California Psychiatrist

The Newsletter of the California Psychiatric Association

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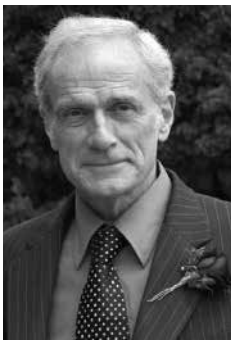
The President's Message

Romancing the Gun



Ronald Thurston, M.D.

By Ronald C Thurston, M.D.
CPA President

Americans have a special relationship with guns–and it's killing us. The Second Amendment to the Constitution reads: "A well regulated militia being necessary to the security of a free state, the right of the people to keep and bear arms shall not be infringed."

The Amendment–which merely assured an existing right–was part of a deal to clinch ratification of our present Constitution. Fearing domination by the new federal government, some states–most notably the largest, Virginia–demanded amendments that explicitly restrained federal powers. In 1789, the first Congress worked out 10 such amendments, which we know as the Bills of Rights.

For many Americans, the Second Amendment's rationale for gun ownership–"the security of a free state"–gives purpose to gun ownership, elevating it from a right to a patriotic duty. Guns defend liberty; Infringement is tyranny. The Supreme Court has consistently limited infringements enacted by federal, state and local governments and, in 2008, ruled that gun ownership is an individual right, unrelated to service in a militia.

The "security of a free state" rationale not only suggests that it is patriotic to bear arms but–by extension–implies that personal weapons ought to keep pace with those owned by potential tyrants, arguably endorsing civilian ownership of military-grade weapons.

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From the President-Elect

5150 Confusion

Tim Murphy, M.D.

By Tim Murphy, M.D.
CPA President Elect

In San Diego and San Francisco Counties, emergency department (ED) physicians who have taken a course and have been certified by their counties can initiate a 5150 hold. The San Francisco ED physician may lift a hold. The San Diego ED physician may not. In Los Angeles and Sacramento Counties, ED physicians cannot place holds under any circumstances.

These are examples of differing policies implementing California's Welfare and Institutions Code 5150, the law which grants authority to "a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team", or "other professional person designated by the county" to detain an individual for purpose of placing that individual in a county designated psychiatric facility. Here are more examples of differing policies:

In Sutter and Yuba Counties, *any* physician licensed to practice in those counties may place patients on 5150 holds. In Shasta County, certain Licensed Vocational Nurses (LVN's) and Licensed Psychiatric Technicians may write holds, but only psychiatrists can release them. In Santa Cruz County, who may write a hold varies from hospital to hospital.

In Alameda County, hospitals decide who can write holds; the

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Inside This Issue

From the Editor ...

Yvonne B. Ferguson, M.D., MPH

If I had to summarize this issue's theme in one word it would be CHANGE. It's here and more is coming. Changes so dramatic that all practicing psychiatrists and their patients will be affected. I'm talking CPT codes, more HIPPA changes, DSM 5, increased demand for services, Laura's Law implementation, yadda, yadda, yadda. Oh, and did I mention the phasing out of newsletter hard copies. That's right. Just two more issues and so many more trees will be spared. This is a large issue packed with vital information that you'll want to read cover to cover. Enjoy and tell us what you think and I look forward to seeing you in San Francisco in May and La Quinta in September.

--Yvonne B. Ferguson, M.D., MPH, Editor

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APA WebSite: www.psych.org

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Capitol Insight Special Insert

Board of Trustees Report, March 2013

By Marc D. Graff, M.D.
Area 6 Trustee

The March 23-24, 2013 Board of Trustees (BOT) meeting was unusually important. Other Area 6 attendees were Dilip Jeste, MD (President), Mindy Young, MD, (Speaker-Elect), and Alan Schatzberg, MD, (Past President).

The major issue (taking up one entire day of the meeting), was discussion about, and work towards, the selection of a new Medical Director of APA. As most of you know, Jay Scully, MD, has been the APA Medical Director for the last 10 years, and has announced his planned retirement as of December, 2013. The Medical Director, since Jay took APA's helm, is now the CEO of APA. There have been only four Medical Directors since 1964—Walter Barton, MD, Melvin Sabshin, MD, Steve Mirin, MD and Jay Scully, MD. Beginning last fall, a process was begun to hire a nationally-known search firm and appoint an APA search committee for this extremely important job. Finalists were interviewed by the search committee in the last month, and candidates were interviewed, considered and discussed by the BOT on March 24, 2013. The selection process is in its final stages, and it is hoped that a Medical Director designee will be in place by the time of the Annual Meeting in May.


Marc Graff, M.D.

Another major issue was dealing with insurance carriers abusing the 2013 CPT code changes (paying less to treatment providers and authorizing less service for patients). As noted in a statement approved by APA's general counsel: "The BOT voted to use all reasonable resources, including litigation, and approved the budget presented by the APA's attorney, to end the practice of some insurance companies of violating the Mental Health Parity and Addiction Equity Act (2008) [MHPAEA] by using strate-

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Legal Update

New Legal Developments

By Dan Willick, J.D., Ph.D.

Introduction

There have been several significant legal developments since my last column. The federal government has issued new HIPAA regulations. There have been billing problems for psychiatrists regarding the revised CPT codes. Finally, the California Supreme Court has issued a significant ruling upholding the psychotherapist-patient privilege in the case of *People v. Gonzalez*.

New HIPAA Regulations

On January 17, 2013, the U.S. Department of Health and Human Services ("HHS") issued new regulations regarding the HIPAA privacy rule and security rule. The 563 page discussion of these changes may viewed online at http://federalregister.gov/a/2013-01073. Commentators view these new rules as tightening the responsibilities of HIPAA business associates and subcontractors to HIPAA business associates. In a nutshell, the new rules require HIPAA business associates and their subcontractors to comply with heightened privacy and security requirements. The rules will require healthcare providers to revise their business associate agreements. Other provisions of the new rules tighten limits on use of patient records for marketing, prohibit sale of patient information without patient consent, and provide heightened patient control over sharing of information with insurance companies so that a patient can forbid sharing of information with an insurance company where the care was paid for entirely by the patient. The new rules contain other changes which the limitations of space do not permit us to review. For most aspects of these new rules, the compliance deadline


Daniel H. Willick, Esq.

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CPT Coding Changes Lead to Parity Abuses

Melinda Young, M.D.

By Melinda Young, M.D.

Beginning January 1, 2013, more than 650 code changes were made to the CPT manual, including significant changes to the psychiatry section, with the creation of new codes and guidelines as well as code deletions. These changes were intended to more accurately reflect the work psychiatrists do and improve patient access to care. Instead, they have been used as justification by some payors to abuse the situation by creating obstacles to treatment of psychiatric patients by their psychiatrists. Problems differ from state to state, from carrier to carrier and, at times, from psychiatrist to psychiatrist. They range from denial of authorization to lowered reimbursement rates when compared to rates in effect prior to January 1, 2013, failure to reimburse for psychotherapy add-on codes, denial of more than one "procedure" on a given day (an E&M code plus a psychotherapy add-on code), requiring patients to make two co-pays for two "procedures" on the same day (an E&M code plus a psychotherapy add-on code), reimbursement at a lower rate for the same E&M codes when used by psychiatric physicians compared with non-psychiatrist physicians, etc.

CPA AND APA ARE WORKING FOR YOU

CPA and APA are committing significant resources to understand the situation, to support psychiatrists and their patients, and by using all available legal means to correct the abuses that are taking place. Effective actions also address state and federal legislators and regulatory bodies because of violations of state and federal law. In addition to actions taken by CPA and APA, individual psychiatrists and their patients can often be effective agents of change because they are parties to the contracts with insurers, hold all the information about abuses, and are *voting constituents* of legislators.

In California, efforts have included letters to specific insurance carriers, elected representatives, the California Department of Insurance and the California Department of Managed Health Care. In New York, the New York State Psychiatric Association, employees of The State of New York, CBS and SYSCO have brought a nationwide class action suit against UnitedHealth, United Behavioral Health (UBH) and OptumHealth. The APA is working in conjunction with plaintiffs' counsel. And in Connecticut, the APA, the Connecticut Psychiatric Society and the Connecticut State Medical Society have written to Anthem Blue Cross and Blue Shield of Connecticut, requesting that Anthem immediately cease its unfair coding and payment practices that violate the Mental Health Parity and Addiction Equity Act of 2008, the Connecticut parity law, the Health Insurance Portability and Accountability Act (HIPAA) and the Connecticut Unfair Trade and Unfair Insurance Practices Acts.

THE RESULTS

In California, **Blue Cross** agreed, on March 5, to correct an acknowledged "system problem" causing a double co-pay to be deducted. Blue Cross reports it is in the process of automatically reprocessing the affected claims.

In California, **Blue Cross** has also made the decision to increase rates for several of the new psychotherapy codes, including CPT codes 90833, 90836, and 90838. For psychiatrists on the standard Prudent Buyer fee schedule, Blue Cross has increased pricing for E&M codes 99202-99205, 99212-99215, 99223, and 99232-99233. The new pricing went into effect on March 13, retroactive to January 1. Blue Cross reports it is in the process of reprocessing the affected claims and that interest will be paid automatically, as required by law. Written notification will be sent to physicians on both these issues.

Also in California, **ValueOptions, Inc.** informed psychiatrists on March 21 that it had reviewed its transition to new CPT codes and concluded that it needed further adjustment in the Evaluation and Management codes and the psychotherapy add-on codes that would reimburse physicians for psychotherapy. ValueOptions promised to update its fee schedules and reprocess claims for services provided after January 1, 2013 to reflect corrected rates.

NEXT STEPS:

While this is a good beginning, more changes clearly need to occur.

CPA is seeking specific information for use in informing legislators and regulators about these problems and to engage in lobbying and legislative efforts for the benefit of

its psychiatrist members and their patients. Contact CPA Government Relations Director Randall Hagar at randall-hagar@calpsych.org to report violations. Please provide your name, phone number, email address, and complaint details, including the name of the insurance plan and the specific problem that has occurred, taking care to remove information that might identify any particular patient. CPA will also forward your information to APA, which will help craft specific letters of complaint to be sent to the appropriate parties. CPA will help you determine to whom these letters should be sent.

Nationally, the **APA's Board of Trustees** voted on March 24, 2013 to use all reasonable resources, … including litigation, … to end the practice of some insurance companies of violating the federal law, and approved the budget presented by the APA's attorney to end these practices. APA has a dedicated website for CPT Parity Abuses at http://www.psychiatry.org/cptparityabuses. Member login is required.

CPA IS HERE TO HELP YOU!

The California Psychiatric Association ("CPA") engages in lobbying and legislative efforts for the benefit of psychiatrists and their patients. CPA is seeking information for use in informing legislators and regulators about the following problem:

Recent revisions to CPT coding are being abused by some payors to discriminate against psychiatric patients and their psychiatrists and as a pretext for denial of authorization or appropriate payment for psychiatric and substance abuse diagnosis and treatment.

1. Effective complaints are based on specific information. CPA will help you address problems in California and will forward your information to APA to address the problems nationally. Contact CPA Government Relations Director Randall Hagar at randall-hagar@calpsych.org to register your complaint and to receive assistance.

Please provide specific information regarding these practices to CPA. You must include the following information, taking care to not provide information that might identify any particular patient:

Your information:
Name
Phone
Email

Complaint details:
Insurance plan
Specific problem(s)
Not paying for E&M codes
Not paying for psychotherapy add-on codes
Not recognizing add-on codes
Charging 2 copays when an E&M code is used with a psychotherapy add-on code
Reduced rates, and which rates were reduced
Reimbursing for M0064 only in lieu of the deleted 90862 code
Prior authorization required for the use of E&M codes 99214 and 99215
Other –
Details of the problem(s). Please do not provide CPA or APA with the name of your patient or other information which identifies your patient. However, please keep track in your records which patient or patients your complaint concerns.

2. Effective complaints must reach the right "ears". CPA will forward your information to APA, which will help craft a letter of complaint to be sent to state and federal legislators and regulatory bodies, based on the specific problems you and your patients are facing. CPA will help you and your patients determine where to send these letters.

Your letters should go to:
The Insurance plan
Your state Assemblymember and Senator
Either the CA Dept. of Insurance or the CA Dept. of Managed Health Care
Your US Congressmember and Senators

Your patients' letters should go to:
Their insurance plan
Their employer's HR department
Their state Assemblymember and Senator
Either the CA Dept. of Insurance or the CA Dept. of Managed Health Care
Their US Congressmember and Senators

HOW TO FILE A COMPLAINT OR APPEAL A DISPUTED CLAIM

1. Determine who has jurisdiction over the plan and associated claims:

- **Insurance companies, agents and plans that are licensed by the California Department of Insurance**

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are regulated by that department. See their website at www.insurance.ca.gov.

- **Health plans underwritten by managed care companies and HMOs** fall within the jurisdiction of the Department of Managed Health Care. See their website at www.dmhc.ca.gov, or call 888/466-2219.
- **Self-funded health plans sponsored by companies** are regulated by the United States Department of Labor: 866/275-7922.
- **Self-insured health plans that are sponsored through federal, state, or local government employment; school districts, or churches:** Complaints must be filed with the plan directly.
- If you do not know who regulates a particular health plan, you can ask the health plan.

2. Steps for filing a claim dispute with a licensee of the **CA Department of Insurance**

- **For patients** with a claim dispute with one of the Department's licensees:

  Complete and file a Department "Request for Assistance" form. The form is available on the Department's website at www.insurance.ca.gov. Click on "Request for Assistance" at the top right corner of the home page.

  A "Request for Assistance" form can also be mailed directly to the patient. Contact the Consumer Hotline at 800/927-HELP (4357) or at 213/897-8921 (for out-of-state callers).

- **For healthcare providers** with a billing dispute with one of the Department's licensees:

  Complete a "Healthcare Provider Request for Assistance" form, available at www.insurance.ca.gov. Select "Consumers" on the far left side of the red line toward the top of the page > "Health Related Insurance Information" > "Consumer and Healthcare Provider Inquiries and Complaint Information". Click on this section, scroll down to the Health Care Provider Complaints section, select "File A Complaint – Health Care Provider Request for Assistance (HPRFA)" and follow the instructions.

3. Steps for filing a claim dispute with the **CA Department of Managed Health Care**

- For **patients** with problems or complaints, see www.dmhc.ca.gov
  - o From "Home", select "Problems and Complaints" and follow the directions.
  - o If a complaint is urgent, or if you already filed a complaint and are not satisfied with your health plan's decision, call the Help Center at 866/466-2219.
  - o To file a complaint that is not urgent, fill out and mail a Complaint Form.
- For **healthcare providers**, go to www.dmhc.ca.gov. Select "Health Care Providers" from the selections in the upper left corner, and select the "Claims Issues" box in the middle of the page. Or call 877/525/1295

Note: all of the foregoing documents on CPT issues were developed by Melinda Young, MD.

Letter to the Editor

Our small psychiatric community in San Luis Obispo is in crisis.

Following the killings in Aurora, Colorado and Newton, Connecticut, lawmakers have been embroiled in a national debate about how to control gun violence. There has been discussion about the need to detect individuals who are seriously mentally ill and the need for early evaluation and treatment of persons who potentially or overtly pose a risk of harm to others in the community.

Psychiatrists are physicians who are uniquely trained to evaluate and treat the seriously mentally ill patients who suffer from conditions such as Schizophrenia, Bipolar Disorder, and many other disorders that can pose a risk of harm to the patient and/or the community. There is a national (and local) shortage of psychiatrists. Of the current practicing psychiatrists 55% are over the age of 55 and many are expected to retire in the near future.

Why is there a shortage? Psychiatrists are some of the least paid specialists in medicine. With the tightening economy and booming debt of medical education new physicians shy away from this low paying specialty. Psychiatrists are underpaid because they provide time consuming face-to-face services as compared to physicians who engage in performing well reimbursed procedures often requiring

minimal time consuming face-to-face contact.

Commencing January first of this year the American Medical Association revised the billing codes for psychiatrists to allow them to receive appropriate compensation for the complex services they provide. Unfortunately some insurers have hijacked this change and have reduced reimbursement to improve their bottom line. For example compared with 2012 I am now being reimbursed by a major insurer 60% less for a thirty minute consultation; 49% less for a 45 minute consultation; and 28% less for a comprehensive initial evaluation. This insurer covers over one third of patients in my 24 year old practice and I am only one of over twenty psychiatrists affected in San Luis Obispo County. Several of my colleagues have had to take out bank loans to keep their practices afloat.

Unless this situation is rectified many psychiatrists in this community will be unable to afford to provide services to a substantial number of current and new patients at a time when more services are being demanded. Expansion of Mental Health coverage under the Affordable Care Act in 20114 will further strain the existing short supply of psychiatrists.

The aforementioned insurer had provided no advance notification of their intent to slash reimbursement, in violation of their own provider contract, and when questioned claim they are looking into the problem and expect resolution in several weeks time. In the meantime payment for claims has been delayed and what claims have been paid are a fraction of the 2012 reimbursement.

My colleagues and I, the San Luis Obispo Psychiatric Association, are challenging this egregious behavior by contacting multiple professional medical and psychiatric organizations , local, state and federal representatives.

Regardless of how our particular crisis is resolved it has become apparent to us that psychiatrists in private practice are virtually powerless in negotiating with large for-profit medical insurance companies. Given the current national legislative mindset about reducing health costs while expanding medical services, the writing is on the wall about how physicians will be leveraged to accept lower reimbursements. The bigger question is how can we, physicians/psychiatrists, move into a position to collectively bargain not only with insurance corporations but ultimately, the government?

I look forward to your feedback. Sincerely,

David E. Powles, M.D., F.A.P.A.

Letters to the Editor may be edited for length and clarity

Access to Effective Care is at Risk

Joe Mawhinney, M.D.

By Joe Mawhinney, M.D., DLFAPA
Chair, CPA Access to Care Task Force
Chair, Assembly Executive Committee Access to Care Work Group

At its November meeting, the APA More than ever as the ACA rolls out, patients and the psychiatrists serving them need organized psychiatry to expose the increasing problems of access and to advocate for meaningful solutions. In the interest of true health care reform, equitable, efficient and effective care should be our highest priority. We must consistently advocate for the Public Health and the highest value of the health care dollar with a focus on access to effective care, quality indicators and outcomes-oriented research from a global perspective. Barriers, delays, excessive administrative overhead and complexity affect timely and appropriate access, increase disability, decrease productivity and educability and result in cost shifting to other systems while profits soar in the for profit managed care corporations and pharmacy benefit managers.

Escalating out-of-pocket costs further reduce utilization and have been shown by CDC studies to result in increased utilization of emergency services, hospital care and chronic disability. A healthcare system which discourages early effective interventions and which interferes with effective disease management for severe persistent and chronic recurrent disorders provides false savings, increased pain and suffering for patients and families as well as frustration and burnout of practicing psychiatrists exacerbating an already existing manpower shortage trend for psychiatrists avoiding or leaving insurance based practice.

Implementation of the ACA means a significant increase

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"What is to be done?"


Barton J. Blinder, M.D.

By Barton J. Blinder, M.D., Ph.D. - Area 6 APA Assembly Representative

At the writing of this report, our specialty is confronted once again by pressing issues that will have major bearing on the future of our practice and the welfare of our patients. I'd like to bring you up to date on actions of the Assembly and APA to respond to challenges on several fronts.

1. Gun violence: upcoming are several Action Papers at the May Assembly meeting at our APA Annual Meeting in San Francisco. These requests will deal with prevention of violence, rational regulation and restriction of gun ownership and the possession of military style and destructive weapons, further refinement of APA policy regarding safety, mental health, and gun violence issues. In the past week, APA Board of Trustees has adopted a policy statement on gun violence and mental health which was the result of an ad hoc emergency work group. The statement is balanced with evidence-based documentation and reasonably in accord with other medical specialty societies. It speaks to the need for parity and expanded services in mental health, safety, and prevention.

2. CPT coding (urgent issues regarding confusion, chaos, and compensation): In the past three months, the APA has been increasingly active in addressing the chaotic national situation with regard to CPT coding, effecting the practice of members throughout the country, resulting in restricted treatment, decreased compensation, and in some instances declining ability of patients to adhere to appointments and treatment recommendations. Although well intentioned efforts were made to prepare for the CPT changes through education of our members, it appears that the insurance industry, either through misinformation, lack of preparation, or intent, has created a crisis for all concerned. In the past week, APA has created a vigorous task force to collect instances of abuse and confusion reported by members and resources to respond with as much guidance as possible currently. Efforts are being formulated to communicate with the insurance industry to clarify the current confusion and consider all possible means to remedy the situation toward achievement of required parity and restoring reasonable compensation.

3. Safety and quality of care: APA and the Assembly continue to monitor and be concerned with regulations and legislation that impinge upon practice, quality of care, and patients' safety. Attempts at legislation advancing the prescribing and treatment by non-medical health professionals continue to be an area of challenge for us. Issues related to availability of psychiatric treatment, geographic distribution of practitioners, fitting into complex systems of care, and assuring availability of all levels of treatment are continued areas of study to determine how our specialty can respond in the best interest of patients.

4. Access to Care: The pilot Access to Care Task Force assigned to Area 6 continues to meet and gather data regarding obstructions to availability of treatment including pharmaceutical formulary restrictions, managed care, obstructions to the duration and necessary level of treatment including violations of parity regulations. Recent concerns have been the increasing tendency for members to opt out of all insurance panels and Medicare. This trend if it continues, will run head-on into the full implementation of ACA in January 2014 where close to 90% of the population will be covered by a degree of reasonable benefits while only a percentage of psychiatrists in practice will be connected to or accepting such benefits. This must be studied with regard to equitable compensation and accountability in this system that will encourage a reasonable degree of colleagues to consider joining insurance panels so that the population will be served. The training of residents to meet the complexities of practice in the future, both in the private sector and organized systems of care such as Accountable Care Organizations and multi-specialty group practices which will emphasize integrated care is another area high on our agenda.

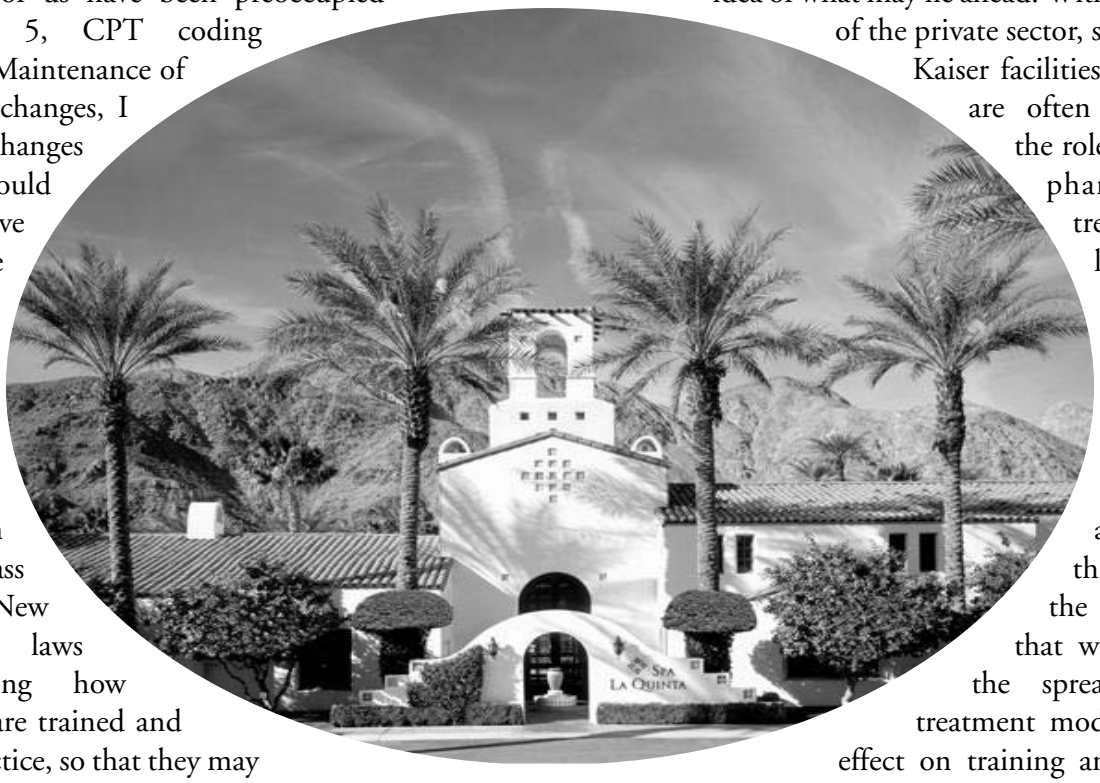
These are some of the issues on the front burner of our concerns. Please do not hesitate to contact me (bblinder@uci.edu) and Joe Mawhinney (Deputy Area Representative – drmawhinney@sbcglobal.net) with comments, opinions, and suggestions for us.

The 2013 California Psychiatric Association 26th Annual Premier Conference at La Quinta Resort and Club

Bruce S. Milin, M.D.

By Bruce Milin, M.D.,
Annual Meeting Chair

A significant segment of this year's conference will focus on events likely to bring about major changes in both the training of psychiatrists and their future practice settings and models. The APA is discussing these changes and I believe that everyone in our field needs to better understand what is occurring and to have a voice in the process. While most of us have been preoccupied with DSM 5, CPT coding changes and Maintenance of Certification changes, I believe the changes that could potentially have a far more profound impact on our profession are receiving little attention at the grass roots level. New healthcare laws are redefining how psychiatrists are trained and how they practice, so that they may better integrate with primary care. It appears that this restructuring is inevitable and will occur with or without our input. As Robert McCarron, who serves on our planning committee, has stated, the real issue is how and if we can shape the new structure to provide the best patient care. We are planning to have most of the Saturday portion of the conference be devoted to presentations by a panel of individuals knowledgeable about what is occurring. I strongly encourage all CPA members to attend this meeting in order to learn more about these topics and to participate in the interactive panel discussion.



While integration in healthcare seems inevitable and desirable, it could relegate psychiatrists to do primarily E/M, leaving our non MD colleagues to do nearly all that we would term psychotherapy. Such a shift has already occurred to a large extent, but acceleration of this process combined with the push towards integrated treatment models may drastically alter the roles of psychiatrists. We can look to those areas where integration has already occurred in both the private and public sectors to get an idea of what may lie ahead. Within some areas of the private sector, such as certain Kaiser facilities, psychiatrists are often relegated to the role of providing pharmacological treatments and little else. This also happens in mental health clinics in the public sector. We all need to think about the implications that will arise from the spread of these treatment models and their effect on training and practice. I once again urge all of you to attend this year's meeting in order to learn more about this topic. I also urge you to encourage attendance by colleagues who are most likely to be affected by changes, especially those who are just entering the field and those who train them. We all need to make an effort to alert residency training directors, residents, and early career psychiatrists to the importance of this year's major topic, as these groups will be most affected and should be strongly encouraged to attend.

News From the PAC

Lawrence Malak, M.D.

By Lawrence Malak, M.D.
CPA PAC Chair

I want to thank you for your continued support of the CPA Political Action Committee this past year. The PAC is a vital part of the efforts of our organization to ensure the election of qualified representatives. Your ongoing contributions allow us to elect persons committed to support both our patients and the practice of psychiatry.

This upcoming year many familiar challenges await us. Potential cuts to mental health funding threaten to further reduce access to psychiatric services while tests of mental health parity jeopardize our efforts to bring equality to mental health patients and providers. However, this is also an exciting time. We have a chance to be an active force in shaping the future of healthcare and psychiatry in the state of California. As healthcare reforms become reality in 2014, supporting your PAC will allow the CPA to have a positive impact as these policies are formulated.

So let us sustain the momentum we have gained and get back to work. Your investment in the PAC is an investment in the future of psychiatry.

California Psychiatric
Political Action Committee (PAC)
1029 K Street, Ste. 28, Sacramento, CA 95814

Please fill out the requested information below
(required by state campaign reporting laws).

Name _____
Employer _____
Address _____
Home Phone _____
Office Phone _____
Fax _____
District Branch _____
Amount: $1000 $500 $250 $150 Other_____

o Check enclosed- Make checks (corporate checks okay) to: CPPAC

o Or charge my: (circle one) VISA Mastercard

o Charge full amount **OR** o Equal Monthly Installments
(credit cards only, $100 minimum)

Credit Card Number: _____
Expiration Date _____

Thank you for your contribution
Contributions not deductible on Federal Income Tax

CPA-Alf is dedicated to public education, legislative and legal advocacy. Contributions to the CPPAC (California Psychiatric Political Action Committee) for the purpose of electing qualified candidates to the California Legislature, are collected separately from CPA-ALF due to regulatory requirements

DB Corner

CCPS Update

By Shannon Suo, M.D., CCPS President

On the heels of a very successful CCPS Annual Meeting, I would like to share with the members of CPA what CCPS has been doing. March 22-24 over 100 members with their families gathered at The Clement Intercontinental Hotel in Monterey to learn, reconnect, and recharge in the beautiful coastal weather. We enjoyed talks by UC faculty from Davis, Kern, San Francisco, and their residents on such topics as bullying, sleep disorders, chronic pain, and the health care home. Our MITs had their questions answered by a panel of 10 psychiatrists from all levels of experience and settings in the resident social. We resurrected the job fair in conjunction with our exhibit hall and hope to expand next year to include more prospective employers as opportunities grow in the Central California region, such as the birth of a new training program in Visalia, which welcomes 12 new residents to the UC Irvine-affiliated program this summer!

Shannon Suo, M.D.

Saturday night's Presidential reception and banquet brought recognition to two distinguished members: Sam Castro, newsletter editor for the CCPS Society Page newsletter for over 25 years and Francis Lu, a relatively new CCPS member, but previous recipient of the Cap Thomson Lifetime Achievement award, and invaluable in his contributions to CCPS and cultural psychiatry over

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SAVE THE DATE

CALIFORNIA PSYCHIATRIC ASSOCIATION PREMIER CONFERENCE

September 27-29, 2013
LA QUINTA, CA

La Quinta Resort and Club

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Letter to the Editor

Letter to the Editor

Thanks for including the Letter to the Editor from Dr Bob Larsen about AB 863. This hits the nail on the head. I used to think that Jerry Brown was concerned about patients and injured workers, but now I think that Schwarzenegger has more empathy than Jerry Brown. I hope you will go into more depth about how the worker comp system has reneged on their mission of being a benefit delivery system. The tragedy of this bill is that none of the legislators even read this voluminous document before they passed it by a very large plurality.

Jim Robbins, MD

Now Available: State Disability Insurance Online Poster!

The California Employment Development Department (EDD) has implemented a new electronic claim filing system, known as State Disability Insurance (SDI) Online, for claimants, physicians/practitioners, employers, and voluntary plan administrators.

SDI Online is secure and convenient. When a patient files their claim online, the physician/practitioner or their authorized representative is able to electronically certify the claim using SDI Online. This secure online system provides expedited claim processing for patients and will save physicians/practitioners time and money.

To increase awareness of this new online system, the EDD has created a poster to promote and encourage the participation and use of SDI Online. To download a copy of the poster for your office, visit our website at www.edd.ca.gov/Forms/. Search for keyword "SDI Online poster."

You may also order hard copies of EDD forms, including the Claim for Disability Insurance Benefits, DE 2501, from this website. Orders may take two to four weeks for delivery.

To register for an SDI Online account, or to add an authorized representative to certify for your practice, visit our website at www.edd.ca.gov/Disability. For more information, call the phone line dedicated to physicians/practitioners at 855-342-3645.

NEWSLETTER ELECTRONIC CONVERSION

The next two issues of the newsletter will be the last to be mailed generally. Many members have already signed up to have their copy sent by email. After the next two issues everyone will receive it by email unless you do not have access to email. Please call 800-772-4271 to let CPA know if you would like the newsletter sent by regular mail.

Please be certain your email is updated with Lila Schmall at lila-schmall@calpsych.org.

President's Message (Continued from page 1)

However, the first Congress did not distinguish between personal and military firepower. Except for canon, the cutting edge military weapon at the time was the same as that used at home: a single-shot musket that took 15 seconds to load. Assaults required a bayonet.

Rapid-fire, military-grade assault rifles have made mass shootings easier. That's what these rifles were designed for. It's not that I don't like assault rifles. I once slept with one. We all did, when I was a corporal in the Marine Corps. I still have my sharpshooter medal–but I don't own a rifle or a gun. Assault rifles have a place in our armed forces, where their owners are well regulated. Unless civilians can be as well regulated as the military–which is the very definition of tyranny–then military-grade weapons ought to be restricted to the armed forces.

Mass shootings–4 or more deaths–provoke national outrage but actually account for less than one percent of our massive total 30,000 annual firearm deaths. We have double the gun deaths of the next leading industrial nation, and three times more than most. We have double the number of guns–90 guns for every 100 Americans–than the next leading nation and three times more guns than any other industrial nation. Worldwide, the number of gun deaths parallels the number of guns; the ratio of deaths per guns is, more or less, universal. This means we have more gun deaths simply because we have more guns, not less gun safety. This means that, if we are to reduce gun deaths to that of other civilized nations, we must either reduce the number of guns by two-thirds or triple our gun safeguards! Good news: Canadians fend off tyranny with only 30 guns–and suffer only one-fifth the firearm deaths.

One of three Americans owns a gun, putting guns in nearly half of all households. Household members are the usual victims. Two-thirds of firearm deaths are suicide! Homicide–mostly gunshot–is the second leading cause of death for youth 14-25 years old–and the leading cause in many neighborhoods. Wayne LaPierre, CEO of the National Rifle Association, recently spoke for many gun owners when he asserted that a gun is just a "tool"–dangerous only in the wrong hands. He meant criminals and people with mental illness. He called for more reporting and national registries of "lunatics" and, perhaps only to give credit to his argument, increased funding for treatment. Blaming the shooter distracts from controlling the gun, but it's a distinction without a helpful difference.

Stigmatizing mental illness is bad. Funding is good. Universal criminal background checks and gun registration are sensible. Are most shooters mentally ill? Maybe–the two out of three that kill themselves are at least emotionally distraught. Their suicidal impulse–often fueled by alcohol and drugs–is rendered lethal by the available gun. Most homicidal shooters are not mentally ill, but impulsivity–often fueled by alcohol and drugs–increases the odds of death.

Indeed, impulsivity appears be the most common shooter characteristic. The incidence of mental illness is not more frequent in America, just gun-assisted suicidal impulsivity. The incidence of violence is not more pervasive in America, just gun-assisted lethality. If it's the shooter, not the gun, then it's impulsivity that needs regulation--and that brings us back to safeguarding the gun.

The British reduced overdose suicide by nearly 25% when they required that OTC pain pills be sold in small-quantity blister packs. Gun-assisted impulsivity can be managed in similar ways. thurstonrc@gmail.com

5150 Confusion (Continued from page 1)

county is not involved at all in the designation of individuals. Whoever is designated to write a hold may also lift it.

In San Diego County, if an individual is placed on a hold by law enforcement but is then taken to a non-psychiatric hospital for medical evaluation and treatment (for example, to have sutures placed in a self-inflicted laceration), the hold remains in effect so long as the patient remains in the emergency room. In Los Angeles County, the hold is voided if law enforcement leaves after bringing the individual to the hospital.

5150 holds are often mistakenly referred to as "72 hour holds", another subject of confusion. Many counties (but not *all* counties) understand the law as saying that the "72 hour hold" actually refers to W & I code Section *5151*, which gives authority to the designated psychiatric hospital to hold patients on an involuntary basis for a period of up to 72 hours for evaluation. Under this interpretation, the clock starts at the time of admission to the LPS facility – not when the 5150 is written. The 5150 hold merely authorizes *transportation* to the designated (LPS) facility, and is untimed.

But what if the unavailability of a psychiatric bed means

(Continued on page 14)

5150 Confusion (Continued from page 13)

that a patient in a non-psychiatric hospital on a 5150 hold has to wait days for a bed at a psychiatric facility. For how long does the 5150 hold remain in effect. *Forever?!!*

The California Hospital Association (CHA) has compiled a list of "gray areas" in which laws regulating the treatment of individuals being detained for involuntary assessment and treatment are currently subject to differing interpretations. There are more gray areas than black and white. Who may write a hold, who may release it, and when the clock starts, varies by county, and in some cases, by hospitals within counties.

CHA has embarked on an ambitious and clearly expensive effort to bring some order and clarity to 5150 policies. Their motivation includes clarifying the responsibilities of non-psychiatric hospitals that find themselves confused and worried about the liability – and costs – of holding patients for days as they try to locate an accepting psychiatric hospital with an available bed. They also hope that specifying that ED physicians statewide may lift holds as well as write them will decrease the number of patients jamming emergency rooms waiting for beds at psychiatric hospitals, as many of these patients improve long before a bed becomes available.

Bringing order to 5150 policies is a worthy endeavor, but facilitating the release of holds is not a solution for those patients who truly require psychiatric hospitalization. For them, discharge from a crowded emergency room could easily end in tragedy. The real problem is the statewide decline in psychiatric beds. From 1995 to 2010, while the state's population grew by nearly 7 million, 40 psychiatric inpatient units closed, and psychiatric beds declined from 9,353 to 6,590. Even with increased medical coverage promised by the Accountable Care Act, CHA is pessimistic about reversing this trend. Low reimbursement rates and exceedingly restrictive utilization review have made it very difficult for psychiatric units to be economically viable. Significant expansion of state and county facilities is even more unlikely, given the current climate of economic austerity.

CPA will continue its work with the CHA to bring order to the chaos of California's 5150 policies, while maintaining the flexibility required by counties that face challenges involving differing geography and resources. But facilitating the discharge of psychiatric patients from emergency rooms is only an answer for those who truly recompensate. We must also develop strategies to expand the availability of in-patient treatment for our most critically ill patients.

Trustees Report (Continued from page 3)

gies such as CPT code changes as a means of discriminating against psychiatric patients and their psychiatrists and denying patients access to care for which they and their employers have paid."

APA has set up a members-only web page "CPT Parity Abuses" which can be found at www.psychiatry.org/cpt-parityabuses. APA (that's us) will be soliciting examples of specific instances of CPT Parity abuses. Your help will be necessary—please help!

The DSM 5 will be out at the Annual Meeting on May 18th. It will weigh in at 994 pages. There are discounts for APA members and bigger discounts for trainees. There will also be a number of other associated publications, including electronic versions.

There was a discussion of the BOT Ad Hoc Work Group on the Role of Psychiatry in Healthcare Reform (Paul Summergrad, MD, Chair). Integrative and collaborative care models were suggested to be key features of future healthcare. Psychiatry as a field is lagging in the adoption of electronic health records, and resembles a cottage industry more than other fields in the house of medicine. Studies such as the Milliman Report show that persons with a treated psychiatric and/or substance use disorder constituted 14% of the total insured studied, but accounted for over 30% of total health spending.

The BOT meets again at the APA Annual Meeting in May.

Legal Developments (Continued from page 3)

is September 23, 2013.

Problems Under the Revised CPT Codes Regarding Billing And Collections For Psychiatric Services

Elsewhere in this newsletter, there is a discussion of the problems under the revised CPT codes for billing and collecting for psychiatric services. CPA has provided its members with a template to use in objecting to improper denials of reimbursement. APA is working on the problem as well. Furthermore, the California Medical Association has also been involved and appears to have obtained a correction to the problem by Blue Cross of

California for its providers. Among the problems reported is that when a psychiatrist bills E/M codes and then bills for psychotherapy as an add-on service, some payers require the patient to pay two copays or deny the add-on payment for psychotherapy. The other problem reported is that the rates paid are decreased from the rates paid for the same service prior to the revision to the CPT codes.

The CPA will be lobbying regulators and considering proposed legislation to deal with these issues. CPA encourages its members to report incidents of improper denial of billing under the new CPT codes, as well as other practices by payers which are unfair. Such reports may be sent to randall-hagar@calpsych.org.

The California Supreme Court Reaffirms The Psychotherapist-Patient Privilege In *People v. Gonzalez*

On March 18, 2013, the California Supreme Court issued its opinion in *People v. Gonzalez*, reaffirming the viability of the psychotherapist-patient privilege. In *People v. Gonzalez*, a district attorney filed a petition to commit the defendant as a sexually violent predator ("SVP"). The defendant had been on parole and a condition of his parole was to obtain psychotherapy treatment. In the proceeding to commit the defendant as a SVP, the Court ordered the disclosure of the defendant's psychotherapy treatment records. The Supreme Court reversed this order based upon the psychotherapist-patient privilege. However, the Supreme Court also ruled that the defendant could be confined as a SVP based on other evidence produced in support of the SVP petition from outside of the defendant's psychotherapeutic treatment.

Conclusion

Legal turmoil continues to be the order of the day for laws governing health care. This will continue for the immediate future given the fundamental reorganization in the delivery of healthcare which is under way. I venture to say that the practice of medicine, in general, and psychiatry, in particular, are undergoing revolutionary change with no end in sight.

Access to Effective Care *(Continued from page 7)*

in patients seeking care. Creative use of new treatment models involving integrated care, physician extenders and interdisciplinary teams as well as technologies such as telepsychiatry will be necessary. Will Psychiatry be part of the solution? Will Psychiatry be marginalized? Or will we be able to engage medical students, residents, fellows, early career psychiatrists and others to be leaders and part of the solution?

Together, with a shared vision in concert with kindred spirits, we can use the opportunity created by the current health care situation to bring about positive change. Continuing focus on patient access to effective care, value of the health care dollar and a global systems approach to outcomes can keep our priorities in mind.

CCPS Update *(Continued from page 10)*

the span of his career.

At the Council meeting on Friday, we voted to make a donation to CPA to assist with sponsorship of MITs to the annual CPA meeting—following the lead of one of our members, Daniel Grabski, who generously donated $1000 to sponsor CCPS residents to attend the CPA meeting!

CCPS recognizes MITs as the source of new blood and energy to our organization, and over 20 residents from the current 3 programs attended the meeting with comped rooms and free registration, partially supported from another donation from Ravi Goklaney, past president of Kern Chapter and CCPS. On Sunday, before the conclusion of the program, 3 residents competed for the Resident Vignette Award and Scott Summers (PGY-2) from UC Davis was the audience favorite, presenting on a transgender patient he had seen in his intern year.

CCPS looks forward to the APA meeting in our "backyard" in May and hopes to see friends and colleagues who weren't able to make the March meeting!

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PSYCHIATRIC MEDICAL CONSULTANTS NEEDED

Interested in moving away from direct patient contact? **Prefer not** to buy malpractice insurance, deal with overhead costs, and be on-call? **Want** your health benefits paid for, work flexible hours, either part or full time, and have your weekends free? Then join our team of professionals. The California Department of Social Services is seeking a few good psychiatrists who are interested in working with outside treating sources and other State professionals that evaluate medical evidence to determine its adequacy for making disability decisions as defined by Social Security Regulations. On the job training is provided.

Interested applicants must have a current CA MD/DO License. Full time salary ranges can start at $8,711 to $9,398 per month depending on experience and credentials.

Job locations: Roseville, Sacramento, Stockton, Fresno, Oakland, San Diego, Covina and Los Angeles.

Interested? Contact us at (916) 285-7596 or Lynda.L.Harris@ssa.gov.

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UCSF FRESNO PSYCHIATRY FACULTY POSITION

The University of California San Francisco Fresno Medical Education Program (UCSF Fresno) and Central California Faculty Medical Group (CCFMG) are seeking candidates for a 1.0 FTE faculty position at the Community Regional Medical Center's Ambulatory Care Center (ACC) in Fresno. One of the primary functions of this position will be collaboration with and supervision of mental health clinicians (RNs, LCSWs) working the various clinics within the ACC (Family & Community Medicine, Internal Medicine, Pediatrics, Ob-Gyn), providing integrated mental health services in a medical clinic setting. In addition to working with/managing the clinic staff, duties will include psychiatric evaluation, psychiatric medication management, as well as coordination of care with other services as needed. As part of the UCSF Fresno Psychiatry Program, additional responsibilities will include supervision of psychiatric residents, fellows, and medical students on core and elective psychiatry rotations at the ACC, participation in UCSF Fresno Psychiatry Grand Rounds, and didactic seminar series.

Fresno offers a modest cost of living with close proximity to national parks and other recreational activities. Salary and faculty appointment are commensurate with experience. Must be Board Certified/Board Eligible

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"UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an affirmative action/equal opportunity employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for covered veterans. All qualified applicants are encouraged to apply, including minorities and women."

Register Now!

DSM 5 - What You Need To Know

Jointly Sponsored by the American Psychiatric Association and the San Diego Psychiatric Society

June 8-9, La Jolla Hyatt at Aventine

Darrel Regier MD, MPH, *Vice-Chair DSM 5 Task Force*

Dilip Jeste MD, *APA President* **
John Oldham MD, *APA Past President* *
Joel Dimsdale MD **
Jan Fawcett, MD **
Tim Fong MD
James Harris, MD*
Walter Kaufmann MD *
Walter Kaye MD
Jonathan Meyer MD
Sanjaya Saxena MD
Sid Zisook, MD

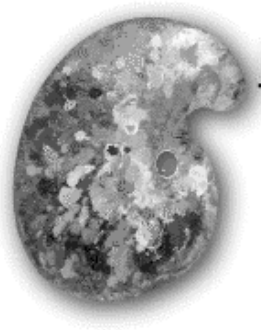
***DSM 5 Work Group Chair*
**DSM 5 Work Group Member*

All diagnostic areas will be covered. Learn from the foremost authorities about the changes and the science behind those changes. DSM 5 will be available for your purchase!

Beautiful La Jolla, on the bejeweled coastline of San Diego, is the site for this 1½ day weekend event. ***Register online now at www.dsm5sandiego.org***

For assistance, contact Janelle Kistler at (858) 300-2787 or janelle.kistler@sdcms.org

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Psychiatric Association (APA) and the San Diego Psychiatric Society. The APA is accredited by the ACCME to provide continuing medical education for physicians. The American Psychiatric Association designates this live activity for a maximum of 12 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Continuing Education credits provided through the Academy for Professional Excellence.



APA Art Association Exhibition

~May 19-22 2013~

San Francisco, CA

North Lobby, Moscone Convention Center

▲Ceramic ▲Digital Art ▲Crafts ▲Graphics ▲Jewelry ▲
Painting: Oil ▲Painting: Water-based ▲Painting: Mixed ▲ Poetry ▲Fiber ▲
Photography: B&W ▲Photography: Color ▲Sculpture ▲

The APA Art Association was founded by the late Norman R. Schulack in 1969 in Miami, FL. The APA Art Association offers the chance to set free and enfranchise the dormant artist within each and every one of us. A vast world of imagery and ability to reach beyond arbitrary barriers and a whole new set of human values awaits those willing to leap. Beware, however, that once the hurdle is behind, it is essential to be neither timid nor alarmed (though some may be startled) at the extent of the liberated artistÕs domain. Membership in the APA Art Association is open to all members of the APA, their spouses or significant others (we define Õsignificant others as spouse-like partners) and to all full-time staff members of the APA and the Canadian Psychiatric Association.Ó

For further information or to submit your entries and dues, contact Robert H. Trivus, M.D., President, APA Art Association, phone: 412-531-2520, email: trivusr@earthlink.net

HELLENIC AMERICAN PSYCHIATRIC ASSOCIATION
14th ANNUAL HAPA MEETING

Tuesday May 21st 2013
Time: 6:00PM- 8:00PM
Place: SF Marriott Marquis
San Francisco, CA
IN CONNECTION WITH THE APA 2013 ANNUAL MEETING

HAPA is proud to feature two timely special scientific presentations

"Improving the quality of medical education worldwide:
The contributions of ECFMG and FAIMER"
&
" The Women's Mental Health Clinic at Eginition Hospital, Athens, Greece: The first ten years "

A Dutch treat dinner at a local restaurant at 8:30PM follows the conclusion of the meeting. **You MUST pre-register to attend both the meeting and the Dutch treat Dinner** by paying your HAPA 2013 dues of $52.00 for members and $25.00 for MITs. Note that the annual dues have remained constant since the founding of HAPA in 1999.
You can pay your dues on the HAPA Website <www.hellenic-psy.org> thru Paypal or register by email: <maria@lymberis.com> and mail in your dues to Maria T. Lymberis, MD 1500 Montana Av, #201, Santa Monica, CA 90403

For more information about HAPA and for a HAPA Membership Application: visit our website: <www.hellenic-psy.org>

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Dr. Marcia Mshewa
Senior Psychiatrist Supervisor
Marcia.Mshewa@dsh.ca.gov
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Or visit:

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We look forward to hearing from you!

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