MARYLAND PSYCHIATRIC SOCIETY

MPS NEWS

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In This Issue

Deadline for submitting articles to *MPS News* is the 15th of the month preceding publication. Please email to heidi@mdpsych.org.

MPS News Design & Layout
Meagan Floyd

The next MPS Council meeting will be 8 PM Tuesday, **November 10** in the MPS office.

President's Column

Physician-Assisted Suicide

Physician-assisted suicide, also referred to as Death with Dignity or Aid in Dying, is an issue that has been at the forefront of news throughout the United States over the past several years. These laws allow physicians to assist a terminally ill patient to die by prescribing medication that will hasten his/her death. Currently, statutes have been enacted in Oregon, Vermont, Washington and California to allow physician-assisted suicide. In Montana, a court ruled that a physician charged with homicide in an assisted suicide could use patient consent as a defense. The ban against assisted suicide has been reinstituted in New Mexico.

Among the states that have legalized physician-assisted suicide, there are several common elements. First, patient must be at least eighteen years of age. Second, the patient must be diagnosed with a terminal illness that will lead to death within the next six months. Third, the patient must make two oral requests (separated by 15 days) and one written request. Fourth, two physicians must certify that the patient is mentally competent to make the decision. If either physician suspects that the patient's judgment is impaired, a referral is made for a psychological evaluation.

During last year's Maryland legislative session, House Bill 1021, entitled, "Richard E. Israel and Roger 'Pip' Moyer Death with Dignity Act," was introduced. In this bill, a terminally ill patient (having a medical condition that will likely result in death within six months) requesting aid in dying would: 1) make an initial oral request to the physician, 2) make a witnessed written request to the physician, and 3) make a second oral request to the physician at least 15 days after the initial oral request and 48 hours after the written request. The patient would have the choice of whether to inform family members. The attending physician would ensure that the patient is making an informed decision by informing him/her of: 1) diagnosis, 2) prognosis, 3) risks and results of medication, and 4) treatment alternatives. A second consulting physician would examine the patient, confirm the diagnosis of a terminal illness, verify that the patient made a request to aid in dying and verify that the patient has made an informed decision. If either physician suspects that the patient might be suffering from a condition that would impair his/her judgment, a referral would be made to a mental health professional for a competency evaluation.

Last year, the Maryland Psychiatric Society opposed passage of this bill, and Dr. Annette Hanson provided oral testimony. The MPS was opposed to passage of the bill for several reasons (lack of assessment by a mental health practitioner, no mechanism to challenge a competency assessment, an individual's ability to bar a physician from notifying family, lack of accountability to the Board of Physicians). The bill did not pass in the Maryland legislature.

Over the past several months, it has become clear that further physician-assisted suicide legislation will be introduced in the upcoming legislative session. Groups/organizations, both for and against physician-assisted suicide, have contacted us. Those in favor of this legislation have contacted us with the purpose of addressing the concerns we raised.

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Those against this legislation have contacted us for our support.

In discussions within our organization, it has become apparent that the issue of physician-assisted suicide, apart from the mental health concerns, raises diverse opinions. Many of our members have expressed opinions both in favor of and against physician-assisted suicide. We as an organization will not present an opinion until a bill has been filed and we have reviewed the bill. A competency evaluation by a psychiatrist is vital, as treatable mental illness, such as depression, often presents with suicidal ideation. Given that the ending of one's life is irreversible, the mental health concerns of this process are paramount.

Brian Zimnitzky, M.D.

Awards for Advancing Minority Mental Health

The APA Foundation Awards for Advancing Minority Mental Health recognize psychiatrists, other health professionals, mental health programs and other organizations that have undertaken efforts targeted to underserved minority communities, particularly those in the public health system or with severe mental illness. These include innovative and supportive programs or initiatives to raise awareness of mental illness, increase access to quality mental health services and improve the quality of care. The deadline to apply for the 2016 awards is **January 22, 2016**. The awards will be presented during the May APA annual meeting in Atlanta. Download the application.

The deadline for paying APA and MPS dues is March 31.

Following the APA's decision to change its dues policies, the MPS Council voted to move the MPS drop date in line with the new APA date, and MPS members voted to ratify the change. FY16 MPS dues notices were sent June 10. Members who do not either pay dues in full or schedule a payment plan before the deadline will be dropped as of March 31.

The MPS sent a third invoice to members who still owed dues in October. Reminders will continue each month with late fees added. If you still owe MPS dues, please remit your payment as soon as possible. Please contact the MPS with questions, or to discuss dues relief options or payment arrangements.

Thanks for your continued support!

New REMS for Clozapine

A recent FDA safety communication announces changes to monitoring for neutropenia associated with clozapine, and the approval of a new shared REMS (risk evaluation and mitigation strategy) program for clozapine. **As of October 12**, clozapine is only available through the Clozapine REMS Program, which replaces the six existing registries maintained by individual manufacturers. Patients who are already being treated with clozapine are being automatically transferred to the Clozapine REMS Program. Prescribers and pharmacies are required to be certified in the REMS Program under a transition schedule that began October 12.

Per the FDA, they have "clarified and enhanced the prescribing information for clozapine that explains how to monitor patients for neutropenia and manage clozapine treatment." Prescribers will now have greater latitude to make "individualized treatment decisions if they determine that the risk of psychiatric illness is greater than the risk of recurrent severe neutropenia, especially in patients for whom clozapine may be the antipsychotic of last resort."

For background information, please click here.

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PRMS, Manager of The Psychiatrists' Program
Medical Professional Liability Insurance for Psychiatrists
1-800-245-3333
TheProgram@prms.com
Twitter: @PsychProgram

The Maryland Medicaid Pharmacy Program implementation details appeared on page 4 of the October issue, and on the MPS website. Since the launch, members have reported technical, personnel, and process problems, including:

- Technical issues related to website operation and certification.
- Intermittent access to customer service representatives.
- Issues related to a certified prescriber's ability to cover for or designate others to prescribe clozapine, such as psychiatric residents.
- Unnecessary registration burdens that could create potentially harmful delays in the initiation or discontinuation of clozapine treatment.

In response, the FDA released an alert stating that **prescribers and pharmacists should continue clozapine prescribing and dispensing, using their clinical judgment to consider the best interests of the patient even if they encounter problems with the Clozapine REMS certification program.** The APA shared its clinical concerns with the FDA, and will collaborate on implementation of the clozapine REMS. The APA requests that members notify them of any other implementation challenges.

Please visit the new unified Clozapine REMS website.

October MPS Committee Chairs Meeting Highlights

Dr. Zimnitzky opened the meeting with introductions and a review of committee responsibilities.

Academic Psychiatry Committee - Robert Roca, M.D., Chair
The committee will continue the RFM and ECP paper contest, which has proven successful. Winning authors will be recognized at the MPS annual meeting, and articles could be considered for publication in *The Maryland Psychiatrist*.

Book Club - Elizabeth Beasley, M.D., and Virginia Ashley, M.D., Co-Chairs
Book Club enthusiasm continues. The group meets several times a year, rotating to participants' homes, with discussion of a selected book and refreshments. It was suggested that the titles of the selected books be published in *MPS News*.

Child and Adolescent Psychiatry Committee
Dr. Zimnitzky is coordinating with the president of the Maryland Council of Child and Adolescent Psychiatry to develop a potential workgroup to advise the MPS on child and adolescent matters during the Maryland General Assembly.

Disaster Psychiatry Committee - Eduardo Espiridion, M.D., Chair
Dr. Espiridion is a member of the APA disaster psychiatry listserv that allows participants to correspond with other District Branch disaster committee chairs.

Distinguished Fellowship Committee - Neil Warres, M.D., Chair
The committee performs the enviable task of identifying MPS members whose impressive accomplishments are most worthy of this national honor.

Diversity Committee - Stephanie Durruthy, M.D. & Theodora Balis, M.D., Co-Chairs
A reactivation of this committee is being planned.

Early Career Psychiatrists Committee – Jessica Merkel-Keller, M.D., Chair
Dr. Merkel-Keller seeks to hold some social events for ECPs at a restaurant, home or other venue to simply meet and greet, and later lead to networking. Other committee chairs offered to attend these gatherings to serve as resources, if asked. She explained that the events help both recruitment and retention, without the pressure of a lecture - purely a social event. She will develop a plan for this initiative.

Editorial Advisory Board - Nancy Wahls, M.D., Chair & Editor
The Maryland Psychiatrist will continue as an e-publication for Maryland psychiatry on medications, ethics, obituaries and general articles of interest. Dr. Wahls's goal is to recruit more writers and perhaps to improve online availability of the publication. If sponsors or advertisers can be found to cover the costs, a print version may be considered.

Ethics Committee - Joanna Brandt, M.D., Chair
The committee meets twice a year, unless there is a case. Ethics recommendations regarding complaints about members are approved by the MPS Council before final recommendation to the APA.

Forensic Psychiatry Committee
Due to their close collaboration and coordination, the President determined that this committee be combined with the Legislative Committee.

Geriatric Psychiatry Committee - Marsden McGuire, M.D., Chair
This committee continues to interface with other organizations that address mental health needs of geriatric patients. Dr. McGuire would like to hold a social gathering of members interested in geriatric psychiatry during the coming year. The committee will also continue providing input on legislation as needed.

Legislative Committee - Jennifer Palmer, M.D. and Anne Hanson, M.D., Co-Chairs
As this is one of the most active MPS committees, new members are always welcome. Training for the online LAC Forum will be available for the 2016 legislative session. A strong relationship has developed with our lobbying firm, Harris Jones and Malone. In conjunction with the MPPAC, the committee supports Advocacy Days in late January-early February when members meet with the General Assembly leadership. Close to 300 bills were reviewed in 2015, with letters and testimony was provided on over 18 bills. The MPS coordinates with MedChi in reviewing legislation and providing testimony. Participation from other MPS committees serves to strengthen MPS input.

Membership and Recruitment Committee - Susan Lehmann, M.D. & Merle McCann, M.D., Co-Chairs
The committee is extremely active and works to retain members. For 2016, APA and MPS dues drops will advance to the end of March rather than June. Members are receiving repeated alerts about the shorter time for paying dues. Programs for recruiting Resident Fellow Members and Early Career Psychiatrists are being developed. Lunch events for residents and fellows are being held at the psychiatry departments of Johns Hopkins and University of Maryland. The committee and Council are reviewing the suitability of the new APA dues discount program for the MPS.

Payer Relations Committee - Laura Gaffney, M.D., Chair
Parity, preauthorization of medications, network adequacy, Medicaid participation and other issues are focus areas for advocacy and research throughout the year. The committee will continue to work with APA on parity issues. Currently, the APA is working with several DBs to collect the reimbursement amounts that psychiatry and primary care providers receive for the same CPT

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codes. The committee requests that MPS members participate in this project.

Program and Continuing Medical Education Committee – Jason Addison, M.D., Chair
The November 7 program, *Addictions Update: From Screening to Treatment and Everything In Between,* will be held at Sheppard Pratt Conference Center. The Spring symposium is currently being planned to address the different mental health issues faced by diverse populations. MedChi and MPS are discussing a possible joint CME program for Fall 2016 that would include Richard Kogan, M.D.

Public Psychiatry Committee - Ann Hackman, M.D., Chair
Dr. Hackman will attend the monthly Behavioral Health Administration meetings at Spring Grove with the MPS Executive Committee. Her goal for this year is to have an actual in-person committee meeting. Relevant issues for the committee include access to care, the possibility of outpatient civil commitment and social justice concerns.

Residents and Fellows Committee - Lori Schwartz, M.D. (UMd) & Paul Nestadt, M.D. (JHU), Co-Chairs
The recent MPS bylaws change granted RFMs representation with a vote on the MPS Council. Through social events, the committee would like to develop some type of program for both Hopkins and University RFMs. Both recruitment and retention are also a focus. Committee members at the meeting offered to attend some of these informal RFM meetings to network.

Comment on Dementia Performance Measures

The APA and the American Academy of Neurology seek member input on updated quality measures for Dementia management. These measures may influence future quality improvement accountability programs and psychiatric clinician reimbursement. The 30-day comment period is open **through December 1**. Click here to read the measures and submit comments.

Refer a Colleague and Support the Maryland Foundation for Psychiatry

Last month, PRMS donated $50 to the Maryland Foundation for Psychiatry thanks to referrals by MPS members! When a PRMS client refers a psychiatrist or group practice to PRMS, they donate $25 to the doctor's branch (regardless of whether insurance is purchased or not). To learn more about this program, please contact Melanie Smith at smith@prms.com.

Maryland News

Allmond Case Update

The amicus brief orchestrated by the MPS for the Allmond v. DHMH case was filed October 21 with the Maryland Court of Appeals. The MPS retained Andrew Baida, a past solicitor general for Maryland, now in private practice with Rosenberg Martin Greenberg, to develop the brief.

The MPS received financial assistance from the following organizations: American Psychiatric Association, Johns Hopkins University, Maryland Hospital Association, MedStar, Sheppard Pratt Health System, University of Maryland and Washington Psychiatric Society. Since these organizations have substantial knowledge and experience relevant to the issues in the case, they signed on to the amicus along with the MPS. NAMI Maryland, a statewide network that seeks to improve the quality of life for individual with mental illness and their families also signed on.

This MPS initiative was spearheaded by Jeff Janofsky, M.D., Anne Hanson, M.D. Several people assisted with drafting the brief by reviewing the document and providing input, including a group of forensic fellows who helped identify support in the medical literature.

The case involves Gary Allmond, a criminal defendant who was found not competent to stand trial and criminally committed to Clifton T. Perkins Hospital Center. In 2014, Allmond refused psychotropic medications to treat his underlying psychotic disorder. The hospital staff, following Maryland's newly revised statute for involuntary medications on psychiatric inpatient § I0-708(g) of the Health-General Article, Maryland Annotated Code), found that Allmond met the new statutory criteria for administration of involuntary psychiatric medication. Allmond appealed to an Administrative Law Judge (ALJ), who found medications should be administered involuntarily, and then he appealed to the Howard County Circuit Court who upheld the ALJ's decision. In May, the Maryland Court of Appeals (Maryland's highest appellate court) agreed to hear the appeal.

Allmond argues that § I0-708(g) of the Health-General Article is unconstitutional under the Maryland constitution. If the court agrees, psychiatrists would no longer be able to medicate patients over objection regardless of the patient's legal status. This would affect patients who are civilly committed, patients who are committed as not competent to stand trial, as well as patients who are committed following an adjudication of insanity.

The hearing for the case is set for December 4, 2015 at the Court of Appeals in Annapolis. Click here to watch the oral arguments live through the court's web site.

Kery Hummel, Executive Director

Maryland News

New Report on Maryland Health Care Appeals & Grievances

On September 30, the Maryland Insurance Administration (MIA) issued its 2014 report on the Appeals and Grievance Law enacted in 1998. Under the law, nonprofit health service plans, insurers, health maintenance organizations and dental plans must report their adverse decisions and grievance decisions quarterly to the MIA. These quarterly data are coupled with MIA complaint data in the report. The Appeals and Grievance process begins when a carrier makes an "adverse decision," a determination that a proposed or delivered health care service is not medically necessary. The member (patient), the member's representative, or the treating provider on behalf of the member has the right to protest this decision through the carrier's *internal* review process (a "grievance"). If the carrier again concludes the service is not medically necessary, the member can ask the MIA to review the carrier's grievance decision by filing a "complaint."

Carriers rendered 31,391 adverse decisions in 2014 and 43,537 in 2011, a decrease of 28%. Adverse decisions for physician services decreased by 68% (15,313 in 2011 to 4,841 in 2014). Concerns have been expressed about denials of emergency room services and mental health services; however, the MIA data indicate that there are relatively few adverse decisions for these services (0.5% and 2.4% in 2014, respectively). The number of adverse decisions for these services decreased from 2011 to 2014 (ER decreased 56% - 354 in 2011 and 155 in 2014; MH decreased by 7% - 814 in 2011 and 758 in 2014). It is not clear whether psychiatrists' services are grouped as physician or as mental health services. Grievances increased as a percentage of adverse decisions from 2011 to 2014 (11% to 16%), and carriers were less likely to reverse themselves during the internal grievance process. Carriers upheld adverse decisions 53% of the time in 2014 compared with 42% in 2011.

If the outcome of a grievance filed with the carrier is unsatisfactory, a complaint can be filed with the MIA. The number of such medical necessity complaints increased 9% between 2011 and 2014 from 825 to 898. The percentage of reversals of grievance decisions by the MIA, or by the carrier during the investigation process, decreased to 58% in 2014 from 67% percent in 2011. In 2014, the MIA issued 3 orders based on medical necessity complaints, imposed $2,500 in penalties, and recovered $410,589 for complainants under the Appeals and Grievance law. In comparison, in 2011 it issued 8 orders, imposed $14,500 in penalties and recovered $509,089 for complainants. These recoveries demonstrate that this law remains an important protection for Maryland consumers, in spite of the smaller percentage of Marylanders to whom it applies. When the Appeals and Grievance Law was enacted, the percentage of the population under the age of 65 with insured health benefits (43%) slightly exceeded the percentage of the population under the age of 65 with other employment based health benefits (38%). By 2014, the percentage of the population under the age of 65 with insured health benefits had declined to 21%.

To view the complete report, including adverse decision, grievance and complaint data by carrier, click here.

Discontinued Funding for Emergency Care Impacts IMDs

Over the summer, DHMH changed its process for admitting adult psychiatric patients to Institutions for Mental Diseases (IMDs) within the Public Behavioral Health System. These IMDs include, but are not limited to, Sheppard Pratt, Adventist Behavioral Health, and Brook Lane.

For the past three years, Maryland participated in a Medicaid Emergency Psychiatric Demonstration that made Medicaid funds available to private free standing psychiatric hospitals (IMDs) for emergency inpatient psychiatric care provided to Medicaid enrollees aged 21 to 64. This federal demonstration ended on June 30, 2015. Beginning July 1, all adult psychiatric admissions to IMDs have been paid with state general funds only, which are budgeted significantly lower than the projected cost for fiscal year 2016. As a result, **for all adults presenting to acute care general hospital emergency departments (ED) needing inpatient psychiatry admission, every effort must be made to first admit to an Acute Care General Hospital** rather than an IMD.

Acute care general hospitals must participate in and use the Maryland Psychiatric Bed Registry, which EDs must use to find the nearest acute care general hospitals with an open psychiatric bed. If the ED is unsuccessful in admitting the patient to their own or another acute care general hospital using the Bed Registry, the ED must call no less than four (4) acute care general hospitals to find an open psychiatric bed prior to requesting authorization from ValueOptions for admission to an IMD. Ultimately, admissions to IMDs will be considered as a last resort in situations where no community hospital psychiatric bed is available and emergency psychiatric inpatient treatment is indicated.

Needless to say, this change is having a serious financial impact on Maryland's IMDs. As reported in the August issue, DHMH is seeking a federal waiver from the IMD exclusion. If approved, Maryland could again reimburse IMDs for treatment Medicaid enrollees aged 21-64 with acute psychiatric and substance-use-related needs using federal matching dollars. A copy of the waiver application and supporting documentation can be accessed here.

Maryland News

Update on HIE Regulations

The Maryland Health Care Commission (MHCC) promulgates regulations for the privacy and security of protected health information obtained or released through a health information exchange (HIE). The initial regulations, COMAR 10.25.18, Health Information Exchanges: Privacy and Security of Protected Health Information, went into effect in March 2014. The MHCC is working on amendments to the HIE regulations, which pertain to the privacy and security of protected health information obtained or released through an HIE. It solicited informal public comment on draft proposed regulations last month. Along with some other revisions, two new sections are under consideration:

- Requirements for Accessing, Using, or Disclosing of Data through an HIE for Secondary Use. (i.e. population care management, research, enforcement and reporting).
- Requirements for Accessing, Using, or Disclosing of Data through an HIE in an Emergency.

Advocacy for Children's Wraparound Services

The Maryland Coalition of Families for Children's Mental Health alerted the Maryland Behavioral Health Coalition (BHC) to the termination of Maryland's Care Management Entity (CME) contract as of June 30, 2016. The MPS has signed on to a BHC letter raising concerns with the Governor's Office for Children about how these children with extensive behavioral health needs will continue to be successfully maintained in the home, school and community after Maryland ends the CME program. The state ended enrollment in Wraparound as of October 1, so families are already being denied these services. This action signals the *termination* of a program (CME-funded Wraparound) with broad eligibility criteria, and not, as the state has indicated, an *integration* with similar programs (Targeted Case Management and 1915(i)), because TCM and 1915(i) are more restrictive in terms of both eligibility and services offered. It should be noted that 1915(i) is not even operational yet. For questions about the impact of the CME termination, please contact Ann Geddes at ageddes@mdcoalition.org.

Electronic Preauthorization Update

A 2012 Maryland law requires payors and pharmacy benefit managers to offer electronic preauthorization, including:

1) online access to a list of all medical services and pharmaceuticals that require preauthorization and the criteria for making a preauthorization determination;

2) online system to receive preauthorization requests electronically and assign a unique ID to each request; and

3) approval for all electronic preauthorization requests for pharmaceuticals in real-time or within one business day of receiving all pertinent information and two business days for non-urgent medical services.

Click here for payor links to online lists of services/ medications and electronic preauthorizations.

In 2014, the law was amended to require payors to establish an electronic process that allows providers to override a step therapy or fail-first protocol when submitting pharmaceutical preauthorization requests. **Members should be aware that they can override** under the following circumstances (see section 10.25.17.03(D)):

a.The step therapy drug has not been approved by the FDA for the medical condition being treated; or

b.A prescriber provides supporting medical information to the payor that a prescription drug covered by the payor:

i. Was ordered by the prescriber for the insured or enrollee within the past 180 days; and

ii. Based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition;

Payors must also notify their insureds about the step therapy override.

The regulations, 10.25.17 Benchmarks for Preauthorization of Health Care Services, became effective on October 12, 2015.

Maryland News

Open Enrollment starts November 1

The period for enrolling in a health plan or changing current coverage has begun. **New this year,** dental coverage is available through Maryland Health Connection.

1. Window-shop for 2016 plans and prices. Learn what to consider when choosing a health plan, including which doctors are covered. Compare the 53 available 2016 plans without having to create an account first

2. Determine whether financial assistance is available.

3. Consider shopping even if you're already enrolled. Most 2015 plans will automatically renew into 2016, but a different plan may better meet your needs or save money. Also, be sure to report major changes in household or income.

4. Use the checklist to save time when you apply.

5. Get free, in-person help if you need it.

Open enrollment for qualified health plans officially ends January 31. Enrollments completed January 16 - 31 will have coverage beginning March 1, 2016. Medicaid enrollment continues year-round.

The Maryland Insurance Administration announced that its review process resulted in reductions of rate increases requested by health insurers amounting to savings for consumers of approximately $66.4 million. Small group market rates will decrease by 1.8% overall in 2016. Approximately 4.2% of Marylanders are in the small group market and 3.9% are in the individual market. More than 90% of Marylanders are covered by health insurance plans offered through large employers or employers who self-insure; "grandfathered" plans purchased before March 2010; or federal plans, such as Medicare, Tricare and federal employee plans.

The rate of Marylanders without health insurance dropped from 10.2 percent in 2013 to 7.9 percent in 2014 during the first year of the Affordable Care Act, according to the U.S. Census Bureau. More than 700,000 people are receiving health coverage through Maryland Health Connection, with more than 120,000 enrolled in private plans and more than 600,000 in Medicaid.

ICD-10

ICD-10 Update for Paper Claims

Those who file the paper Form 1500 when submitting claims to Medicare must indicate in item #21 whether ICD-9 or ICD-10 codes are used on the form. If that item is missing, the claim will be returned for correction or resubmission. For services provided prior to October 1, 2015, ICD-9 codes should be used even if the claim is filed after that date; for services after September 30, ICD 10 codes should be used. ICD-9 codes are indicated by using a 9 in item #21, ICD-10 codes are noted with a 0.

The DSM-5 lists both the ICD-9 and the ICD-10 codes for each diagnosis. The ICD-9 codes are in black ink and the ICD-10 codes are to the right of them in gray. For information about how to implement ICD-10 codes using DSM-5, click here.

Ellen Jaffe, Director, Practice Management HelpLine/ Medicare Specialist
APA Office of Healthcare Systems and Financing

Important Note about Physician's Orders

For orders written with ICD-9 codes before October 1, CMS is ***not*** requiring the ordering provider to rewrite the original order with the appropriate ICD-10 code for lab, radiology services, or any other services. For more see the new Physician's Orders FAQ 12625.

ICD-10 Transition Support

- ICD-10 Ombudsman - William Rogers, M.D. responds to questions and concerns, and serves as an advocate inside CMS.
- ICD-10 Coordination Center - a group of Medicare, Medicaid, and information technology experts that has the support of CMS staff to address any issues.
- CMS website and the APA website offer first-line information.
- Contact the MAC (Novitas) for **Medicare** claims questions.
- Contact DHMH for **Medicaid** claims questions.

For private health plan claims questions, please contact the insurer directly.

Presented by the Maryland Psychiatric Society in collaboration with
The Department of Health and Mental Hygiene

Addictions Update: From Screening to Treatment & Everything In Between

Saturday November 7, 2015
The Conference Center at Sheppard Pratt

Agenda

8:00AM-8:30AM—**Breakfast & Registration**

8:30AM-9:30
Medical & Biological Basis of Addiction
Yngvild K. Olsen, M.D.

9:30-10:30
Screening of Substance Abuse Disorders: Current Strategies and Challenges
Enrique Olivares, M.D.

10:30-10:45—**Break**

10:45-11:45
Pharmacologic Interventions for Addictions
Eric Strain, M.D.

11:45-12:30PM
Opioid Addiction in Youth: Approaches to the growing epidemic.
Marc Fishman, M.D

12:30-1:15—**Lunch**

1:15-2:15
The Epidemiology, a Conceptual Framework & a Pragmatic Approach to Treatment of the Co-occurring Disorders Patient
Sunil Khushalani, M.D.

2:15-3:15
Treatment & Recovery Challenges of Co-occurring Disorders
George Kolodner, M.D.

3:15-3:30—**Break**

3:30-4:30
Overdoses & Detox
Christopher Welsh, M.D.

Registration is **$150.00 for MPS Members** and **$200.00 for Non-members**.

Registration fee includes breakfast, lunch, breaks, **electronic** program material and **6.75 CME/CEU credits.**

This activity will fulfill the new MBP opioid CME licensure requirement!

Fees are non-refundable.

Please send check or money order payable to MPS to:
1101 Saint Paul Street, Suite 305 - Baltimore, MD 21202

REGISTER & PAY ONLINE!

Please indicate if you have special dietary needs or require other special accommodations.

APA News & Updates

Fall APA Assembly Preview

This Fall Assembly meeting is momentous. Each District Branch sends a specified number of representatives based on membership. This past Spring, the Assembly passed a major change to the formula so that each DB now has at least two representatives, which results in smaller DBs having more relative weight. As a result, the number of MPS reps expanded from two to three, with Anne Hanson being appointed to the third position, joining Bob Roca and Steve Daviss.

Due to its now larger size, a number of changes have occurred in how the Assembly conducts business. What has not changed is the high quality of the Action Paper process, the mechanism whereby any APA member can, in concert with their Assembly Rep, call on the APA to do something. The Assembly debates the request, amends as needed, and votes on it. Below is the list of papers to be considered during the October 30 to November 1 meeting, with comments on selected papers. As this column was written prior to the meeting, a future column will discuss the results. For more details, please see the 100+ page list of complete Action Papers at http://bit.ly/actionpapers15fall.

12.A Access to Care Provided by the Veteran's Administration

Expands opportunities for psychiatrists to work in the VA system by increasing salaries and loan repayment programs.

12.B Directions to the Area Nominating Committees

Expands the ability for Areas to decide how many candidates they wish to nominate to run for Board of Trustees.

12.C New Names for Psychiatric Conditions

Suggests changes to how the National Center for Health Statistics (ICD-9 & 10 owner) aligns the naming of conditions with other entities.

12.D Prior Authorization

Advocates for reimbursement for time spent obtaining prior authorizations.

12.E Ad Hoc Work Group to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product

Forms a work group to explore the feasibility of developing an advanced electronic clinical decision support tool that the APA would license to EHRs, academic centers, and other entities, resulting in a major product that brings recognition and non-dues revenue to the APA. The tool would be fed data from EHRs and other sources, producing ranked, evidence-based clinical suggestions based on what is known about the specific patient and content from APA practice guidelines and other sources. This constantly evolving product would benefit primary care practitioners and their patients, and would help expand integrated care. [**MPS Action Paper**]

12.F Payer Coverage for Prescriptions from Nonparticipating Prescribers

Addresses the problem discussed on our listserv about certain payers no longer paying for prescriptions written by non-participating practitioners. [**MPS Action Paper**]

12.G APA Support for NIMH Funding of Clinical Research

Advocates for expansion of NIMH-funded clinical research.

12.H Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?

Has the Ethics Committee review this topic and make recommendations.

12.I Strengthening the Role of Residency Training to Improve Access to Buprenorphine

Adds buprenorphine training to residency program criteria.

12.J Need to Gather Information on Physician Health Program (PHP) Performance

Seeks to improve state PHP programs.

12.K Parity in Permanent Licensure Policy

For both international and US medical graduates, advocates for parity in the number of years of ACGME-accredited training required for licensure.

12.L Partial Hospital Training in Psychiatric Residency

Adds partial hospital program (PHP) experience to residency training criteria.

12.M Addressing the Shortage of Psychiatrists

Sets up a task force to explore funding of scholarships to medical students who agree to go into psychiatry.

12.N Advocating for Medicaid Expansion

Advocates for Medicaid expansion in those states which have not yet done so, as well as workforce issues and psychiatrist participation.

12.O Systems to Coordinate and Optimize Psychiatric Inpatient Bed Availability for Referral of Psychiatric Emergencies

Explores expansion of effective psychiatric bed registries.

12.P Making Access to Treatment for Erectile Disorder Available under Medicare

The title says it all.

12.Q Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations

Makes it easier for a subspecialty or section organization to have Assembly representation.

(Continued on next page)

APA News & Updates

12.R Senior Psychiatrist Seat on the Board of Trustees (BOT)

Changes the Trustee-at-large position on the BOT to a Senior Psychiatrist (Life member for at least 5 years) position. There is already an ECP position.

12.S Need for Position-Specific Email Addresses for Leadership Roles in the APA

Would change, for example, Renee's address from rbinder@psych.org to apapresident@psych.org, so that the email address for the position never changes and such mail would be forwarded to the person.

12.T Election of Assembly Officers

This will be the most contentious Action Paper for this session. Assembly officers (Speaker, Recorder, etc) are elected by Assembly Reps. If a rep requests a "vote-by-strength," then the number of APA members represented by each DB is used to determine who wins. Some feel that this severely dilutes the impact of certain reps on the election because those who represent residents, early career psychiatrists, minorities, subspecialties, and sections essentially have only 1 vote, while a DB rep may have 450 votes (ie, if they represent 450 APA members). Others feel that such a change would, in effect, give some APA members two votes. It's complicated, but essentially boils down to giving a louder voice to less represented groups.

Steven R. Daviss, M.D.
Robert P. Roca, M.D.
Annette L. Hanson, M.D.
Assembly Representatives

APA Congressional Advocacy Network

The new APA Congressional Advocacy Network (CAN) empowers member psychiatrists to connect with members of Congress and speak on behalf of the APA on mental health issues. Psychiatrists will build personal relationships with their representatives and communicate about the mental health issues that matter most. The APA will provide the resources and guidance needed for CAN to be effective. Instead of reacting when legislative issues arise, sustained relationships will add considerable value toward APA's long term success in advocacy. Becoming a Congressional Advocate means serving as a key contact on mental health to a member of Congress, so when important issues arise, psychiatry can quickly deliver its message through direct, personal communication. If you want to learn more, click here or email Adam Lotspike.

MPS Members Prominent in 2016 APA Election

The APA Nominating Committee's slate for the 2016 election includes two past MPS presidents (Drs. Everett and Daviss), a former Assembly representative (Dr. Jayaram) and an Affiliate member (Dr. Peele). Following are the votes to be cast by MPS members:

PRESIDENT-ELECT
Frank W. Brown, M.D.
Anita S. Everett, M.D.

TREASURER
Bruce J. Schwartz, M.D.
Linda L.M. Worley, M.D.

TRUSTEE-AT-LARGE
Rebecca W. Brendel, M.D., J.D.
Geetha Jayaram, M.D.
Richard F. Summers, M.D.

AREA 3 TRUSTEE
Steven R. Daviss, M.D.
Roger Peele, M.D.

RESIDENT-FELLOW MEMBER TRUSTEE-ELECT
Adrian Jacques H. Ambrose, M.D.
Uchenna B. Okoye, M.D., M.P.H.
Matt Salmon, D.O.

Voting will be open from January 4 to February 1, 2016. For more information, click here.

APA Statement on Psychiatrists' Role in Reducing Physical Health Disparities

The statement is broadly worded to allow for a range of ways in which psychiatrists can be involved in the management of common medical conditions, depending on clinicians' competence, confidence, and training. Attention to the common medical conditions that are often comorbid with mental illness is an essential component of psychiatric practice, according to the position statement approved by the APA Board of Trustees at its meeting in June.

Psychiatry's role in patients' overall health care may include screening for common medical conditions, counseling patients to reduce preventable cardiovascular risk factors, taking steps to limit the harm that can come from use of psychotropic medications, monitoring the medical care being delivered by other medical providers, or engaging in management of some common medical conditions when warranted by the clinical situation and with appropriate support and training. The position statement further calls for education of psychiatrists and trainees in primary care skills and for funding for that education (click here for more details).

Medicare News & Information

Part D Prescriber Enrollment Update

In October, CMS announced changes to the Part D prescriber enrollment requirement and delayed its enforcement of until **June 1, 2016**. Virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Medicare Part D drugs must be enrolled or have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D. To allow sufficient time for processing, prescribers should submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare Administrative Contractors (MACs) by January 1, 2016, or earlier, to avoid their patients' prescription drug claims from being denied beginning June 1. Click here for the changes as well as clarifying information regarding the enrollment process.

Physicians Not Billing Medicare for Chronic Care Management

Modern Healthcare reports on the new Medicare payment that averages $42 per patient per month for non-face-to-face chronic care management services, such as consulting with other doctors caring for the same patient. Although CMS estimates 35 million Medicare patients would be eligible, it has only received reimbursement requests for 100,000 beneficiaries thus far. The article describes some of the possible reasons for slow adoption of the new code, but expects usage to increase. For more details on these services, click here.

Value Modifier Review Period Ends November 9

The period for requesting an informal review of the 2016 Value Modifier ends November 9. The 2014 Annual Quality and Resource Use Reports (QRURs) are now available for every group practice and solo practitioner nationwide. These reports show 2014 performance on the quality and cost measures used to calculate the 2016 Value Modifier. For groups of 10 or more, the QRUR shows how the Value Modifier will apply to Medicare payments in 2016. For other groups and solo practitioners, the QRUR is for informational purposes only.

Access the 2014 Annual QRURs on the CMS Enterprise Portal using an Enterprise Identify Data Management (EIDM) account with the correct role. For more information on how to access the 2014 Annual QRURs, visit How to Obtain a QRUR. Additional information and how to request an informal review is available on the 2014 QRUR website and through the Help Desk at pvhelpdesk@cms.hhhs.gov or 888-734-6433 (select option 3).

Physician Compare Preview Ends November 16

The preview period for 2014 PQRS measures on Physician Compare has been extended to allow group practices and individual eligible professionals to review their measures before they are publicly reported. To learn more about which measures will be publicly reported (depression screening) and how to preview your measures, visit the Physician Compare Initiative page.

Reminder – Informal Review of PQRS Reductions

There are no hardship exemptions for the PQRS payment adjustment. If you believe that the 2016 PQRS payment reduction is being applied in error, you can submit an informal review request. All informal review requests must be submitted **before November 9** via a web-based tool, the Quality Reporting Communication Support Page. CMS will send a decision via email within 90 days. These decisions will be final and there will be no further review or appeal.

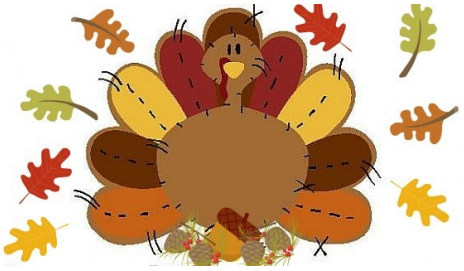
Click here for a 2014 PQRS overview with steps for completing the informal review process.

Holiday Hours

The MPS office will be closed on November 11 in observance of Veterans Day.

The MPS office will be closed on November 26 and 27 in observance of Thanksgiving.

The MPS office will be closed on December 24, 25, 31, and January 1 in observance of the holiday season.



Electronic Health Records

New EHR Meaningful Use Regulations

More than 1,300 pages of new regulations released in October outline requirements for the electronic health record (EHR) meaningful use program, with several changes applying this year. The AMA has identified some of the most important changes that will affect physician practices. The regulations fall under two new rules—one that modifies Stage 2 of the meaningful use program and finalizes requirements for Stage 3, and one that establishes technological parameters for the new edition of certified EHR technology.

On the upside, the first rule eases and streamlines some of the requirements for Stage 2. But the rule simultaneously ignores calls from Congress and physicians to hold off on Stage 3 until the program is reassessed for practicality and alignment with new payment and delivery reforms. Immediate improvements to Stage 2 include:

- Physicians have a shortened reporting period for 2015 – just 90 consecutive days instead of the full calendar year.
- The overall number of measures physicians must report on has been reduced.
- The threshold for the requirement for patients to view, download or transmit their records has been cut down from 5% of patients to just one patient in 2015 and 2016.
- The threshold for the secure messaging requirement has been scaled back from 5% of patients to simply having the capability to send secure messages in 2015, and doing so with at least one patient in 2016.

While these are positive modifications, CMS didn't release the final regulations until Oct. 6—several days into the final 90-day period of the year. Equally concerning, the regulations now require a public health and clinical data registry reporting objective that previously was optional.

Fortunately, physicians can apply for a hardship exemption and avoid penalties if they are unable to meet meaningful use requirements this year as a result of the delayed publication of the regulations. The AMA is encouraging physicians to apply for a hardship exemption under the "extreme and uncontrollable circumstances" category, even if they are uncertain whether they will meet the program requirements this year. Doing so will not preclude physicians from receiving an incentive if they do meet meaningful use requirements this year, but applying can serve as a safety net in staving off a penalty. The exemption application will be available early next year. "In the past, CMS has considered these applications seriously and, in fact, has approved over 85 percent of hardship exemptions," the agency said in a recent FAQ.

CMS made relatively few changes in the final Stage 3 regulation from what was proposed. Overall, publishing the final Stage 3 rule signals to vendors that these are the requirements for the program, and they may begin developing systems to meet these standards. Under the rule, all physicians will be required to meet Stage 3 requirements beginning in 2018. The finalized rule as currently written would be very burdensome for physicians, to put it mildly. Among the many mandates will be upgrading to EHR products that meet the new certification requirements. Read a summary (log in) of the main requirements for Stage 3 outlined in the new regulations.

From October 21 *AMA Wire* post

For More Information:

Final Rule: EHR Incentive Program -- Stage 3 and Modifications to Meaningful Use in 2015 through 2017

Final Rule: 2015 Edition Health IT Certification Criteria, 2015 Edition Base EHR Definition, and ONC Health IT Certification Program Modifications

Fact Sheet: EHR Incentive Program and Health IT Certification Program Final Rule

Fact Sheet: EHR Incentive Programs in 2015 and Beyond

Fact Sheet: 2015 Edition Health IT Certification Criteria, 2015 Edition Base EHR Definition, and ONC Health IT Certification Program Modifications Final Rule

What You Can Do Now

Unfortunately, the rules do little to address the fact that the meaningful use program is not working. Worse yet, they could lead to less time with patients, more poorly performing EHRs and costly penalties for non-compliance. Make your voice heard: CMS is allowing a 60-day comment period to hear feedback on Stage 3, and how it can be improved and better aligned with the new Merit-Based Incentive Payment System and alternative payment models. Share your personal experiences and challenges with EHRs directly to CMS through the AMA's grassroots action network.

Electronic Health Records

APA Resources for Electronic Health

Information and resources on health information technology topics are available on the APA website. Developed by the APA Committee on Mental Health Information Technology and APA staff, the topics include: guidance on choosing the right EHR; privacy and security (HIPPA and more); overview of national health information technology initiatives; and potential advantages of electronic prescribing.

Most EHRs Fall Short

The AMA and MedStar's National Center for Human Factors in Healthcare developed an EHR User-Centered Design Evaluation Framework. The framework employs a 15-point scale intended to go beyond the National Coordinator for Health Information Technology (ONC) criteria and evaluate EHR vendors' compliance with best practices for a user-centered design process, and to encourage the ONC to raise the bar on federal usability certification. (In 2013, a study from the AMA and the RAND Corporation found that EHR usability represents a vexing challenge to physician satisfaction.) The framework analysis showed that out of the 20 products evaluated, only 3 met each of the basic capabilities measured. View the assessment for full results on all 20 products.

New EHR Info Online

Requirements for Previous Years contains all the program requirements and resources for previous years of the Electronic Health Record (EHR) Incentive Programs:

- 2014 Definition of Stage 2
- 2014 Definition of Stage 1
- 2014 Certified EHR Technology flexibility reporting
- 2014 Clinical Quality Measures (CQMs) reporting
- 2013 Definition of Stage 1
- 2013 CQM reporting
- 2011 and 2012 Definition of Stage 1

The corresponding web pages for these programs have been removed from the website; all resources can now be found on the new web page.

Also, CMS updated its guidance on switching EHR vendors with two new FAQs on how to continue participating in the EHR Incentive Programs or apply for a hardship exception after switching vendors:

- Can providers that have switched Certified EHR Technology vendors apply for a hardship exception to avoid the Medicare payment adjustment? See FAQ 12653.
- What if your product is decertified? See FAQ 12657.

For more information, visit the EHR website.

CLASSIFIEDS

EMPLOYMENT OPPORTUNITIES—continued

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PART TIME ADULT PSYCHIATRIST - The outpatient psychiatric clinic at MedStar Franklin Square Medical Center is expanding. We currently have 11 psychiatrists and 16 psychotherapists. We are looking for a part time psychiatrist, 16-20 hours per week. Psychiatrists will have 75 minutes for evaluations and 25 minutes for medication management. We offer flexible hours, CME reimbursement, 6 weeks paid time off, 403B match, medical benefits, and paid malpractice ins. The atmosphere is collegial, and most of our staff has been here for years. Please fax CV to Stephen Pasko, Director at 443.777.2060 or call 443-777-7925 for details.

The Inpatient Psychiatry Units at MedStar Franklin Square Medical Center have expanded and are in need of the following psychiatrists: A PART TIME CHILD PSYCHIATRIST to work in an 11 bed adolescent unit; A FULL TIME ADULT PSYCHIATRIST to work in a 29 bed unit, and; A FULL TIME PSYCHIATRIST to work on the consultation and liaison service. MedStar Franklin Square Medical Center is a community hospital located in Baltimore County. We offer flexible hours, 6 weeks paid time off, CME reimbursement, 403B match, medical benefits, paid malpractice insurance and a collegial atmosphere. Please email CV to Corneliu Sanda, M.D., Chair, at Corneliu.sanda@medstar.net or call 443-777-7144 for details.

Inova Behavioral Health is expanding and we are looking for new physicians to join our team! Our extensive continuum of care includes an urgent psychiatric and addiction assessment center (IPAC), inpatient psychiatry, inpatient detoxification, partial hospitalization programs (PHP), intensive outpatient programs (IOP), outpatient psychiatric appointments and outpatient counseling services. We are hiring at many of our locations in Northern Virginia, including Fairfax, Falls Church, Ballston, Mount Vernon, and Leesburg. For more information about our services and locations, please visit http://www.inova.org/healthcare-services/behavioral-health/index.jsp. INOVA offers a generous compensation plan, salary and bonus, as well as a comprehensive benefits package with paid malpractice insurance. Inquiries will be handled in strict confidence. Interested candidates should contact Stephanie Woodley, Physician Recruiter at Stephanie.Woodley@inova.org.

Key Point Health Services is actively seeking Psychiatrists and/or Nurse Practitioners for Permanent or Contractual positions in Catonsville, Dundalk, Aberdeen, Towson, and Perryville. Prescribers provide direct psychiatric assessment and care to individuals and families in Key Point treatment programs, including psychiatric evaluation, psychopharmacotherapy, and other psychiatric interventions as applicable for the populations assigned. Reviews charts, and consults with staff to develop accurate assessments and treatment plans. Based on assessments writes orders for medications required and develops plans for non-medical interventions. Ensures that clients and families are appropriately informed and obtains necessary consents for treatment. Completes required documentation including consents, assessment notes, contact notes, recommended treatments, etc. Ensures that documentation is adequately maintained. Key Point offers a full range of benefits under the State of Maryland satellite employee program and generous paid time off. Requirements: Current license to practice in the state of Maryland Must clear OIG, SOR, criminal, and drug screen. If working with children will require fingerprinting. Email CV to jobs@keypoint.org. www.keypoint.org

AVAILABLE OFFICE SPACE

Beautiful office with large windows for rent in Crofton, Maryland in lovely, modern elevator building with covered parking available. Office is on the third floor, with wonderful views, in a suite with a psychiatrist, a social worker, and a receptionist. Crofton location is convenient and central to Washington, D.C., Baltimore, Annapolis and the suburbs in between in a highly populated area. Cleaning, utilities included, shared waiting room is fully furnished, $1200 per month. Please call Jill Joyce, MD at 410-721-5030.

ELLICOTT CITY -- Full time (unfurnished) and part time (attractively furnished) offices in established, multi-disciplinary mental health suite. Ample parking and handicapped access. Expansive, welcoming waiting rooms with pleasant music throughout. Private staff bathrooms, full size staff kitchen with refrigerator, microwave, dishwasher, Keurig coffees and teas. Staff workroom with mailboxes, photocopier, fax machine, secondary refrigerator and microwave. Wireless internet access available. Plenty of networking and cross-referral opportunities with colleagues who enjoy creating a relaxed and congenial professional atmosphere. Convenient to Routes 40, 29, 70 and 695. Contact Dr. Mike Boyle, 410-465-2500

Spring Grove Hospital Center

PSYCHIATRISTS
(Contractual)

Spring Grove Hospital Center is a State of Maryland in-patient facility. SGHC is located in Catonsville, a suburb of Baltimore.

We are looking for **contractual** Psychiatrists willing to provide daytime coverage to our inpatients units for a minimum of 15 hours a week.

Adjustable work schedules are negotiable. Continuing medical education (CME) is available on site. Off-hours coverage is provided primarily by medicine rather than psychiatry.

Interested candidates, please visit www.dbm.maryland.gov to apply for our ***contractual*** Physician Clinical Specialist (Board Certification Required).

Send CV to:
Elizabeth Tomar, MD, Clinical Director
55 Wade Avenue
Catonsville, Maryland 21228
410-402-7596 * 410-402-7038 (fax)
elizabeth.tomar@maryland.gov

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