don’t mean the same thing!
What is an EMC or Psychiatric EMC?

Operational Terms --

- **EMTALA** – EMC includes psychiatric disturbances
  - CMS Guidance – danger to self or others
- **Licensing** – Psychiatric EMC – mental disorder and danger to self, others or gravely disabled
What is an EMC or Psychiatric EMC?

Payment Terms

- **Medicaid** – No mention of psychiatric disturbances in definition of an EMC
- **Medi-Cal MHP** –
  - Danger to self, others or gravely disabled;
  - Meet “medical necessity” criteria; and
  - Require an inpatient admission
Mental Health Plans (MHPs)

• Each county has a MHP in which Medi-Cal recipients are enrolled (but some exceptions)
• MHPs are prepaid inpatient health plans
  • Required to cover certain inpatient hospital or institutional services
• They are not Knox-Keene licensed, but subject to contracts with Cal. Department of Health Care Services, and state and federal laws
Medi-Cal Plans (MCPs)

• Knox-Keene licensed plans (except a COHS) that operate under comprehensive risk contracts
• Models include: two plan, geographic, rural regional, county operated health systems (“COHS”), and San Benito
• Subject to contracts with Cal. Department of Health Care Services state, state law [to varying degrees] and federal law
Financial Responsibility of MHPs

Specialty Mental Health Services

- Services for adults and children that meet “medical necessity” criteria
- Includes inpatient services, psychiatrist services, targeted case management, certain rehabilitative mental health services, crisis intervention, crisis stabilization services, outpatient services, etc.
Financial Responsibility of MHPs

Specialty Mental Health Services - Medical Necessity -

- Has one of the listed diagnoses in the DSM-IVE
- Cannot be safely treated at a lower level of care and
- Requires psychiatric inpatient hospital services as the result of a mental disorder as the result of one of the following
  - Cannot be safely treated at a lower level of care and
  - Requires psychiatric inpatient hospital services as the result of a mental disorder

Reference: (See Appendix A to CHA White Paper and Appendix B to Slides)
MCP Coverage of Mental Health Services

- Covers “outpatient mental health services”, i.e., outpatient services for members with **mild to moderate** mental health conditions
- Includes individual or group mental health evaluation and treatment (psychotherapy), psychological testing when clinically indicated to evaluate a mental health condition, psychiatric consultation for medication management, and outpatient laboratory, supplies and supplements
- Does not overlap with specialty mental health services
Emergency/Post-Stabilization Services

- MCPs and MHPs must cover emergency and post-stabilization services in non-contracted facilities
- Medi-Cal - emergency services may encompass “screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition …”
Medicaid Rules

• Post-stabilization services are covered services
  • Must be related to an EMC
  • Apply to services after an EMC is stabilized
  • Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the EMC
Emergency/Post-Stabilization Services (cont.)

**Medicaid Rules** — MCP or MHP are financially responsible for non-network post-stabilization services —

- Are pre-approved by a plan provider or representative; or
- Are not pre-approved, but are needed to maintain a patient’s stabilized condition within one hour of a request to the plan for pre-approval of further post-stabilization care; or
- Are not pre-approved, but administered to maintain, improve, or resolve the patient’s stabilized condition if:
  - The plan does not respond to a request for pre-approval within one hour;
  - The plan cannot be contacted; or
  - In certain instances where plan and physician cannot agree on enrollee’s care
Example of emergency coverage from an MCP —

• Emergency services and care include transportation, medical screening, examination and evaluation by a provider or appropriate personnel for both physical and psychiatric emergency conditions.

• Examples of psychiatric emergency medical conditions include, but are not limited to:
  • Thoughts or actions about hurting yourself or someone else
  • Unable to care for yourself, such as being unable to feed, shelter or dress yourself due to a mental disorder

Example of Post-Stabilization Services for an MHP (DHCS Template)

Your MHP is financially responsible for (will pay for) post-stabilization care services to maintain, improve, or resolve the stabilized condition if:

• The MHP does not respond to a request from the provider for pre-approval within 1 hour
• The MHP cannot be contacted by the provider
• The MHP representative and the treating physician cannot reach an agreement concerning your care and an MHP physician is not available for consultation. In this situation, the MHP must give the treating physician the opportunity to consult with an MHP physician
• The treating physician may continue with care of the patient until one of the conditions for ending post-stabilization care is met. The MHP must make sure you don’t pay anything extra for post-stabilization care

Memoranda of Understanding ("MOUs")

- MCPs and MHPs must execute MOUs to coordinate care and responsibility
- MOUs should include the following:
  - Basic requirements, including covered services and populations
  - Oversight responsibilities of the MCP and MHP
  - Screening, assessment and referral
  - Care coordination and information exchange
  - Reporting and quality improvement requirements
  - Dispute resolution
  - After-hours policies and procedures
  - Member and provider education
Memoranda of Understanding ("MOUs") (cont.)

The Reality – Are MOUs helpful?

NHeLP Report (January 12, 2017)

• Reviewed 101 MOUs between MCPs and MHPs
• “… many of the MOUs fail to meet the minimum requirements of the law.”
  • 1/3rd – did not discuss one or more required topics
  • 20% – did not cover two or more topics
• Variations in specificity of coordination or inclusion of assessment tools
• Details vary – length vary from 5 to 62 pages
• “… DHCS has provided minimal oversight of the coordination between MHPs and MCPs.” Will intervene if requested to resolve a dispute
• Copies of MOUs are available at Los Angeles office of NHeLP

Source: http://www.healthlaw.org/issues/medicaid/Mental-Health-Services-in-Medi-Cal#.WVbbylFJmUk
Summary of DHCS’ Likely View of MHP Obligations for Emergency Psychiatric Services

• Emergency/inpatient services if the member:
  • Has an included diagnosis (see Appendix B);
  • Meets medical necessity criteria;
  • Cannot be safely treated at lower level of care;
  and
  • Requires inpatient hospital services due to one of the several reasons as a result of an included mental disorder
Emergency Services –

• Facility charges for emergency services – patient meets medical necessity criteria and is admitted for psychiatric inpatient services at the same facility that provided the emergency services.

• Facility charges for professional services of a mental health specialist provided in the ED if the services do not result in an inpatient psychiatric admission in the same or another facility.

• Professional services of a mental health specialist provided in the ED to determine whether the patient’s condition meets medical necessity criteria or required to assess whether medical necessity is met.
Summary of DHCS’ Likely View of MHP Obligations for Emergency Psychiatric Services (cont.)

**Outpatient Services** - If the member:

1. has an included mental health diagnosis;
2. has a significant impairment in an important area of life function, or a reasonable probability of deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate;
3. the focus of treatment is to address impairment;
4. the expectation that proposed treatment will significantly diminish impairment, prevent significant deterioration; and
5. the condition would not be responsive to physical health care-based treatment
Emergency Services

- All professional services (excluding a mental health specialist) required for the emergency services and care, regardless of whether the condition meets MHP medical necessity criteria
- Facility and professional charges for emergency services when the services do not result in an inpatient admission
  - Includes patients with an excluded diagnosis or whose condition does not meet medical necessity criteria

Outpatient Services – diagnosed mental health disorder as defined by the DSM resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning
Who Pays for this Scenario?

- **The Facts:** Patient presents to non-designated ED with suicidal ideation/a specific plan; ED physician -- patient has a psychiatric EMC; patient transferred to designated hospital with the expectation of inpatient admission.
- If patient meets medical necessity criteria and is admitted to receiving facility, the MHP is responsible for the inpatient stay at the admitting hospital.
- Who pays for the ED services at the sending hospital?
  - Do the MCP/MHP contracts or the MOU help?
  - ED physician claims may be covered by the MCP.
  - Any ED mental personnel claims may be covered by the MHP.

For further information, see CHA White Paper, Scenario 5.
Who Pays for this Scenario? (cont.)

- Patient presents to a non-designated hospital ED and is determined to have an psychiatric EMC – suicidal ideation with a specific plan
- The ED physician and county staff agree that patient requires inpatient psychiatric placement – County places a 5150 on the patient
- Neither the hospital or County can find no acute inpatient psychiatric placement – hospital admits patient to inpatient bed
- County makes daily visits to assess patient, and writes a 5150 multiple times to cover the stay
- After two weeks, physician and County agree that patient can be discharged
- Who pays for the stay?
Emergency/Post-Stabilization Service Dilemma

Analysis of Case –

• Patient was admitted, but not for psychiatric inpatient services (is MCP is responsible)?

• But – was medical necessity met?
  • Patient only stayed because lack of network
  • County personnel involved in patient care
  • Emergency services were of a level consistent with severe, not mild or moderate

• What’s in the MHP/MCP contracts or MOU?
Strategies and Tips

• Give a copy of the CHA White Paper to the reimbursement team
• If contracted with either plan, review contract to assess plan and hospital/physician obligations
• Review applicable MOUs (available via Public Records Act)
Strategies and Tips (cont.)

• If non-contracted, wise to give notice when treating a MHP patient who presents to the ED
• Consider pursuing payment from both plans, but must be transparent to avoid double dipping
• Post-Stabilization Services –
  • If the ED physician believes a patient’s psychiatric condition is stabilized (regardless of a 5150 hold), trigger MHP/MCP notice for post-stabilization services
Improving Your Mental Health Well-Being
**Resources**

- Keep a current list of designated facilities
  - Ask for their admission criteria
  - Explore a telemedicine arrangement
- If a regional CSU, explore a transfer agreement
- Review county behavioral policies for 5150s
- Expand your database of and relationships with community resources for psychiatric patients
- Engage with patient advocates for 5150s
Don’t Give Up – Be Proactive and Persistent –

• Engage your county to acknowledge the problems and be part of the solution

• Seek authority for designation of ED physicians to write a hold and to release a hold
  • If the county says no, seek county counsel opinion if a hold can be enforced by non-designated professionals

• Ask the county department when the 72-hour clock starts/ends

• Reach out to the county patient advocates

• Publicize the problems if ignored
Don’t Give Up – Be Proactive and Persistent –

• Publicize the problems if ignored
• Work with other hospitals, stakeholders and community organizations
• Bring your issues to regional VPs of HASC, HCNCC or HCSDI and CHA
  • Look for regional strategies and solutions
• Bring your issues to your local county supervisor, state legislators and other public officials
Questions and Discussion?
Appendix A
Requirements for 1799.111 Holds
1799.111 — Conditions to Apply a Hold

- A hospital – acute or psychiatric, that is **NOT** a county-designated LPS facility, and
- The licensed professional staff, or physician providing emergency services, in any department of the hospital —

  “shall not be civilly or criminally liable for detaining a person if all of the following conditions exist during the detention”
(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician, or staff psychologist, the person, as a result of a mental disorder, presents a danger to self, others or is gravely disabled.
(2) The hospital staff, treating physician, or appropriate licensed mental health professional, has made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person...
When does documented and repeated unsuccessful efforts to find placement begin?

- Telephone calls must begin at the “earliest possible time” the physician has determined that the person is medically stable for transfer.
- “In no case shall the contacts … begin after the time when the person becomes medically stable for transfer.”
1799.111 — Conditions to Apply a Hold (cont.)

(3) The person is not detained beyond 24 hours; and

(4) There is probable cause for the detention
(5) If the person is detained beyond 8 hours –

- Discharge or transfer for further evaluation or treatment has been delayed due to the need for continuous and ongoing care, observation or treatment by the hospital; and

- In the opinion of the treating physician or staff clinical psychologist, the person, due to mental disorder, is still a danger to self/others or gravely disabled.
A hospital – acute or psychiatric, that is NOT a county-designated facility, and

• The licensed professional staff, or physician providing emergency services, in any department of the hospital —

“shall not be civilly or criminally liable for the actions of the person detained up to 24 hours … after that person’s release from the detention at the hospital …” if the following conditions are met:
(1) The person has not been admitted to a license acute or psychiatric hospital for evaluation or treatment under Welfare & Institutions Code Section 5150; and
(2) The release from the hospital is authorized by a physician or staff clinical psychologist –

- Based on a face-to-face examination of the detained person
- The person does not present a danger to self or others or is gravely disabled
1799.111 — Conditions to Release a Hold (cont.)

(2) If the release is authorized by a staff clinical psychologist –

• He/she must first consult with the physician
• If a dispute, detention must be maintained unless the “hospital’s medical director” overrules the physician opposing release
• The psychologist and physician must document their findings, concerns or objections in the patient record
Appendix B
Medical Necessity Criteria for MHP Services
Medical Necessity Criteria
Psychiatric EMC or Inpatient Services

<table>
<thead>
<tr>
<th>Has one of the following diagnoses in the DSM-IVE:</th>
</tr>
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<tbody>
<tr>
<td>• Pervasive development disorders;</td>
</tr>
<tr>
<td>• Disruptive behavior and attention deficit disorders;</td>
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<tr>
<td>• Feeding and eating disorders of infancy or early childhood;</td>
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<tr>
<td>• Tic disorders;</td>
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<tr>
<td>• Elimination disorders;</td>
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<tr>
<td>• Other disorders of infancy, childhood, or adolescence, cognitive disorders (dementia with delusions or depressed mood);</td>
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<tr>
<td>• Substance induced disorders (with psychotic, mood, or anxiety disorder);</td>
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<tr>
<td>• Schizophrenia and other psychotic disorders;</td>
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<td>• Mood disorders;</td>
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<tr>
<td>• Anxiety disorders;</td>
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<tr>
<td>• Somatoform disorders;</td>
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<tr>
<td>• Dissociative disorders;</td>
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<tr>
<td>• Eating disorders;</td>
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<tr>
<td>• Intermittent explosive disorder;</td>
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<tr>
<td>• Pyromania;</td>
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<tr>
<td>• Adjustment disorders;</td>
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<tr>
<td>• Personality disorders.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cannot be safely treated at a lower level of care and Requires psychiatric inpatient hospital services as the result of a mental disorder as the result of one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has symptoms or behaviors due to a mental disorder that:</td>
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<tr>
<td>• Represent a current danger to self or others, or significant property destruction;</td>
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<tr>
<td>• Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;</td>
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<tr>
<td>• Present a severe risk to the beneficiary's physical health; or</td>
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<tr>
<td>• Represent a recent, significant deterioration in ability to function.</td>
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<tr>
<td>• Requires admission for one of the following:</td>
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<tr>
<td>• Further psychiatric evaluation;</td>
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<tr>
<td>• Medication treatment; or</td>
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<tr>
<td>• Other treatment that can reasonably be provided only if the patient is hospitalized.</td>
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</tbody>
</table>