

Mental and Nervous Disorder Benefits

In General

The Plan provides limited mental and nervous disorder benefits. The Schedule of Benefits may sets forth certain benefit limitations:

- In hospital limitation (thirty days, e.g.).
- Outpatient limitation (50% co-payment rate, e.g.).
- Limit on one number of outpatient visits per benefit year.

Covered expenses not paid because of the mental and nervous co-payment reduction do not count toward the out-of-pocket limitation.

After HIPAA, the practice of placing a dollar cap on such benefits (either on a benefit year or calendar year) was made illegal. An exception would be where a governmental entity opted out of HIPAA.

Mental and Nervous Disorders

The mental disorders normally encountered include the following:

- Schizophrenia
- Manic-depression (Bipolar disorder)
- Depression
- Chemical Dependency
- Organic brain syndrome.

There are numerous mental-related conditions which are not covered:

- Sex-identity psychoses
- Tobacco dependence.

Chemical Dependency

The Schedule of Benefits usually sets forth whether or not chemical dependency is to be treated as a mental and nervous condition. Chemical dependency is recognized as an illness by the medical profession.

Drug Addiction. A style of living that includes drug dependence, generally both physical and psychological; continuing use of and involvement with a drug. Addiction implies the risk of harm and the need to stop drug abuse.

Alcoholism. A chronic disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary discretionary use of ordinary compliance with the social drinking customs of the community, and which may interfere with the drinker's health, interpersonal relations, or economic functioning. Alcohol is classified as a drug. Therefore, alcoholism is a form of drug dependence.

Adjudicating Chemical Dependency Claims

The examiner should know at the onset of adjudication the scope of the plan benefits.

- Are benefits payable at all or under limited conditions? What are the inside limits, if any?
- Are benefits extended to facilities which serve chemical abusers or are they limited to the more restrictive hospitals as defined by the plan?

Medical care likely to be provided with a drug/alcohol abuse include the following:

- Detoxification or withdrawal
Medical complications are often involved such as delirium, confusion, trauma, or unconsciousness)
- Structured Rehabilitation
These programs are composed primarily of coordinated educational and psychotherapeutic services provided on a group basis. Depending on the subject matter, a series of lectures, discussions, films, and group therapy sessions are led by either physicians, psychologists, or alcoholism counselors from the hospital or various outside organizations. In addition, individual psychotherapy and family counseling may be provided in selected cases. These programs are conducted under the supervision and direction of a physician. Patients may directly enter an inpatient hospital rehabilitation program after having undergone detoxification in the same hospital or in another hospital or may enter an inpatient hospital rehabilitation program without prior hospitalization for detoxification.
- Care Environment
Some hospitals also provide services on an outpatient basis, either individually or as part of a day hospitalization program for treatment of alcoholism. These services may include, for example, drug therapy, psychotherapy, and patient education and may be furnished by physicians, psychologist, nurses, and alcoholism counselors to individuals who have been discharged from an inpatient hospital stay for treatment of alcoholism and require continued treatment or to individuals from the community who require treatment but do not require the inpatient hospital setting.
- Chemical Aversion Testing

Chemical aversion therapy is a behavior modification technique that is used in the treatment of alcoholism. Chemical aversion therapy facilitates alcohol abstinence through the development of conditioned aversions to the taste, smell, and sight of alcohol beverages. This is accomplished by repeatedly pairing alcohol with unpleasant symptoms (e.g., nausea) which have been induced by one of several chemical agents. While a number of drugs have been employed in chemical aversion therapy, the three most commonly used are emetine, apomorphine, and lithium. None of the drugs being used, however, have yet been approved by the Food and Drug Administration specifically for use in chemical aversion therapy for alcoholism. Accordingly, when these drugs are being employed in conjunction with this therapy, patients undergoing this treatment need to be kept under medical observation.

- Electrical Aversion Therapy
This is a behavior modification technique to rosier abstinence from ingestion of alcoholic beverages by developing in a patient conditioned aversions to their taste, smell and sight through electrical stimulation. Electrical aversion therapy has not been shown to be safe and effective and therefore is excluded from coverage.

Nature of Care for Chemical Dependency

Hospital Care is Indicated

- Impaired reasoning and memory
- Dehydration
- Medical illness (e.g., poorly controlled diabetes/asthma)
- Severe secondary psychiatric illness (e.g., depression)
- Multiple addiction or intravenous drug use
- Poor family support or chaotic/unstable home environment
- Suicidal behavior
- Inaccessible outpatient treatment program
- Noncompliance failure in outpatient treatment program.

Outpatient Care is Indicated

- Is patient in school or employed?
- Is the patient in late stages of abuse.
- Does the patient have support for treatment (family, employer, co-workers)?
- Does the patient now suffer from several psychiatric or medical conditions in addition to alcoholism or addiction?
- Is the patient an intravenous drug user?
- Is the patient participating in a Methadone program?

Nature of Outpatient Care

- Evaluation

- Detoxification
- Group therapy
- Family participation
- Education
- Physician counseling
- Psychiatric counseling
- Self-help groups
- Relapse prevention.

Chemical Dependency Benefits

The benefit is available where medical care units are exclusively devoted to drug/alcohol abuse treatment. These units may be medical or psychiatric in nature. They may be free-standing or connected with another facility.

The treatments which must be offered includes:

- Detoxification
- Counselling
- Medical care.

The facility must be staffed by professionals working on a day and night basis under the direct supervision of physicians and must follow programs set forth and managed by either of these:

- Chemical dependency unit of a psychiatric hospital.
- Chemical dependency hospital.

The care and services must be reasonable and customary.

Related Considerations

Disease and Depression

When an initial diagnosis of depression is given, hospital records should be obtained and the cause of the hospital treatment reviewed to determine whether there are underlying organic causes.

Such conditions as hepatitis, mononucleosis, tuberculosis, diabetes and hypoglycemia may manifest the symptoms of depression. The types of tests run during the hospital stay and the discharge summary will be helpful in pinpointing a diagnosis.

Examiners should also be alert for indications of diseases which damage the central nervous system or create diminished blood supply to the brain (e.g., arteriosclerosis, epilepsy). Such conditions may manifest symptoms which appear to be related to mental/nervous disorders.

Mental and Nervous Conditions and Prescription Drugs

If a plan provides for the outpatient treatment of mental/nervous conditions, the cost of prescription drugs used in that treatment may be covered at the same rate at which physician's visits are paid (e.g. both drug and physician charges may be paid at 50% of the reasonable and customary fee for the service provided).

This applies to both standard and state-mandated outpatient benefits.

Family Consultations

Psychiatric treatments may require consultation among a psychiatrist and a psychologist and members of a family, other than the patient, to properly evaluate the condition. Charges from an initial consultation with a parent, parents, guardian or spouse are reimbursed under the patient's claim. Charges for such a consultation are not to be used to establish a claim for the parent, guardian or spouse.

Weekend Passes

During an inpatient psychiatric hospital confinement, a patient may be granted a weekend pass. The weekend pass concept is a recognized tool in the therapeutic treatment of certain mental illnesses.

- The patient is being treated for a mental illness condition.
- The patient is confined in a hospital which is solely dedicated to the treatment of mental illness or in a psychiatric unit of a general hospital.

Organic Brain Disorders – Mental or Physical

What is the correct handling of a mental disorder (manic depression, schizophrenia, e.g.) which is traditionally classed as a mental disease but has an organic disorder as the cause? The reason why so many of these claims problems have gone to court is that the plan document is ambiguous. The Plan Document should define mental illness by ICD-9 code is to avoid such litigations.

Relevant Court Decisions

Participant was denied a claim for a disability payment. The medical testimony was that there was nothing organically or neurologically wrong with Participant. Participant insisted that he suffered from traumatic neurosis. The court believed, by the preponderance of evidence, that Participant had no valid claim for a benefit.

Participant's son was confined to a *child-caring* facility. It offered: group therapy, recreation, vocational, social, academic services and medical care, on-call, as

needed. The facility, by the court, failed to meet the definition of a hospital and the son's claims were not payable.

Plan paid for regular hospitalization but excluded mental institutions or similar. Care was given at Tranquilaire Mental Health Center, a regular hospital in all regards except it specialized in psychiatric diagnosis and treatment. The court said the plan was unclear when it used the term *mental institution* and that it may well have meant to exclude only the permanent custodial-type of *insane asylum* and not the short term psychiatric hospital. As a result of the courts logic, the plan was held liable.

Participant had a hospitalization for abdominal discomfort and a possible viral disease. While there, a psychiatrist was called to consult with Participant as to his possible problems with drinking and depression. The hospital bill contained a reference to *depression reaction*. Since there was a plan exclusion therefore, the entire claim was denied. the court held the confinement was primarily for non-nervous problems and as a result, the plan was liable.

The children of Participant had psychiatric counseling due to their parent's divorce. The plan did not define mental illness. The plan denied the claims because there was no evidence of any mental illness. The court made the plan pay; children's reaction to parent's divorce was reason enough to be mentally ill.

Plan would pay for treatment by a doctor or a *psychologist under the direction of a doctor*. In Participant's case, his daughter was treated by psychiatric social worker. When the bills were denied, Participant sued. The court agreed that the claim was not payable.

Participant's son was classed a borderline personality. A claim for hospitalization for mental and nervous came in on the boy. Plan denied such claim. The court found a way to make the hospitalization medically necessary so as to get the claim paid.

A psychiatrist prescribed long term care in a hospital school program

- Individual psychotherapy
- Group, family and activity therapy.

Blue Cross had to pay the denied charges plus legal fees.

Plan clearly excluded care for alcoholism and drug abuse. Plan accordingly issued a denial. Participant made these arguments:

- Depression preceded the alcoholism.
- Substantial portion of the hospital care was for depression.

The court considered both arguments and yet held that the Plan was correct in its denial because the proximate treatment was for alcoholism and that care was excluded by the plan.

Covered person was discharged from the hospital when the Plan's \$25,000 mental and nervous limit was reached. Participant claimed his expenses were for

medical care and not mental and nervous care and the \$25,000 maximum was of no avail. Diagnosis was *Klinefelter's Syndrome*, a genetic disorder with mental manifestations (severe psychoneurosis, e.g.). Participant had a long history of mental and emotional problems. Court, in essence, held that Participant may well have had a physical problem and sent the case down to a lower court for a trial of facts, essentially ruling favorably for Participant.

While hospitalized for alcoholism, participant was treated for depression. Claim was turned back due to alcoholism exclusion and contested. Court held that the denial of the claim using the alcohol exclusion was proper since a substantial portion of the treatment was for alcohol abuse.

Participant was treated at Oaks Treatment Center for a psychiatric disorder. Oaks had no surgery facility, also no inpatient medical care facilities, each of which was required by the plan document. The court held, therefore, that Oaks was not a hospital as defined by the plan.

Defendant shot himself intentionally; Plan excluded intentionally self-inflicted injuries. Court held expenses were not covered. The argument by Participant was that exclusion applies to participant but not covered dependents. Court held claim to be deniable.

Plan was silent as to whether drug and alcoholism was a medical or a mental/nervous condition. Participant demanded payment; Plan refused. Court held it was a medical condition but did not hold plan guilty of arbitrary and capricious action in denying the claim.

The court held the Plan was arbitrary and capricious when it processed a claim for autism as a mental claim and not a psychiatric illness. Blue Cross wanted to treat the hospitalization as a mental/nervous claim; Participant believed it was medically related. The court held that it was medically-related and therefore deserving of greater benefits.

Participant was hospitalized for 90 days in a psychiatric hospital for these reasons:

- Depression
- Eating disorders
- Drug Abuse.

Participant sought large punitive damages when claim was cut back due to the eating disorders. Plan showed this to be its practice with eating disorders:

- Acute care – pay
- Nonacute care – deny.

Court held that punitive damages were not appropriate; claim was payable, however.

The plan had a \$500 per year mental and nervous maximum for medical; its long term disability plan excluded mental and nervous related disabilities. The Plan's maximum per year costs would be \$500. Participant sued, claiming that manic depression was functional and organic but not mental. The court held that, regardless of its medical

definition, it was a mental disease within the meaning of the Plan. The claim held to have been properly denied.

Participant suffered postpartum depression. Participant said the Plan should treat these as medical-related and not mental-related. The court held to the contrary. They are mental-related bills.

Plan said benefits were available for a *licensed psychologist*. An *unlicensed psychologist* submitted a bill which was denied by the Plan. Participant sued, alleging a violation of the Sherman Antitrust Law. The allegation was that unlicensed psychotherapists are victims of a trade conspiracy to deny them getting benefits on assignment by Blue Cross. The court noted that state laws requiring licensing are quite clear; also was the Blue Cross language in the Plan that only *licensed* psychologists may be covered is quite clear. Conclusion: claim was properly deniable.

Participant was a psychologist employed by the Veteran's Administration and a participant in the federal government's health care plan administered by Blue Cross. Participant had care, as a patient, from a psychoanalyst. When Participant sued Blue Cross the lower court found that Blue Cross had erred in these ways:

- Incorrectly reduced the sessions from four a week to two a week.
- Had the claim reviewed by unqualified persons.
- Failed to timely process Participant's claims.

On review, the appeals court believed that punitive damages were not appropriate because Blue Cross did *not* act with "reckless disregard of the rights of others while aware that such conduct willfully and deliberately failed to avoid these consequences." Also, Blue Cross regularly retained medical reviewers who were *not* deemed to be *full-time employees* as contemplated by California's Code of Civil Procedure §998.

Parents sought to have their son, an alcoholic, age 20, declared handicapped so that he might be a covered participant in their health care plan. His medical diagnosis was one of personality disorder and alcoholism. Plaintiffs presented considerable evidence establishing that such a disability which would qualify son to be a handicapped person and therefore continuable as a plan participant. Defendants presented a weak defense. Court held that a personality disorder such as alcoholism was indeed, a disability and a handicap.

The plan did not clearly define *mental and nervous disorder* but did have a reduced lifetime limit therefore. The dependent child had a physical condition called *organic brain syndrome* or *congenital encephalopathy*; the symptoms were behavior problems (hyperactivity, hyperexcitability, hyperkinesis, self-abuse and attempted suicide, overeating, feelings of insecurity, etc. The course of treatment was lithium and amoxapine (behavior), Haldol (anti-psychotic), Ativan (anti-anxiety) and Prozac (anti-depressant) as well as therapy. The medical profession classes this condition as organic mental syndrome and as a mental disorder. The plan invoked the limit; the participant objected. The court reviewed *de novo*. The court was instantly mindful that the plan term was not defined. When such is not defined, there is hopeless confusion. In *Kunin v. Benefit Trust Life Insurance Company*, autism was held to not be a mental illness. Other courts have held that mental illness is one where there are behavior problems with no demonstrable physical

or organic reason. The court resolved the conflict by holding for the participant; Phillips did not suffer from a mental illness.

Participant received outpatient care from a psycho-therapist; such therapist did work under the direction of a physician. Since the billings were by therapist (not a licensed provider) the claim was denied. The court agreed that the denial was proper.

Participant's condition was physical in nature but its symptoms manifested themselves in what a layperson would characterize as mental. Did the inside limit on mental and nervous care apply? The court said that such limits should apply.

The court held that neither an insurer nor a managed mental health care organization can be held liable for a psychologist's alleged violation off patient confidentiality when the disclosure concerns a patient's confession to child molestation.

Participant had a psychological-sexual aberration resulting in prison time and loss of his license to practice optometry. Because of his mental illness, he sought disability due to loss of ability to work. The court said no, his loss of work was due to his loss of his professional license which was due to his prison time.