PHYSICIANS' GUIDE TO STATE LEGISLATION

CASE STUDY

ADMISSION OF PSYCHIATRIC PATIENTS

Issue

Psychiatric patients deemed dangerous by the emergency physician could not be admitted to psychiatric units without certification of coverage by managed care organization (MCO) reviewers. Reviewers would often delay or deny coverage.

ACEP Position

An official position has not been developed.

Background Information

At times, people come to the emergency department (ED) when no other medical services are available. This practice has occurred more frequently with the growth of managed care because of decreased direct and timely access to primary care providers. In 1994, there were 150 to 250 psychiatric evaluations in Maryland EDs every day. The average stay in the ED was 6 to 7 hours, with a range of 3 to 30 hours, with concomitant tie-up of treatment space. A psychiatric patient requires more attention and care than does the average patient. During the initial evaluation, many of these patients were clearly identified as dangerous to themselves or others, but it was difficult for the reviewer to appreciate this fact during the initial telephone screening provided by the MCO.

Much of the delay occurred during placement. It patients did not have insurance; the state hospitals would take them. However, if they had valid coverage through an MCO, there often was a conflict between the treating ED and the intake person for the medical plan. Nearly all psychiatric managed care is provided by private companies subcontracted by the MCOs. MCOs admit they had little knowledge of the processing done by these unregulated, subcontracted companies.

Many EDs have psychiatric social workers dedicated to the department to assist in admitting patients. Many EDs have found that getting psychiatric patients admitted is too time consuming without dedicated personnel.

Maryland ACEP (MACEP) believed that automatic admission approval with no denial allowed for the first 24 hours would be sufficient for most initial evaluations in a structured setting (psychiatric inpatient facility). If admission occurred on a weekend or holiday, the restriction needed to extend until the next business day of the MCO reviewer. The automatic approval would apply even if the admission was voluntary. This solution facilitates cooperation with the patient, who could be in imminent danger and still be able to agree to relinquish control to others. MACEP also was concerned that the receiving psychiatric facilities could refuse admissions seemingly

according to their whims, in contrast to other types of medical facilities that were much more regulated by the Emergency Medical Treatment and Active Labor Act (as it existed at the time of this bill).

Legislative History in Maryland

This bill was introduced in the 1994 legislative session. After a hearing in the assigned House committee, the chair convened an informal working meeting between the parties. Compromises included that the admitting physician must concur that the patient is a danger; that the condition must be treated medically; and that the admission must be allowed until the next business day of the MCO.

The bill passed the House, but the assigned Senate committee reported the bill unfavorably by a 6 to 5 vote. One of MACEPS's supporters voted nay by mistake and therefore could ask for reconsideration. However, the chairman of the Senate committee was so aggravated by measures used by others to try to pass the Patient Access Act that he held all bills associated with physicians. The session ended without further action.

In the 1995 legislative session, this issue was reintroduced in an identical bill. The MCOs presented vague testimony, not unlike the year before. Surprisingly, the main problem came from the Maryland Psychiatric Society. The psychiatrists stated that they wanted 72 hours of guaranteed admission because they could not safely evaluate the patient in less time. Unfortunately, political realities dictated that a 72-hour provision would mark the bill as a money grab by physicians, and therefore it would not pass.

MACEP was able to persuade the psychiatrists that the bill was intended solely to move patients out of the ED. Members threatened to educate the legislators about how emergency physicians conduct the great majority of emergency psychiatric evaluations in Maryland, significantly downplaying the role of the psychiatrists in this process. The psychiatrists then supported the bill.

The bill passed easily in both committees and both chambers, and was signed by the governor without further comments.

Arguments in Favor of this Position

- Most often the MCO reviewer is not a psychiatrist, but someone of unknown training. The reviewer has financial incentives to minimize admissions, while the emergency physician is on the scene, without financial motive to admit. Who is more interested in the welfare of the patient?
- The bill helps relieve ED overcrowding and provides timely admissions.
- Most psychiatric patients are sent to the ED anyway for "medical clearance." Thus, the MCOs send them to the emergency physicians, then block further disposition when there is disagreement.
- Many reviewers are not employed by the MCOs but are subcontractors. The MCOs have little or no oversight over the quality of these reviewers, only over their cost.
- A very forceful argument used in Maryland said that if the reviewer denied coverage, the patient would fall into the state hospital system, paid for by taxpayers.
- Additional ED staff would be needed to deal with the "hassle factor."
- One-third of psychiatric patients are teenagers.

Arguments Against this Position

- Emergency physicians overreact and want to admit too many patients.
- Some psychiatric hospitals had been sanctioned recently for paying kickbacks for referrals to their facilities, where all patients were "dangerous" and therefore committed.
- The reviewers promised to arrange same-day or next-day follow-ups with their mental health workers.
- The evaluating emergency physician is not a psychiatrist.
- In Maryland, the passage of a mental health parity bill (all psychiatric and substance abuse patients must be treated

as medical patients) alleviated the red tape.

Potential Proponent Organizations

State Medical Society, psychiatrists, psychiatric social workers, psychologists, consumer advocates, Emergency Nurses Association, and other nursing groups.

Potential Opponent Organizations

Psychiatrists, MCOs, health maintenance organizations, and mental health managed care companies. In Maryland, the AFL-CIO and the Chamber of Commerce generally follow the Health Maintenance Organizations lead, reacting to their threats of raising premiums.

Possible Strategies

- Have anecdotal cases and witnesses available. In one MACEP case, a teenager threatened his parents. The patient was brought to the ED by the police, who found that he had Molotov cocktails and an AK-47 assault rifle. The managed care reviewer, a psychiatrist, said that this patient had been hospitalized before and so had a chronic condition. The reviewer also stated that "if you think he is a danger, send him to the state hospital."
- Emphasize ED overcrowding and the need for additional staff.
- Note the number of psychiatric patients seen in the ED. Legislators will be surprised.
- Note the lack of quality of care oversight of MCO subcontractors.
- Note the contrast in motivation for admission between the emergency physician and the reviewer.
- Emphasize the poor logic of a remote reviewer overriding the on-site evaluation of the emergency physician.

For more information on this issue,
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