NCPA North Carolina Psychiatric Association NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The Promise and Burden of the 2013 CPT Coding Changes

Arthur Kelley, M.D.

Beginning Jan. 1, 2013 psychiatrists will have the ability to more accurately bill for the services they deliver to patients. On that date, new CPT codes will go into effect and some old codes will go away. Of particular interest for those who do psychiatric assessments and medication management is the fact that 90801 and 90862 will go away. For assessment, psychiatrists will instead be directed to use the Evaluation & Management (E&M) codes (99201-99205) or one of two new codes (90791 or 90792, psychiatric diagnostic assessment without or with medical services) for new patients and E&M codes for documenting follow-up visits with established outpatients. Although there are other new codes and modifiers that have been developed, it is not clear which of these additional codes will be reimbursed by insurance companies. So, the above mentioned codes will most likely be the go-to codes for outpatient psychiatric care that involves assessment and medication management.

Although I have not used the E&M codes in my psychiatric office practice, I do use them in the primary care practices where I am co-located. Using the E&M codes in these settings enables me to more accurately bill for the actual work that I do with a patient because the codes build in factors that reflect complexity of the patient and the complexity of the medical decision making.

For example, I use a different code when seeing a child with uncomplicated ADHD who takes one medication versus one with ADHD and Oppositional Defiant Disorder who is on three medications and arrives in the office saying he wants to hang himself. The great promise of the coding changes is that we will now be able to use the E&M code that most accurately reflects the work involved with each patient we see and to be reimbursed accordingly.

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Workshop Addresses 2013 CPT Coding Changes

On December 7, more than 170 psychiatrists and practice staff attended a sold-out CPT Coding & Practice Management workshop in Greensboro. "This is the biggest change to coding that psychiatry has seen since 1997," said Robin Huffman, Executive Director of NCPA. "We wanted to provide an opportunity for our members to hear about these changes and get real-world examples from experts in the field." Attendees heard from coding consultant Emily Hill about the upcoming CPT coding changes and Courtney Cantrell, Ph.D. from the NC Division of Medical Assistance about Medicaid coverage and allowable billing codes. Other presenters discussed strategies for efficiently managing a practice and the incentives and arguments for the use of electronic health records.

"We are still determing other ways to educate our membership about these changes. Unfortunately, like with other large transitions, the dire training needs probably won't surface until after implementation starts on January one," Huffman said.

For available resources, see pages 14-15.

2012 Annual Meeting & Scientific Session a Success

More than 300 people, including 200-plus psychiatrists, made their way to Wrightsville Beach in September for NCPA's Annual Meeting & Scientific Session – the highest attendance in the meeting's history.

The program committee, chaired by **Dr. Marvin Swartz**, sought out speakers from across the country and the state, including: Dr. Jay Scully, Medical Director and CEO of the APA; Dr. Gabrielle Carlson with Stony Brook University School of Medicine; and Dr. Robert Ursano with the Uniformed Services University and Center for the Study of Traumatic Stress, and more.

The Annual Meeting also hosted NCPA's Business Meeting where Executive Council and other members discussed priorities for the association and reports from each committee, including the Membership and Nominating Committees, the Treasurer's Report. Handouts are available online in the members only section of www.ncpsychiatry.org.

Preparations for the 2013 Annual Meeting are underway – save the date for Sept. 19-22, 2013 in Asheville!

NCPA NEWS

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The NCPA News is a publication of the NC Psychiatric Association, 4917 Waters Edge Drive, Raleigh, NC 27606.

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From the President's Desk...

Debra A. Bolick, M.D., D.F.A.P.A.

When I was elected to be President of the NCPA I set fout goals for my term. The first was to build up the NCPA office so we could accomplish more and better serve our members. This summer we welcomed Kristin Milam as our Communications Director and Katy Dorman as our Membership Coordinator. These staff members have done an excellent job. Their enthusiasm, creativity and work ethic have contributed greatly to the smooth operations of our office. With the professionalism and expertise of our Executive Director, Robin Huffman, we have a winning team.

> ***"Increasing your involvement can be as simple as reading the e-news and using the resources on the NCPA website..."***

My second goal was to produce an outstanding Annual Meeting. I am proud to report that this year's Annual Meeting and Scientific Session held September 28-30 in Wrightsville Beach was a record-breaking meeting. We had the highest number ever of attendees (close to 300), the highest number of registered physicians, and the highest gross revenue. Thanks to the program committee and staff for producing a fantastic meeting.

My next goal, increasing membership, has been a more difficult one to reach. For the past few years we have seen the membership in NCPA drop. Though there are numerous reasons psychiatrists elect to drop their dues, we need to do everything possible to sustain and grow our membership. The North Carolina Psychiatric Association is the premier organization that represents the needs of the profession and our patients. Our purpose can be best exemplified in our mission statement: "To promote the highest quality care for North Carolina residents with mental illness, including substance use disorders; Advance and represent the profession of psychiatry and medicine in North Carolina; and Serve the professional needs of its membership."

My final goal was to prioritize the issues that the NCPA is working on. At the Annual Meeting, attendees were asked to complete a survey ranking their top priorities for the organization. The responses were: Integrated care/medical homes, the NC public mental health system, federal healthcare reform, legislation impacting psychiatry, and CPT code changes. This feedback will guide our staff in their efforts and help them help our membership.

Now, halfway through my term as president, I am proud of what we have been able to accomplish. However, there is still work to do – especially when considering our membership. Not only do we need to continue to grow our ranks, but also increase participation among our current members. Increasing your involvement can be as simple as reading the e-news and using the resources on the NCPA website; or you could go further and respond to requests for feedback, participate on a committee or attend association events.

Like any organization, NCPA is only as strong as our members. While it's obvious from the progress we've made in the past six months that we are a strong group, there is always room for positive change and growth. I hope that as you renew your membership this New Year, you will find a renewed sense of connection and involvement.

Medicaid Changes in the Works—Act Now!

Robin B. Huffman, Executive Director

There is so much going on with North Carolina Medicaid, it is hard to keep things straight. There are some important urgencies that need YOUR attention, whether or not you are a Medicaid provider.

Proposed Changes to ACTT

Psychiatrists familiar with public sector patients and services should be aware of the ACTT service—Assertive Community Treatment Team. This is a wrap-around service provided by a consistent team of mental health professionals who visit, treat, and provide support to patients in their home and community setting. For psychiatrists who work in ACTT, we hear how much they value this type of care delivery, how much you really learn about a patient when you visit them in their home and see the difference from visit to visit in how they are taking care of themselves, their plants, their homes. It is a valuable insight into the life of a severely mentally ill patient.

ACCT Action Steps >>

- **Read policy:** It's available online at http://www.ncdhhs.gov/dma/mpproposed, click on the "8A. Assertive Community Treatment (ACT) Team Service Definition" link.
- **Send public comment** to webmedpolicy@dhhs.nc.gov and copy NCPA on your comment.

By virtue of getting this service, patients are recognized by NC Medicaid as being severely, persistently mentally ill: priority patients for this service are those with schizophrenia, bipolar disorder, chronic depression. This is one of the reasons why psychiatrists are included as part of the ACT Team.

DMA has proposed changes to the ACTT policy, one of which eliminates the requirement for a psychiatrist on the team. Instead, the physician can be substituted on the team with a "psychiatric provider," either a nurse practitioner or physician's assistant (the latter of which is required by the document to be under physician supervision).

As a group, psychiatrists value the role of these professionals on the treatment team and value their work. However, psychiatrists who work with these professionals also recognize that for many, there is a lack of specific psychiatric training and experience, critical factors for treating the SPMI population outside of an office setting.

NCPA is developing an official response to the DMA proposal. If others are interested in providing public comment, we encourage you to send an email comment NO LATER THAN JANUARY 12, 2013 to DMA. webmedpolicy@dhhs.nc.gov.

Being a Medicaid Provider under the Waiver

As our public mental health system moves from the LME (local management entity) system to a capitated model through the LME/MCO (managed care organization), there is some confusion. In a nutshell:

- LME/MCOs will become the agents for Medicaid and will be required to develop their own Medicaid provider panels and payment systems. There are currently 11 LME/MCOs, and the entire system is directed to be fully capitated by July 1.
- Psychiatrists treating patients insured by Medicaid will have to apply to be credentialed by the local LME/MCO in order to bill Medicaid.
- Psychiatrists will bill the LME/MCO, not NC DMA.
- While there were early assurances to NCPA that the waiver would be "just like being part of a private sector Medicaid panel," key differences are that there is no "out of network" payment, that psychiatrists must apply to each LME/MCO if they see patients from other parts of the state, that credentialing may or may or may not use CAQH to ease the application process.
- If you see Health Choice patients, you will still need to be registered with NC DMA as a provider in good standing.
- If you have issues with the application or credentialing process at a LME/MCO, let the NCPA office know and feel free to call the LME/MCO's Medical Director for assistance. Without exception, every time members have followed these steps, the LME/MCO's response was positive and helpful.

<<See page 13 for more information about remaining on the DMA Medicaid panel as a mechanism for ensuring you are a Medicaid provider in good standing in case waiver implementation is somehow delayed.

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Physician Involvement in ACOs – The Time is Now

Julian D. ("Bo") Bobbitt, Jr., Esq., Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P., Raleigh, NC

> *"The most significant challenge of becoming accountable is not forming an organization, it is forging one."*
> *~ Phillip I. Roning*

Due to the unsustainable costs of health care, the movement toward accountable care with value based reimbursement is inevitable. There is a window of opportunity for the physician community to control its own destiny by developing fair, sustainable, and successful collaborative systems, frequently referred to as accountable care organizations (ACOs). Not being prepared and defaulting to the status quo through passivity, however, is also a choice that promises less access, lower quality, more work, and less compensation for physicians. The choice is clear. This article will provide a non-technical overview of ACOs and discuss the eight essential elements of a successful, sustainable ACO.

What Are ACOs and Do They Really Work?

Former Administrator of the Centers for Medicare and Medicaid Services (CMS) Mark McClellan, M.D., Ph.D., described an ACO as follows:

ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.

The very label "accountable care organization" tends to convey an impression that an ACO must meet a particular type of organization. In retrospect, it probably should have been called "Accountable Care System." It is about function, not form. "While ACO formation and ongoing structural, operational, and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development."

Savings Are Achievable

One pediatric ACO-type project, which achieved improved measured quality, may provide some direction on whether savings are really achievable. Beginning at the medical home level, through Community Care of North Carolina (CCNC), care coordination for child and adolescent Medicaid beneficiaries has yielded well-documented results. On December 15, 2011, the actuary Milliman Inc. issued a public report on CCNC savings. For children age 20 and under (excluding Aged, Blind, and Disabled), risk adjusted costs were about 15% less in FY 2010 ($218.09 Per Member Per Month vs. $185.15) for patients in CCNC. The dollar savings to the Medicaid program were significant: 2007, $177-million; 2008, $202-million; 2009, $261-million; 2010, $238-million.

Building on this pediatric medical home ACO base, and recognizing that: (1) the 5% of children who are chronically ill consume 53% of Medicaid child care costs, (2) referral patterns for these complex patients are not local but statewide (often to different academic medical centers for different needs), and (3) patient engagement is not just with the child but also parents, teachers, and others, CCNC is now sponsoring the Child Health Accountable Care Collaborative of North Carolina (CHACC). It will transform often isolated medical homes. The state's academic medical centers are involved. CHACC will include high-risk pediatric patients with a heterogeneous mix of complex chronic conditions or technology assistance and yield net projected savings of $24,089,682 over three years, in addition to the previously-noted medical home savings levels.

Extending pediatric care along the entire continuum in this manner, while monitoring quality, access, and savings, positions these coupled programs to leverage significant savings in the future.

A Specialist-Led ACO Initiative: The Complex Obese Patient Project ("COPP")

COPP focuses on the obese patient population with at least one chronic condition, using best practices across

Continued on page 11...

NCPA Members in the News

In September, Port Human Services in Greenville held a dedication ceremony to rename its recovery center after **Dr. David A. Ames**. PORT provides substance abuse, mental health and intellectual and developmentally disabled services and supports approximately 18,000 children and adults throughout eastern North Carolina; the Dr. David A. Ames Recovery Center deals primarily with addiction to opiates, providing clinical care and therapy.

Dr. Ames (middle) poses with his family after the ceremony.

Dr. John Diamond was recently appointed by the Governor's Office to the North Carolina Commission for Children with Special Health Care Needs. The eight member Commission is charged with monitoring and evaluating the availability and provision of health services for children with special health care needs in NC and to monitor and evaluate the services for special needs children through NC Health Choice, the health insurance program for children. The Commission makes recommendations for modifications or additions to the rules necessary to improve services to these children and make service delivery more efficient and effective.


Dr. Swartz

Dr. Marvin Swartz received the American Psychiatric Association's Health Services Research Senior Scholar Award earlier this year. The award is in recognition of research accomplishments that have made a major impact and have been important contributions to mental health services research.

We want to hear from you!

If you would like to submit an item to be included in Member Notes, please email the NCPA member's name, photo (if available) and details to Kristin Milam at kmilam@ncpsychiatry.org.

It's membership renewal time, and you may be wondering, "Are my NCPA/APA membership dues worth the price?" Well, we feel that the benefits you receive as a member are worth it; here's why:

Your Executive Director Robin Huffman is working to represent our members and make sure psychiatry is at the table when it comes to important decisions and policymaking every day. For example, NCPA sent letters to the major insurers informing and educating them about the upcoming CPT Coding changes so that you get reimbursed in 2013.

NCPA staff and leadership work to develop educational programs that provide you exceptional information and fulfill those CME requirements – in the last three months, alone, members have had access to more than 18 hours of *AMA PRA Category 1 Credits™*. If you have to attend CME anyway, why not get deep discounts as an NCPA member?

Every day, the NCPA office staff fields calls from the public asking for referrals, and our website receives hits from visitors looking for the same information. As a member, you are included – if you choose to be – in our online Find A Doctor tool. We're also transitioning to new web and database software that will improve the referral system. With these updates, more resources will be available, including message boards, listservs and more ways to connect with colleagues.

It's an exciting time to be part of NCPA, and we hope you will continue your membership and grow with us!

Membership Progress Notes – 2012

New & Reinstated Members

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David Beirman, M.D.
Corinne Belsky, M.D.
Edward Benfield, M.D.
Anita Binder, M.D.
Leigh Blalock, M.D.
Charles Browning, M.D.
Julia Burns, M.D.
Nadia Charguia, M.D.
William Chen, M.D.
Fernando Cobos, M.D.
Dan Cotoman, M.D.
Jane DeVeau, M.D.
Amanda Dorn, M.D.
Charles Dunham, M.D.
Sheritia Faulcon, M.D.
Dionne Harrison, M.D.
Myleme Harrison, M.D.
Joseph Horrigan, M.D.
Juli Iacono, M.D.
Javed Iqbad, M.D.
Archana Kumar, M.D.
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James Mattox, M.D.
Monica McGill, M.D.
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Rebecca Moretz, M.D.
Jirpesh Patel, M.D.
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Nerissa Price, M.D.
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Larry Ray, M.D.
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Adam Salisu, M.D.
Binoy Shah, M.D.
Umang Shah, M.D.
Amie Sharrits, M.D.
Steven Vas, M.D.
James Williford, M.D.

New Members-in-Training

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Laura Albert, M.D.
Frank Angotti, M.D.
Daniel O. Ayanga, MBBS
Robert Bahson, M.D.
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Catherine Green, M.D.
Elizabeth Greene, M.D.
Emily Holmes, M.D.
Raunak Khisty, M.D., MPH
Amy Leung, M.D.
Dhipthi Mulligan, M.D.
Sonal Patole, M.D.
Ijaz Rasul, M.D.
Jose Ribas Roca, M.D.
Brittany Rodgers, M.D.
Catherine Rogers, M.D.
Kelly Schofield, M.D.
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Allie Thomas-Fannin, M.D.
Olga Thompson, M.D.
Felicia Walker, M.D.
Alicia Watson, M.D.
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Transfer In

Durga Bestha, M.D.
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Tayyba Buttar, M.D.
Yongyue Chen, M.D.
Saramma Eappen, M.D.
Carmen Espaillat-Serje, M.D.
Richard S. Hamilton, D.O.
Charin L. Hanlon, M.D.
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Omar Manejwala, M.D.
Aiko McGlynn, D.O.
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Alexander, Spessot, M.D.
Turhar Tahkre, M.D., Ph.D.
Gregory Weiss, M.D.
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Transfer Out

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Yesne Alici-Evcimen, M.D. (New York)
Corinne Belsky, M.D. (Illinois)
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Christine Wilder, M.D. (Ohio)
Jennifer Wildpret, M.D. (Pennsylvania)

The Eight Essential Elements of an ACO

"[C]linical transformation has less to do with technical capabilities and more with the ability to affect cultural change."
~ Gary Edmiston & David Wofford

1. Culture of Teamwork – Integration
The most important element, yet the one most difficult for physicians to attain, is a team-oriented culture with a deeply-held shared commitment to reorganize care to achieve higher quality at lower cost. Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than just banding together for contracting purposes. Furthermore, physicians tend to be cynical about prior "next best things," such as HMOs, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning.

2. Primary Care Physicians
Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, 'it seems clear that in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role." This need is logical when you examine the highest impact targets identified for ACOs: (a) prevention and wellness; (b) chronic disease management; (c) reduced hospitalizations; (d) improved care transitions across the current fragmented system; and (e) multi-specialty co-management of complex patients.

3. Adequate Administrative Capabilities
There are three essential infrastructure functional capabilities: (a) performance measurement; (b) financial administration; and (c) clinical direction. For example, ACOs qualifying under the Medicare Shared Savings Program must have a leadership and management structure that includes clinical and administrative systems that align with the aims of the Shared Savings Program. The ACO must have an infrastructure capable of promoting evidence-based medicine and beneficiary engagement, reporting on quality and cost metrics, and coordinating care.

4. Adequate Financial Incentives
Three tiers of financial income models are available to ACOs: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.
Shared Savings. If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50%) of those savings is shared with the ACO. To maximize incentivization, the savings pool should be divided in proportion to the level of contribution of each ACO participant. If primary care has especially high medical home management responsibility, this responsibility may be accompanied by the addition of a flat per member/per month payment.
Savings Bonus Plus Penalty. As with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks but also will be liable for expenses that exceed spending targets. This model is called "symmetric" or "two-sided," and the bonus potential is increased to balance the accountability for exceeding pre-set goals. Fee-for-service is retained.
Capitation. A range of partial capitation and full capitation models are possible. Fee-for-service payments are replaced by flat payments plus potential bonuses and penalties.

5. Health Information Technology and Data
ACO data are usually a combination of quality, efficiency, and patient-satisfaction measures. The data will usually have outcomes and process measures. Nationally-accepted benchmarks are emerging. Three categories of data needs exist for an ACO: baseline data, performance measurement data, and data as a clinical tool. The ACO will need the capability to move data across the continuum of care in a meaningful way, often termed "health information exchange" capability.

6. Best Practices Across the Continuum of Care
Another essential element of a successful ACO is the ability to translate evidence-based medical principles into actionable best practices across the continuum of care for the selected targeted initiative or initiatives. "The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today's delivery system, unnecessary spending relating to substandard clinical coordination, aggravated with the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice."

7. Engagement
Patient engagement is another essential element. Unfortunately, many of today's healthcare consumers erroneously believe that more is better, especially when they are not "paying" for it, insurance is. It is difficult to accept a compensation model based on improved patient population health when that is dramatically affected by a variable outside of your control, patient adherence.

8. Scale-Sufficient Patient Population
It is okay, even desirable, to start small or "walk before you run." However, potential ACOs often overlook the requirement that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. The Medicare Shared Savings Program, for example, requires that an ACO have a minimum of 5,000 beneficiaries assigned to the ACO.

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the continuum from diagnosis to discharge, created by a multi-disciplinary team with the goal of increasing quality, patient satisfaction, and savings for this patient population. It creates: (1) better information at the primary care diagnosis and treatment design phase, (2) better information flow along the entire continuum of care, (3) improved transition from the outpatient to the inpatient setting, (4) improved perioperative processes and outcomes, and (5) improved post-op follow up.

Anesthesiologists became aware of a new value-adding role in accountable care: that being the agent for patients transitioning from the medical home to the hospital, navigating the perioperative process while in surgery, and returning to the medical home. They realized that their highest opportunity lay with complex patients frequently in and out of the hospital, where fragmentation of care and lack of patient follow-up is particularly bad under fee-for-service. Surgeons, anesthesiologists, and other specialists not normally associated with ACOs found a particularly successful model through which to contribute to better health and lower costs.

The Time is Now

The North Carolina Psychiatric Association, along with 26 other NC medical societies and organizations, and in collaboration with key physician leaders and experts in accountable care, is implementing an initiative known as "Toward Accountable Care." The Toward Accountable Care (or "TAC") Initiative will provide specific and practical tools for physicians and other health care providers to successfully navigate, and thrive in, this new collaborative care environment. Drawing on years of research and experience, the TAC Initiative will develop a comprehensive ACO guide, with the goals of empowering physicians to develop successful ACOs through the provision of specific guidance and resources, and providing specific strategies and step-by-step guidance for ACO development and participation by each medical specialty. Building on the core ACO product, the Initiative will undertake a multi-media educational campaign to assist the health care provider community in developing successful, sustainable ACOs. The Initiative will also provide guidance on receiving funding through the Medicare Shared Savings Program and CMS Advanced Payment Program.

For more information, interested parties should contact Melanie Phelps of the North Carolina Medical Society at (919) 833-3836 or mphelps@ncmedsoc.org. The time is now, and the choice is clear. The current system is unsustainable. America is betting big on the ACO alternative. Ψ

What do I need to know about Medicaid Recredentialing?

- Providers and provider groups should go through the recredentialing process with the State's Division of Medical Assistance (DMA) every three years (the process is going on now).
- If you are a provider seeing Medicaid patients (especially if you are a Health Choice provider), completing the recredentialing process allows you to remain an approved Medicaid provider.
- When the 1915b waiver is implemented and all Medicaid patients are under a capitated LME/MCO model, this may not be necessary. However, if 1915b waivers are delayed, not fully implemented, etc., being a certified Medicaid provider is an important mechanism that allows you to continue to see your patients.
- Recredentialing is the safest route for ensuring you may continue to treat your Medicaid patients.

DMA's website has additional information about the process, http://www.ncdhhs.gov/dma. Or you may contact the CSC EVC (DMA's recredentialing provider) at 866-844-1113.

...Medicaid Changes continued from page 5

Medicaid Audits

Please be aware that there is tremendous legislative pressure on the state Medicaid office to unearth fraud and generate paybacks due to fraud. As a result, there is an intensive audit process underway, and psychiatrists are targeted along with other outpatient mental health professionals. We are hearing varied feedback on the audits. Some professionals are finding the audit team respectful and unobtrusive to the practice. Others report that the audit teams are aggressive, disruptive in the lobby and make unreasonable demands on producing charts and records.

Action Steps>>

- Be vigilant in following DMA policy.
- Read the monthly Medicaid Bulletins online.
- Notify NCPA if you experience difficulties credentialing with your LME/MCO.

Please keep NCPA informed of how this process is working for you. Let us know your experience with auditors. There is some concern that there is a "bounty hunter" environment, where auditors are incentivized for any mistakes they are able to find, regardless of the outcome or eventual dismissal of the paybacks. We want to hear your experience.

Conversely, if you have concerns about possible Medicaid fraud or abuse, we encourage you to contact the DMA program integrity department to share your concerns. Ψ

Even More 2013 CPT Coding Information

The upcoming CPT Coding changes that are going into effect on January 1, 2013, are the most comprehensive changes to billing for psychiatric services in more than 15 years. It's imperative that psychiatrists and their office staff are familiar with these changes. "I think a common misconception about these changes is that there is a grace period, and that physicians will really have until February or later to begin using the codes," explained **Dr. Venkata "Amba" Jonnalagadda**, who attended a November APA train-the-trainer course on the coming changes. "Psychiatrists are expected to know and begin using the new codes on January first, without exception. There is no grace period."

The changes separate billing codes used for psychiatric services provided by physicians and other prescribing providers and all other non-prescribing providers, such as a psychologist or a social worker.

NCPA has sent letters to North Carolina insurers notifying them of the coming changes; a template letter is available for members to send to their providers at www.ncpsychiatry.org (see red box below for more details).

Frequently Used Evaluation & Management (E/M) Codes		
Office/Outpatient Services	99201-99205	New Patient Office Visit
	99211-99215	Established Patient Office Visit
Inpatient/Hospital Services (does not include Nursing Facilities)	99221-99223	Initial Hospital Care
	99231-99233	Subsequent Hospital Care
Nursing Facility Services	99304-99306	Initial Nursing Facility Care
	99307-99310	Subsequent Nursing Facility Care
Domiciliary, Rest Home or Custodial Care Services	99324-99328	Domiciliary or Rest Home Visit for a New Patient
	99334-99337	Domiciliary or Rest Home Visit for an Established Patient
Home Services	99341-99345	Home Visit for a New Patient
	99347-99350	Home Visit for an Established Patient

CPT Coding Resources Available!

Visit NCPA's website, www.ncpsychiatry.org, and click on the "Resources" menu along the top.

There you will find resources including the CPT Code Crosswalk (at right), E/M Summary Guide, link to the APA's CPT resources page, documentation templates, and a template letter for physicians to send to insurance carriers.

...CPT Coding continued from cover

The burden, of course, is the documentation in the medical record. The documentation must support the E&M code you choose to submit. This is no easy task. Arriving at the correct code to submit requires the use of a complicated formula that takes in to account the extent of the history taking (chief complaint, HPI, review of systems and past family and/or social history), the comprehensiveness of the mental status exam, and the complexity of the medical decision making. A few scribbled words and abbreviations that only you can read does not cut it and places you in danger of an audit. Consistently submitting the highest codes also puts you in danger of an audit.

In my opinion, having ussed these codes, I would recommend that every psychiatrist get training with an experienced trainer. For most just reading a book or article will not be sufficient. My training consisted of attending seminars conducted by a trainer and then having that trainer compare the documentation in redacted progress notes with the E&M code I billed. This approach was invaluable in solidifying my confidence regarding documentation. I was fortunate to have the trainer actually review my notes. This is probably not a readily available experience but you can simulate one by gathering a group of colleagues and reviewing each other's redacted notes.

As the New Year approaches, I encourage you to make a resolution to put forth the effort to get good training about the new codes – both the highlighted above and the others that are part of this significant change. Ψ

www.psychiatry.org

Psychiatric Services
2012 to 2013 Crosswalk

American Academy of Child & Adolescent Psychiatry
www.aacap.org

2012			2013		
Service	**CPT Code**	**2013 Status**	**Service**	**CPT Code**	**Report with interactive complexity (+90785)**
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	**90791**	When appropriate
			Diagnostic evaluation with medical	**90792**	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	**90791**	Yes
			Diagnostic evaluation with medical	**90792**	
Psychotherapy					
Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	**90832**	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	**90834**	
75-80 min	90808, 90821		60 (53+*) min	**90837**	
Interactive individual psychotherapy 20-30 min	90810, 90823	DELETED	30 (16-37*) min	**90832**	Yes
45-50 min	90812, 90826		45 (38-52*) min	**90834**	
75-80 min	90814, 90828		60 (53+*) min	**90837**	
Psychotherapy with E/M (there is no one-to-one correspondence)					
Individual psychotherapy with E/M, 20-30 min	90805, 90817	DELETED	E/M plus psychotherapy add-on	**E/M code** (selected using key components, *not* time) and one of: **+90833** 30 (16-37*) min **+90836** 45 (38-52*) min **+90838** 60 (53+*) min	When appropriate
45-50 min	90807, 90819				
75-80 min	90809, 90822				
Interactive individual psychotherapy with E/M 20-30 min	90811, 90824	DELETED			Yes
45-50 min	90813, 90827				
75-80 min	90815, 90829				
Other Psychotherapy					
(None)			Psychotherapy for crisis	**90839, +90840**	No
Family psychotherapy	90846, 90847, 90849	RETAINED	Family psychotherapy	**90846, 90847, 90849**	No
Group psychotherapy	90853	RETAINED	Group psychotherapy	**90853**	When appropriate
Interactive group psychotherapy	90857	DELETED			Yes
Other Psychiatric Services					
Pharmacologic management	90862	DELETED	E/M	**E/M code**	No

*Per CPT Time Rule

N.C. Psychiatric Association
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Raleigh, NC 27606
www.ncpsychiatry.org

What's Inside:

Calendar of Events

February 17, 2013
NCPA Executive Council Meeting

March 21-22, 2013
Clinical Update and
Psychopharmacology Review 2013
Cape Fear Botanical Garden • Fayetteville

May 17-22, 2013
APA Assembly & Annual Meeting
San Francisco

Looking for a last-minute tax deduction or gift ideas? ***Please consider making a donation to the Psychiatric Foundation of North Carolina. Tribute donations are a great way to support the Foundation while honoring a loved one, colleague or friend.***

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