Managed Mental Health Care: Intentional Misdiagnosis of Mental Disorders

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Managed health care regulations affect the manner in which counselors provide and deliver services. Counselors are challenged by ethical and legal dilemmas when diagnostic codes in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) are not honored for insurance reimbursement. In this article, the authors examine violations of codes of ethics and legal statutes and the consequences related to intentional misdiagnosis of mental disorders for reimbursement. They explore implications for counselors and offer suggestions for professional conduct.

Managed mental health care has significantly affected the counseling profession. Managed care guidelines determine whether and how counselors deliver services and whether services are reimbursable. Counselors are particularly challenged when insurance reimbursement is denied because managed care organizations (MCOs; Danziger & Welfel, 2001; Glosoff, 1998) are not honoring codes in the American Psychiatric Association’s (APA’s; 2000) *Diagnostic and Statistical Manual of Mental Disorders*. (Note: For the purposes of this article, unless otherwise specified, the notation DSM refers to the manual in a general sense.) Clients may not be able to afford out-of-pocket pay for treatment. Hence, counselors and clients may agree to submit inaccurate mental health diagnoses that are reimbursable so that clients can receive counseling. Wylie (1995) called this practice “diagnosing for dollars” (p. 22). Rappo (2002) emphasized that it is health cost that is being managed versus health care.

In this article, we provide an overview of the effectiveness of managed health care systems and their impact on mental health counselors. We review ethical and legal dilemmas involving informed consent, confidentiality, client autonomy, competence, treatment plans, and termination that had not existed prior to the introduction of managed health care systems. We outline the relationship between the DSM and insurance reimbursement for delivery of services and examine how MCO regulations regarding certain diagnostic codes prompt intentional misdiagnosis of mental disorders for insurance reimbursement. We provide reasons why insurance reimbursement is denied based on certain DSM diagnostic codes. We examine violations of the American Counseling Association’s (ACA; 1995) *Code of Ethics and Standards of Practice* and the American Mental Health Counselors Association (AMHCA; 2000) “Code of Ethics of the American Mental Health Counselors Association” in relation to intentional misdiagnosis of mental disorders for receipt of insurance reimbursement, as well as legal consequences surrounding this issue. We consider implications for counselors and offer suggestions for professional conduct regarding intentional misdiagnosis.

During the 1980s, MCOs emerged as an approach to curb spiraling health care costs. Burgeoning expenditures involving health care maintenance captured the nation’s attention to the extent that significant measures had to be taken to control health care spending. Despite efforts made during the 1980s to contain health care spending, the U.S. Department of Justice Health Care Fraud Report Fiscal Years 1995 & 1996 (1997) indicated that health costs still exceed 1 trillion dollars each year.

In general, managed health care involves consumers, medical and mental health professionals, hospitals and nursing homes, and mental health agencies that fall under mandates of MCOs such as health maintenance organizations, managed mental health care organizations, preferred provider organizations, independent practice associations, and Medicare and Medicaid. The primary function of MCOs is to form relationships among payers, providers, and consumers so that services and their outcomes are influenced and monitored (Cuffel, Snowden, Masland, & Piccagli, 1996). MCOs also define and determine access and delivery of health care services, as well as regulate distribution of insurance reimbursement.

**Effectiveness and Impact of Managed Care**

Varying viewpoints exist regarding the effectiveness of managed health care during the 1980s and 1990s. Some authors...
believed that managed care was a realistic method of controlling cost while maintaining quality health care (Cummings, Budman, & Thomas, 1998). Others thought that cost containment initiatives would reduce consumer insurance premiums while lowering costs for the insurance industry (Johnsen, 1994). Even though progress was made regarding cost containment, quality of care was not emphasized to the extent necessary (McCarthy, Gelber, & Dugger, 1993). As costs in health care increased, so did the number of restrictions placed by insurers on reimbursement for mental health services (Austad, Hunter, & Morgan, 1998; Bilynsky & Vernaglia, 1998; Cooper & Gottlieb, 2000). As a result, providers and consumers expressed concerns about diminishing access to needed services as health care service delivery moved from traditional fee-for-service providers (e.g., consumers purchased insurance from a commercial carrier, paid a deductible, and chose their physician separately; Huber, 1995) to managed care providers (Huff, 2000).

Most mental health counselors strive to meet MCO regulations (Danziger & Welfel, 2001; H. B. Smith, 1999), but they do not agree that managed health care is effective. For example, although 42% of licensed professional counselors (LPCs) were either very satisfied (6.6%) or, at least, somewhat satisfied (35.7%) in working with MCOs, a larger proportion (47%) were not satisfied (H. B. Smith, 1999). An unresolved question was, were these counselors dissatisfied because they had been denied access or because they experienced a provoking encounter(s) with MCOs? Regardless of the answer, results from studies indicated that the majority of mental health counselors perceived MCO requirements as a negative influence on their practices (Danziger & Welfel, 2001; Miller, 1996; Murphy, DeBernardo, & Shoemaker, 1998).

**Ethical and Legal Dilemmas**

Managed health care is here to stay, and it will continue to have both positive and negative effects on providers and consumers (Cummings et al., 1998; H. B. Smith, 1999). A continued movement toward managed health care systems and a departure from fee-for-service methods of care have altered how counselors conducted business for many years (Cuffel et al., 1996; Stern, 1993). For example, now the *staff model* limits mental health benefits to 20 sessions; *brief therapy* limits benefits to 1 to 5 sessions; *capitation* sets outpatient mental health benefits at $1,500 to $2,500; and *medical necessity and standards of practice* use case review or case management of mental health to determine, respectively, whether services are granted and whether services are effective (Cuffel et al., 1996; Kiesler, 2000). At the same time, managed care systems have cultivated ethical and legal dilemmas that did not exist before the enforcement of managed health care (Acuff et al., 1999; Cooper & Gottlieb, 2000; Glosoff, Garcia, Herlihy, & Remley, 1999). Counselors struggle to find a balance between the demands of managed mental health care requirements and obligations to clients. Counselors grapple with ethical and legal challenges involving the following:

1. **Informed consent.** Clients may not know or understand their mental health benefits. A problem arises when, for example, an insurance plan covers 25 sessions per year but the MCO allows only 6 sessions (Cooper & Gottlieb, 2000).

2. **Confidentiality.** Prior to managed mental health care, confidentiality was held paramount except for situations involving harm to self or to others and for court-mandated disclosure. Clients may be unaware that counselors can no longer ensure privacy of disclosure because MCOs may require client information for determining treatment and for insurance reimbursement (Cooper & Gottlieb, 2000; Danziger & Welfel, 2001).

3. **Client autonomy.** Under managed mental health care, providers and the type of treatment are often determined by MCO policies and utilization reviews (Wineburgh, 1998). These restrictions diminish client and counselor autonomy in making mental health decisions that are in clients’ best interests (Danziger & Welfel, 2001; Meyers, 1999; Wineburgh, 1998).

4. **Competence.** MCOs emphasize brief therapy models. When counselors have not received adequate training in brief therapy techniques and interventions, they may not be able to effectively provide services when MCOs limit counseling to only five sessions (Cooper & Gottlieb, 2000).

5. **Treatment plans.** “The first task of a managed care psychotherapist is to accommodate treatment to the parameters of the benefit package” (Austad & Hoyt, as cited in Miller, 1996, p. 356). As such, emphasis is placed on treatment plans that fall in line with MCO payment policy rather than client need.

6. **Termination.** Termination of counseling may be imposed by MCO limitations (e.g., when requests for additional sessions are denied; Corcoran & Vandiver, as cited in Cooper & Gottlieb, 2000).

Another situation that presents ethical and legal challenges and that is the focus of this article involves the relationship between *DSM* diagnostic codes and insurance reimbursement for delivery of service. When certain *DSM* diagnoses are not covered benefits in insurance plans, counselors may be tempted to intentionally misdiagnose mental disorders so that clients can receive services and counselors can receive reimbursement (Danziger & Welfel, 2001; Kirk & Kutchins, 1988; Mead, Hohenshil, & Singh, 1997; Murphy et al., 1998). This is especially true when clients cannot afford treatment without insurance reimbursement (Glossoff, 1998). The upcoming discussion reviews the relationship between the *DSM* and managed mental health care.


**DSM Codes and MCO Regulations: Insurance Reimbursement**

For more than 50 years, the *DSM-I, DSM-II, DSM-III, DSM-III-R, DSM-IV,* and *DSM-IV-TR* (APA, 1952, 1968, 1980, 1987, 1994, 2000, respectively) have been the sources of categories for mental disorders. The various versions of the *DSM* are “among the most important diagnostic documents in the history of clinical counseling, psychology, and social work” (Mead et al., 1997, p. 383) because they provide a common language by which mental health providers can communicate regarding treatment and research (Jampala, Zimmerman, Sierles, & Taylor, 1992). The *DSM* also provides a foundation upon which the effectiveness of counseling and treatment can be weighed and measured (e.g., reduction of symptoms and improved functioning; Hohenshil, 1993). In addition, “The *DSM* is a necessary tool for collecting and communicating accurate public health statistics” (APA, 2000, p. xxiii). Given the fact that the *DSM* is such a powerful, widely used system for classifying mental disorders in the United States (Mead et al., 1997; Seligman, 1999), MCOs have used its codes to determine whether, and to what extent, insurance reimbursement is granted for delivery of mental health services. Despite these benefits, the *DSM* has been highly criticized. For example, Crowe (2000) indicated that the conceptual basis of the definition of mental disorder lacked evidence because it was grounded on particular assumptions as to what constituted normality. Kaplan (1983) criticized *DSM* diagnoses for perpetuating sex role stereotypes and sex bias, therefore contributing to oppression of women. Others have critiqued the *DSM* as a culturally biased system based on North American cultural assumptions that barely consider clients’ contexts and narratives regarding diagnoses (Ivey & Ivey, 1998; Kaplan, 1983; Smart & Smart, 1997). The *DSM* has also been challenged because it lacks empirical evidence that its criteria enhance selection, development, or implementation of treatment (Kraotchwill, Thomas, & McGivern, 1996). Despite the controversy surrounding the *DSM*, it continues to be widely used for (a) billing and reporting to third parties for insurance reimbursement (Hohenshil, 1992); (b) meeting employers’ requirements (D. Smith & Kraft, 1983); (c) satisfying licensure examinations (Hohenshil, 1992); (d) communicating with professionals (Jampala et al., 1992); (e) keeping records, data collection, and research (Mead, Hohenshil, & Brown, as cited in Mead et al., 1997); (f) training in education (Seligman, 1999); and (g) providing counselors’ livelihoods (Mead et al., 1997).

The *DSM* and Today’s Counselors

A primary reason why counselors use the *DSM* system is because third party payers require its coding axes for insurance reimbursement (Danzinger & Welfel, 2001; Hohenshil, 1992; McBurnett, 1996). Adherence to *DSM* criteria and diagnoses weighs heavily in mental health care because specific diagnoses dictate which services are reimbursed by MCOs. Counselors who are preferred providers pay attention to MCO guidelines that regulate insurance reimbursement for mental health services because these rulings govern their financial survival. It has been estimated that for 21% of LPCs working in private practice or in community mental health centers, managed care provided more than half of their income (H. B. Smith, 1999); 85% of private practitioner psychologists reported that managed care provided over one third of their income (Murphy et al., 1998).

When counselors are unable to receive reimbursement for services rendered because certain *DSM* diagnoses are not accepted by MCOs, clients may not receive needed treatment (Rother, 1996), may be prematurely terminated, or may be abandoned (Danzinger & Welfel, 2001). Hence, counselors may be pressured to choose between an accurate diagnosis that does not provide third party insurance reimbursement and a deceptive diagnosis (e.g., intentional misdiagnosis) that does offer payment (Danzinger & Welfel, 2001).

Denial of Insurance Reimbursement

*DSM* codes are denied for insurance reimbursement for different reasons (e.g., medical necessity could not be established; insurance benefits were exhausted). Managed mental health care plans often deny benefits and insurance reimbursement for adjustment disorders, for disorders typically requiring long-term counseling, and for diagnostic codes that bear exclusively Axis II status (Glossoff, 1998). Another common example of unacceptable diagnostic codes involves V Codes assigned on Axis I when they are the primary focus of clinical attention. V Codes are identified in the *DSM-IV-TR* (APA, 2000) sections Relational Problems and Other Conditions That May Be a Focus of Clinical Attention. They include relational problems or problems related to physical and sexual abuse or neglect; adult, child, or adolescent antisocial behavior; intellectual functioning and academic problems; bereavement; religious or spiritual problems; acculturation; and phase of life problems. In general, Axis I disorders are accepted by MCOs for insurance reimbursement with the exception of problems identified as V Codes (Murphy et al., 1998), although levels of distress associated with these problems may be as severe as or greater than distress experienced by Axis I disorders other than V Codes. For example, some MCOs do not reimburse for marital therapy (Murphy et al., 1998), coded as V61.10 Partner Relational Problems. The situation is unfortunate because partner problems can be just as threatening as and even more formidable than other problems assigned to Axis I (e.g., Generalized Anxiety Disorder) that are reimbursable (Wylie, 1995). Partner problems may involve verbal, physical, and psychological abuse; domestic violence; divorce and associated bereavement; and battering. In many partner situations, couples face losing their homes, their immediate and
extended families, their financial security, even their lives. Hence, in order to provide services to couples, counselors may be tempted to intentionally misdiagnose (e.g., suggest that one of the clients be assigned Major Depressive Disorder) so that couples can receive services and insurance reimbursement. However, counselors must keep in mind that assigning and submitting more serious diagnoses for “identified clients” may bear serious consequences. For example, “preexisting conditions” can be used to deny future physical or mental health treatment if clients change insurance policies (Glosoff, 1998). Another outcome may be loss of child custody in a legal court case (Cotttone & Tarvydas, as cited in Glosoff, 1998).

Managed mental health care often presents difficulty for family counselors who operate from a family systems orientation that emphasizes resources and strengths versus pathology (Hawley, 2000). Family counselors recognize that the family system is malfunctioning, not just one family member, and that symptoms and dysfunctional behaviors are manifestations of a faulty system, not the disequilibrium of forces within just one family member (Goldenberg & Goldenberg, 1996). Counseling and interventions are directed toward relationships within the family, not toward just one family member. As such, family counselors may be opposed to assigning Axis I diagnoses other than V Codes because doing so not only labels clients and attaches stigma to mental illness (Brown & Bradley, 2002), but it also establishes grossly inaccurate diagnoses that misrepresent transactional processes occurring within the family system. For instance, Doherty and Simmons (1996) found that in 35% of the cases submitted, family counselors reported they did not use diagnostic codes because they believed diagnoses are “unsystemic” and harmful to their clients.

Although some family counselors believe that assigning diagnoses may not be in their client’s best interest, they also know that in order to receive insurance reimbursement, utilization reviews typically require DSM diagnoses of individuals rather than of relationships (Sank, 1997). When reimbursement is denied, family counselors may find themselves in a triple bind—striving to promote clients’ welfare by helping them gain insurance reimbursement, aspiring to uphold professional associations’ ethical obligations by making and assigning accurate diagnoses, and desiring to meet MCO regulations by providing services for only approved diagnoses. Counselors may become confused about where their primary allegiance lies—with the client, with the professional association, or with the MCO.

When conflict of interest occurs among the client’s needs, counseling ethics, and MCO policies, counselors should strive to clarify their commitments to all entities (Huber, 1995). Ultimately, obligation to the client takes precedence (Bayles, as cited in Greenspan & Negron, 1994). In attempting to honor this commitment, family therapists may intentionally misdiagnose a family member so that insurance can be gained and members can receive treatment. However, counselors need to be aware of the fact that making diagnoses “fit” MCO criteria (Hamann, as cited in Glosoff, 1998) involves ethical and legal concerns and consequences that must be taken into consideration (Daniels, 2001).

### Intentional Misdiagnosis: Ethical Codes and Legal Statutes

Ethical and legal dilemmas and behaviors involved in the process of managed mental health care are complex and multifaceted. When insurance reimbursement is denied because certain DSM codes are not MCO approved, mental health counselors (Danziger & Welfel, 2001), clinical counselors (Mead et al., 1997), social workers (Kirk & Kutchnis, 1988), and psychologists (Murphy et al., 1998) may intentionally misdiagnose mental disorders in order to receive insurance reimbursement for delivery of services. Although intentional misdiagnosis of mental disorders for insurance reimbursement may constitute unethical behavior, it is unclear to what extent counselors know and agree that such behavior is unethical. This behavior could lead to ACA (1995) and AMHCA (2000) ethical reprimands and to loss of license via actions of state licensing boards. Counselors may need more explicit standards to direct their behavior regarding this issue.

#### Violation of ACA and AMHCA Codes of Ethics

The ACA (1995) and the AMHCA (2000) codes of ethics establish principles that define members’ ethical behavior and that form the basis for processing ethical complaints. It appears that intentional misdiagnosis of mental disorders for insurance reimbursement is in violation of the following ACA and the AMHCA codes of ethics:

Regarding primary responsibility, the **ACA Code of Ethics and Standards of Practice, Section A: The Counseling Relationship,** A.1 Client Welfare, Item a (ACA, 1995, p. 2), and the “**Code of Ethics of the American Mental Health Counselors Association,**” Principle 1, Welfare of the Consumer, Item A.1 (AMHCA, 2000, p. 2), both state that “The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.” Counselors violate these principles when they intentionally misdiagnose mental disorders for insurance reimbursement and/or invite clients to be a part of this collusion. For example, in order for a client’s insurance to pay for services, a counselor asks the client if she or he wants to be diagnosed with Major Depression (Axis I, 296.2x; APA, 2000) when, in actuality, the appropriate diagnosis involves a V Code (e.g., a relational problem, employment problem, or religious problem; APA, 2000).

Many counselors may believe they have their clients’ best interests at heart when they agree to intentionally misdiagnose mental status in order to receive insurance reimbursement. Yet, engaging in intentional misdiagnoses of
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mental disorders takes advantage of clients who may be unaware that certain diagnoses carry with them potential and unexpected repercussions. For example, a diagnosis of Major Depression or Generalized Anxiety Disorder may result in being labeled and having to bear the stigma attached to mental illness (Brown & Bradley, 2002). Being assigned certain mental diagnoses may result in denial, cancellation, or refusal to renew health, life, and/or automobile insurance (Mental Health: A Report of the Surgeon General—Executive Summary, 1999; Missouri Department of Labor and Industrial Relations, 2003; Barker, as cited in Strom, 1992), increased table class rates for life and/or automobile insurance (IntelliQuote, 2004), larger medical or mental health insurance copayments and/or premiums (Meyers, 1999; Miller, 1996), and lower lifetime policy limits and higher deductibles and copayments for treating mental illnesses than for treating other physical illnesses (Howard, 1999). Affected clients may be discriminated against for employment, work promotions, and salary increases. Intentional misdiagnosis of mental disorders not only puts the counselor at risk for ethical reprimands, but it also puts the counselor and client in jeopardy of legal consequences. Clients may lose respect for the counselor and for the counseling profession. From this perspective, intentional misdiagnosis clearly is not in the client’s best interest.

AMHCA’s (2000) Principle 1, Item A.2, states that “Mental health counselors are aware of their influential position” (p. 20). ACA’s (1995) A.5, Item a, and AMHCA’s Principle 1, Item 2.D, both state that counselors “maintain respect for clients, and avoid actions that seek to meet their personal needs at the expense of the client” (p. 2 and p. 3, respectively). Clients often regard counselors as experts who hold their best interest at heart, and they trust that counselors will do so. Hence, clients may not question a counselor’s proposal for misdiagnosis for insurance reimbursement. However, when counselors intentionally misdiagnose clients’ mental statuses, they abuse their position of power and break clients’ trust because intentional misdiagnosis involves deceptive behavior. As a result, clients may feel a sense of being used for the counselor’s own gain.

ACA’s (1995) Section E: Evaluation, Assessment, and Interpretation, E.5 Proper Diagnosis of Mental Disorders, Item a, states that “Counselors take special care to provide proper diagnosis of mental disorders” (p. 7). AMHCA’s (2000) Principle 10, Moral and Legal Standards, Item 10.B states that “Providers of counseling services conform to the statutes relating to such services as established by their state and its regulating board(s)” (p. 16). AMHCA’s Principle 11, Professional Responsibility, emphasizes that counselors “accept responsibility for the consequences of their work and make every effort to ensure that their services are used appropriately” (p. 17). These principles are breached when counselors engage in intentional misdiagnosis of mental disorders. Counselors not only misuse mental health services and diagnoses, but they also violate state and federal statutes. In doing so, counselors risk ethical reprimands and legal consequences. Clients who question intentional misdiagnosis may think that if a counselor is willing to engage in unethical and/or illegal behavior in this instance, there may be other situations in which the counselor is willing to be dishonest as well. The counselor loses credibility, and the counseling profession as a whole may be spurned.

Violation of Legal Statutes

The U.S. Department of Justice Health Care Fraud Report Fiscal Years 1995 & 1996 (1997) indicated that in 1995 and 1996, more than $100 billion may have been lost in fraud, waste, and abuse annually. The U.S. General Accounting Office estimated that in 1998, Medicare lost nearly $12 billion in fraudulent or unnecessary claims (Barrett, 2000). Fraud involves “intentional deception or misrepresentation intended to result in an unauthorized benefit” (Barrett, 2000, p. 1). Health care fraud includes many violations, such as falsifying cost reports, upcoding (e.g., billing for a more highly reimbursed service than the one provided), and falsifying or omitting information about a patient’s condition in order to obtain reimbursement (Infante, 2000). Intentional misdiagnosis of mental disorders for insurance reimbursement is also considered health care fraud (Peterson, 2000). Such fraudulent behavior leads to legal censures (O’Leary, 1995) and court actions (Peterson, 2000) by local, state, and federal governments. For example, in the Court of Appeals case United States v. Krizek, it was held that a defendant psychiatrist’s request for fraudulent reimbursement constituted a false claim (Peterson, 2000). False claim schemes involve obtaining undeserved payment for a claim or series of claims for financial gain and are the most common type of health insurance fraud (Barrett, 2000).

The high cost of fraudulent claims spurred the government to renew its commitment to combating insurance fraud (Slade, 2000). The government uses the Health Insurance Portability and Accountability Act of 1996 in its efforts to combat insurance fraud; this act established the Health Care Fraud and Abuse Control Program, which coordinates federal, state, and local law enforcement activities regarding health care fraud and abuse. It strengthened enforcement authority regarding criminal health care fraud (Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 1999, 2000).

The government also uses provisions of the 1986 False Claims Act—embodied in U.S. Code 31, Chapter 37, Subchapter III—to investigate managed care organizations, pharmaceutical companies, hospitals and nursing homes, physicians, psychiatrists, psychologists, counselors, social workers, and so on. The act allows the government to investigate individuals (e.g., counselors) with the requisite knowledge who (a) submit false claims, (b) “cause” such claims to be submitted, (c) make or use false statements to get false claims paid (e.g., intentional
misdiagnosis of mental disorders), or (d) “cause” false statements to be made or used (Slade, 2000). Provisions of the False Claims Act permit private persons, referred to as “qui tam plaintiffs” or “whistleblowers” or “relators,” to bring cases on behalf of the U.S. government and to receive bounties in the millions of dollars from settlements involving fraud cases. Qui tam plaintiffs receive 25% of government judgments. In 1994, the False Claims Act litigations resulted in payment to qui tam plaintiffs of $379 million (Saurborn & Mair, 2000).

The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2001 (2002) reported that in 2001, the federal government won or negotiated more than $1.7 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. In civil fraud cases, the legal threshold is lower in that specific intent to defraud is not required. The government need only show “deliberate ignorance” or “reckless disregard” for the truth. Regardless of whether the fraudulent act is intentional or reckless, the same penalties may be assessed against the wrongdoer and the same reward may be paid to the qui tam plaintiff (Saurborn & Mair, 2000). Hence, counselors cannot escape liability because they have not “done their homework.”

The consequences for defrauding government programs have lasting effects. Counselors convicted of crimes involving Medicare or Medicaid may receive criminal penalties and civil fines and may be excluded from participating in those programs altogether. Medicare and Medicaid providers are prohibited from hiring an “excluded” counselor. Doing so results in exclusion for themselves (Infante, 2000).

Implications and Suggestions for Counselors

If counselors are to keep themselves out of ethical and legal situations in which they may lose their license and/or have criminal charges brought against them, they must educate themselves regarding ethical and legal issues. They must adhere to the professional expectations outlined in the ACA (1995) and the AMHCA (2000) codes of ethics. The following are suggestions for counselors regarding ethical and legal considerations in relation to diagnosis of mental disorders:

1. Advocate for insurance reform so that all DSM diagnostic codes are accepted for insurance reimbursement, thereby eliminating the temptation for counselors to intentionally misdiagnose mental disorders. At state and national levels, inform elected officials about issues surrounding diagnosis and reimbursement (Sank, 1997). Work through ACA and AMHCA, which strive to influence legislation and public policy. Refer to the ACA Office of Public Policy and Information (n.d.) publication Effective Advocacy and Communication With Legislators to learn rules and strategies for effective advocacy. Actively confront managed health care, a system that precipitates fraud via MCO cost containment policies that are inconsistent with ethical practice and client welfare.

2. At the beginning of professional relationships with clients, discuss the regulations and limitations of MCO’s service provisions. Inform clients of limits to confidentiality, including use of electronic transmission of mental health information to insurance providers (D. Smith, 2003) and possible repercussions from disclosing personal information (Kremer & Gesten, 1998). Tell clients that certain services (e.g., partner or parent–child relational problems, academic problems, substance abuse) may not be covered benefits under their insurance plan, that the insurance plan and utilization review direct the type and length of treatment received, and that payment for treatment might be terminated before the client and/or the counselor believe(s) the goals of therapy have been achieved (Applebaum, 1993). If coverage is denied, be prepared to discuss options (e.g., out-of-pocket payment, reduced fee, pro bono services, referral to a community agency; Cooper & Gottlieb, 2000).

3. Hold yourself accountable for providing quality care and delivery of services. Regardless of your counseling role (e.g., counselor, advocate, supervisor, expert witness), ask yourself how you can be the best counselor possible. Consult regularly with your supervisor and manager at your facility regarding managed care, liability, and compliance. The National Committee for Quality Assurance (1996) requires providers of behavioral health care to document the quality of their work, client satisfaction, demonstration of clinical outcomes, and adherence to data-based triage and care guidelines. Two popular client satisfaction measures are the Client Satisfaction Questionnaire-8 and Service Satisfaction Scale-30 developed by Attiksson and colleagues (as cited in Steenbarger & Smith, 1996). Counseling outcomes can be measured by the Global Assessment of Functioning scale, which is included as an axis within the DSM-IV-TR (APA, 2000), and The Behavior and Symptom Identification Scale-32, developed by Eisen, Dill, and Grob (1994). Eisen et al.’s scale assesses day-to-day functioning in areas of household responsibility, work, and leisure; levels of depression, anxiety, and physical problems; and substance abuse.

4. Learn to provide quality care without compromising ethical and legal concerns. Know whether you are in compliance with ethical guidelines and state and federal statutes and antifraud laws regarding managed mental health care. Contact your state health agency and state attorney general’s office to learn about changes in regulations and new laws. Refer to the Department of Health and Human Services (2000) for information regarding managed health care changes.

5. Refer to, and be familiar with, ACA’s (1995) and AMHCA’s (2000) codes of ethics regarding ethical dilemmas involving informed consent, confidentiality, termination
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and abandonment, utilization review and limits to treatment, client and counselor autonomy, diagnosis, and insurance reimbursement. When no clear resolution to dilemmas is apparent, use ethical decision-making processes (Haas & Malouf, 1995; Kitchner, 1984), which may include contacting your professional associations’ ethics committee for consultation.

6. Do not falsify or misrepresent any information or facts regarding insurance claims and cost reimbursement (D. Smith, 2003), including but not limited to intentionally misdiagnosing mental disorders, upcoding, double billing, making claims for services not provided, and so on.

7. Know your risks for liability associated with diagnoses of mental disorders in relation to insurance reimbursement. Educate yourself about the ethical and legal requirements for insurance reimbursement. Maintain liability insurance. Even though counselors strive to meet ethical and legal guidelines, they sometimes find themselves in violation of ethics and law. Seek supervision, consultation, and/or legal advice when needed.

Conclusion

Counselors struggle to find a balance between MCO demands and providing quality service to clients. A primary concern involves certain DSM codes that are not honored by MCOs. When DSM codes are unaccepted, clients may not receive needed services and counselors cannot receive insurance reimbursement, which is their livelihood. Hence, counselors may be tempted to intentionally misdiagnosis mental disorders in order to receive insurance reimbursement. This behavior violates ACA’s and AMHCA’s codes of ethics and constitutes fraud.

It is assumed that counselors who intentionally misdiagnose mental disorders for insurance reimbursement do so because they genuinely care about client welfare. However, is the practice considered to be “business as usual” because it is “in the client’s best interest”? For counselors who refrain from intentionally misdiagnosing mental disorders for insurance reimbursement, is it because it simply is “not right” to do so, because they fear ethical and legal consequences, or because they know that doing so does not ultimately represent the best outcome for clients? How do counselors reconcile their altruistic mission of serving clients with diagnostic exclusions that serve cost containment interests for MCOs? Counselors are forced to choose between allegiance or compliance—providing needed services to clients or adhering to MCO standards that compromise these services. Research is needed to assess counselors’ frames of reference and motivation regarding intentional misdiagnosing of mental disorders.

Another area that warrants research is mental health statistics recorded by the Center of Disease Control and by the World Health Organization (WHO). The DSM-IV-TR (APA, 2000) states that “the initial impetus for developing a classification of mental disorders was the need to collect statistical information” (p. xxv) and that the DSM is used as “a tool for collecting and communicating accurate public health statistics” (p. xxiii). Intentional misdiagnosis of mental disorders results in inaccurate mental health statistics at state, national, and global levels. An example is intentional misdiagnosis using Major Depression or Generalized Anxiety Disorder Codes instead of actual V Code diagnosis. The 1995 WHO report (as cited in Kleinman & Cohen, 1997) indicated that, globally, depressive and anxiety disorders were the leading causes of disability, and the 2001 WHO report indicated that 121 million people worldwide were affected by depression. The question is, how reliable are WHO statistics when research indicated that counselors, psychiatrists, social workers, marriage and family therapists, and psychologists intentionally misdiagnosed mental disorders? This question may never be answered except to say that WHO statistics do not accurately represent the true prevalence of certain mental disorders.

References


