MINDER
Managing Disability

# Dialogue

## Medical Provider Networks - a hinderance to quality care?

Have Medical Provider Networks ("MPNs") been able to live up to expectations of improving access to quality of care and reduce medical costs at the same time?


Recent accusations raised against Dr. Janak K. Mehtani, M.D. ("Mehtani") before the Medical Board of California, Department of Consumer Affairs would suggest not. Specific details relating to case # 02 2012224474, effective January 13, 2015 are available on the Medical Board of California website, under the option "Verify a License". At time of writing, a hearing had not been held and the case status description states, *"The Physician has not had a hearing or been found guilty of any charges".*

---

Has the P&Cs' implementation of MPNs compromised the physician - patient relationship?

---

Following the investigation of a lodged complaint relating to this case, the Executive Director of the Medical Board of California raised the following accusations (1) Gross Negligence, (2) Repeated Negligent Acts, (3) Prescribing Dangerous Drugs without Appropriate Examination or Medical Indication, (4) Failure to Maintain Adequate and Accurate Medical Records and (5) General Unprofessional Conduct.

These accusations relate to three workers' compensation claims for services provided between 2008 and 2013. Two claims were identified as belonging to State Compensation Insurance Fund ("SCIF") (patients JC and RW) while the insurer for the third claim, involving a non-English speaking 47-year old female with a history of hypertension and chronic pain (patient GC) was not identified.

The Workers' compensation reform allowing insurers or self-insured employers to establish Medical Provider Networks consists of three steps - (1) Legislation is enacted, (2) Regulations are developed based on legislative objectives and (3) Implementation whereby claims administrators develop practices and procedures to ensure legislative and regulatory requirements are achieved. This article reviews the claims administrators' implementation of MPNs with reference to patient GC in the Mehtani case.

Insurers promote their MPNs as being quality medical providers who have undergone extensive credentialing before selection with ongoing quality assurance control of their services. Mehtani is a Psychiatrist with a practice in Sacramento. A random sample of insurers' MPN lookup facilities showed Mehtani being currently available to provide treatment, even though there are very serious accusations currently lodged against him. There is no warning, link or reference to the Medical Board website to alert an injured employee or their employer of this fact.

Information shown on claims administrators' MPN websites to assist an employee in selecting a provider or medical specialty, such as a psychiatrist, is limited to basic contact details e.g. address, phone number, distance from a specified location, such as city or zip code, gender and language. In the case of Mehtani, there is inconsistency in the list of languages spoken where some MPNs list Hindi and Punjabi, while others also include Spanish. Does providing only minimal information limit the opportunity for correctly "matching" the patient (i.e. injured employee) to the medical provider, potentially compromising the physician-patient relationship?

Additional information in psychiatry would provide better opportunities for matching patient with psychiatrist. Sub-specialties such as psychosomatic medicine, addiction medicine or administrative psychiatry play key roles in the selection process with special interests such as psychopharmacology and pain management and additional training in psychoanalysis at institutes such as the American Psychoanalytic Association (APsaA) also providing highly specialized care and provision for better matching. Rapport between the psychiatrist and patient is of paramount importance and is assisted further when matching is based on race, ethnicity and cultural groups.

While a review identified 120 psychiatrists located within 2 miles of the central business district of Sacramento ("CBD"), a random selection of insurers' MPNs identified only one psychiatrist, in this case Mehtani, as being within 200 miles of the CBD. Other MPNs showed up to three psychiatrists within 200 miles of Sacramento, one of which was Mehtani. Can this list be considered adequate for the employee to choose a psychiatrist from, let alone attempt to "best match" a patient to a psychiatrist?

Some researchers suggest, that in patients with chronic pain, a psychiatrist may be the best person qualified to distinguish between medical comorbidity and concomitant somatic complaints and that they require careful multidisciplinary treatment, in which psychiatry can play an important role.

Patient GC experienced a number of work related injuries commencing in 2003 and was first seen by Mehtani in 2008 after experiencing depression and anxiety for 2 to 3 years. In line with a multidisciplinary treatment plan, Mehtani referred patient GC out for pain management and to a therapist for cognitive behavior management. Mehtani was to manage medications and provide supportive psychotherapy once a month for 12 months. In this case, who was responsible for approving and selecting the providers? Pain management providers are generally listed on MPN lists, however, in a random selection of MPNs, cognitive behavior therapists and those providing cognitive behavior therapy such as psychologists, mental health nurses and psychiatrists were either not listed or not identified as providing cognitive behavior therapy, further demonstrating the limitations of MPNs in selecting medical providers.

In the multidisciplinary or multidimensional approach to addressing chronic pain, an interdisciplinary approach is also required to maximize a psychiatrist's role in the treatment plan, where all parties involved work in a coordinated fashion. The overall responsibility of ensuring the interdisciplinary team adheres to a common objective rests with the claims administrator. In the case of patient GC, the claims administrator should have been responsible for all the activities performed by the psychiatrist (Mehtani), the pain management provider, the

therapist providing cognitive behavior therapy, the primary treating physician and the pharmacist in cases where medications were being dispensed by an insurer's pharmacy network or a pharmacy was linked to an insurer's pharmacy benefit manager ("PBM"). Pharmacists and pharmacies can be held accountable for failing to identify and verify red flags which may appear when a prescription is presented. In the Mehtani case, the issue of prescribed medications is being raised in the accusations.

Documentation required by psychiatrists has been an issue of contention for some time with many psychiatrists believing that they do not need to perform the same level of documentation generally required for "physiology-based medicine". Lack of documentation has also been raised in the Mehtani case, however this may be a moot point in future. In 2013, Current Procedural Terminology ("CPT") codes for psychiatry were revised with 28 CPT codes deleted and new codes added. For example, CPT code 90862 (Pharmacologic Management/Comprehensive Medication Management) and 90805 through 90829 relating to Psychotherapy with Evaluation and Management ("E&M") were discontinued and replaced with standard E&M codes beginning with 992xx. These require accompanying documentation to conform to the Centers for Medicare & Medicaid Services ("CMS") 1995 or 1997 guidelines for evaluation and management. California Workers' Compensation adheres to these CMS guidelines. The American Psychiatric Association ("APA") has published an abridged and modified E&M documentation standard based on the 1997 CMS guidelines.

Ongoing quality assurance controls for providers can be accomplished in many ways including automation. Technology is available to monitor diagnoses (DSM-5, ICD-9 and ICD-10), treatments rendered (CPT codes) and pharmaceuticals dispensed through the National Drug Code ("NDC") so as to track treatment and recovery progress, as well as monitor each provider's contribution to the objectives set by the claims administrator.

Ongoing quality assurance controls for providers can be accomplished in many ways including automation. Technology is available to monitor diagnoses (DSM-5, ICD-9 and ICD-10), treatments rendered (CPT codes) and pharmaceuticals dispensed through the National Drug Code ("NDC") so as to track treatment and recovery progress, as well as monitor each provider's contribution to the objectives set by the claims administrator.

Although psychiatrists use the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") now in its fifth edition for their diagnoses, they also cross-reference to both ICD-9 and ICD-10 codes which are used by all physicians. For example, the DSM-5 diagnosis of "Anxiety disorder due to another medical condition" cross-references to ICD-9 293.84 and ICD-10 F06.4. DMS-5 diagnosis of "Depression disorder due to another medical condition" cross-references to ICD-9 293.83 and ICD-10 codes F06.30, F06.31, F06.32 and F06.34.

The Mehtani case identified a total of 128 visits with either Mehtani or his nurses and physician assistants, between three patients, over a three year period. There were a total of 40 visits for "Medical Psychoanalysis" with Mehtani and patient GC between 2010 and 2013. All visits would have been invoiced by Mehtani and would have required documentation before payment was made. As lack of documentation was mentioned in the accusation document for all three patients, how was the claims administrator monitoring treatment progress and determining payment for services rendered over the period that Mehtani treated patient GC and the others?

The current health status of all three patients and whether they have returned to normality has not been stated in the accusation document. Patient GC was first injured in 2003, patient JC was injured in 1989 and no injury date was recorded for patient RW. Regardless of the outcome of the Mehtani hearing, could the injured employees file a tort claim against the insurer as to lack of quality care provided by their MPNs? Could a tort claim be filed by the employer against the insurer with regards to lack of controls in place to vet and verify costs associated with providing medical treatments by their MPNs? Although tort claims by the employee against the employer are not permitted under the workers' compensation agreement, the insurer and claims administrator are not direct parties to this agreement.

The question of whether current workers' compensation medical treatment practices based on Group Health Managed Care programs, such as MPNs are diametrically opposed to the workers' compensation ethos of "return to work" where "utmost good faith" between interested parties is aspired to remains unanswered. This article however, suggests that they most probably are diametrically opposed.