

Lawrence J. Conell, MD  
PSV President

## A MESSAGE FROM THE PRESIDENT

As you know, one of our major roles is advocacy for our patients and our profession. How-

ever, with the low rate of reimbursement for psychiatric services and increasing bureaucratic hassles, some of our colleagues ask what the APA and the PSV do for us?

Are they archaic institutions who have lost their effectiveness and lost touch with their constituents? I must admit that over the years, I have on occasion, had similar thoughts - questioning the value of membership. However, having served on the PSV Board in a variety of capacities over recent years and, as your President this year, has helped provide me a different and more appreciative perspective.

On a national level, there are many areas on which the APA has, and is, exerting influence on our behalf as psychiatrists and physicians. While there are many others noted in the October 6, 2006 *Psychiatric News*, below are just a few.

- The DEA has recently published a proposed rule that would reverse an interim policy enacted more than two (2) years ago prohibiting the practice of writing multiple prescriptions on the same date for Schedule II medications. The APA was actively involved in representing our interests and helping achieve this victory for us and our patients.
- The APA PAC is supporting legislation limiting the use of the "physician" label to physicians.
- There is work by the APA to help

get benzodiazepines covered under Medicare Part D.

- There is work by APA representatives to educate our legislators about Scientology propaganda.
- There are many other areas in which the APA is actively involved, ranging from fighting discrimination in health care plans to fighting erosion of medical records privacy.

On a state level, we have remained active, looking out for the interests of Virginia psychiatrists.

- We have signed on to the Amicus Brief supporting Dr. Harold Eist's struggle to protect patient confidentiality.
- We were actively involved with the Virginia Medicaid system on psychiatrists with patients flagged for polypharmacy before they could implement a potentially onerous and Draconian review process. In the proposed system, two (2) psychiatrists had been arbitrarily chosen to serve in an uncertain role of "counseling" psychiatrists with apparently errant prescribing practices. As a result of our involvement, if the program does get implemented at all, we were able to change the focus to a consultative one with a respected colleague, for difficult patients who seem to be requiring unusual dosing or combinations. The PSV was able to convince DMHRSAS to use those psychiatrists we identified as being recognized experts, rather than a managed care-like "hired gun."
- There was a move afoot for legislation allowing non-doctoral level mental health providers to do evaluations in NGR1 cases. However, we were heard early on in this discussion and, while the eventual outcome is not certain at this time, our

response was clear and I believe we were heard.

- We continue to actively monitor and prepare a response to potential moves toward legislation for psychologist prescribing privileges.

There are many other areas in which we have been active in just the last few months, including exploring ethics complaints; ongoing monitoring of legislation that may have an impact on us; and, of course, our successful Fall meeting in Charlottesville with the theme of *Anxiety, Conflict, and Trauma*.

By now, most of you are aware that we have a full time lobbyist, Cal Whitehead, and with his help, recently started our own PAC, again with the purpose of serving the interests of Virginia psychiatrists and our patients. Through Cal and our legislative committee, we are kept abreast of a huge number of issues (such as those noted above) that have the potential to come before the legislature, or impact us from other sources. We are able to get involved in the very beginning phases of discussion, offering us the opportunity for input and influence early in the process.

If you have not yet contributed to our PsychMD PAC this year, please

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## A MESSAGE FROM THE EDITOR

### How Do You Know?

By James Krag, MD

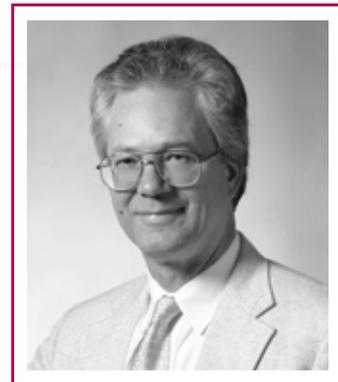
How do we distinguish between *knowing* and *believing* that what we prescribe as psychiatric treatment helps our patients? Over the centuries, too often, physicians have mistaken *beliefs* for *knowledge*. Therefore, a good question to ask ourselves and others regularly is, "How do you know?"

History can help us to not repeat mistakes. From a historical perspective, very capable and intelligent doctors had a desire to help others and creatively developed and vigorously promoted innovations in care. However, in retrospect, at times what they promoted as useful treatment, was not helpful and was even detrimental. Here are two examples.

Benjamin Rush, MD (1745 – 1813), was a friend of Thomas Jefferson and Benjamin Franklin. He was a social reformer against slavery, a promoter of education, a signer of the Declaration of Independence, a member of the Continental Congress, and an army surgeon. His claim to psychiatric fame rested on his writing the first American treatise on psychiatry, *Medical Inquiries and Observations in Diseases of the Mind*, published in 1812. It was republished four times by 1830. For 50 years, no other American text on mental illness was published.

Rush's practice of psychiatry was based on bleeding, purging, the use of the tranquilizer chair and gyrator. Over the years, his mode of treatment was called into question by many of his contemporaries. But he continued to defend and promote his systems. By the mid 1800s, these practices were gradually abandoned. Rush, however, was the first American to study mental disorders in a systematic manner, and he is considered the Father of American Psychiatry.

Walter Freeman, MD (1895 – 1972) brought to the U.S the concept of frontal lobotomy in 1936. In 1950 he published *Psychosurgery in the Treatment of Mental Disorders and Intractable Pain* and reported on the first 711 lo-



botomies he performed. He concluded that 45% yielded good results, 33% produced fair results, 19% left the patient unimproved or worse off and 3% died directly or indirectly from their lobotomies. In 1946, he developed transorbital lobotomy, an office procedure which he showed produced less unwanted side-effects. From his point of view, he *knew* that plunging an ice pick through the tear ducts into the frontal lobes, cured people of mental illness.

Egas Moniz of Portugal performed the first lobotomy in 1935 and, in 1949, he was awarded the Nobel Prize for "his invention of a surgical treatment for mental illness." Twenty thousand people in the United States underwent lobotomies in the four years after the Nobel announcement and one third of the total were transorbital operations. Psychosurgery became a form of treatment used at more than half the public psychiatric institutions in the US.

By the late 1940s, lobotomy had moved from the edge of psychiatric practice to the mainstream. Its practitioners and innovators included some of the most prominent names in neuroscience during the mid-twentieth century. Lobotomies were carried out in the surgical rooms of such well known institutions as Columbia, Johns Hopkins, Harvard and Yale, the Institute of Living and the Mayo Clinic. Of the forty to fifty thousand cases of psychiatric surgery performed in the US during the forty years after 1935, Freeman was involved in less than 10% of the total

The US Veterans administration embraced lobotomies in the years after WWII for use in the growing psychiatric wards of its hospitals. In all of

1946, VA hospital staff performed only 71 lobotomies, but by 1949, the VA was performing an average of 48 lobotomies per month.

In 1954, a new drug called chlorpromazine won FDA approval and was sold under the name Thorazine. The name of the drug was derived from the god Thor and it soon began to assert its power. The manufacturer promoted it, "like a chemical lobotomy" that calmed patients, distanced them from their emotional disturbances, and even eliminated hallucinations, delusions and other symptoms of schizophrenia. Without surgery and at low cost, hospitals could use Thorazine to end the screaming, raving and violence of their most unmanageable patients. By the end of its first year of use in the US, chlorpromazine had been used to treat about two million mental patients.

As Thorazine and other drugs appeared, lobotomy faded away. During the late 1950s and early 1960s, state hospitals abandoned their psychosurgery programs and stopped inviting Walter Freeman to come to demonstrate transorbital lobotomy. The journal articles published about psychosurgery quickly dropped from more than one hundred fifty annually.

In the years that followed, Freeman unwaveringly maintained his conviction that psychosurgery offered a solution and often the best solution for patients entangled in the snare of mental illness. He refused to open his eyes to the possibilities that the new medications offered. He had staked his career on the efficacy of lobotomy, and he would not let go of his beliefs, even when most of his biologically oriented colleagues migrated to medications.

How will history judge us? What do we know about mental illness and the brain and what do we believe we know? When you are in the middle of a social paradigm, it is often difficult to distinguish between knowledge and belief. When we prescribe very potent medications for adults and children, what do we really know about the long-term effects? What do we know about which medications are best for a particular disorder?

Studies like the CATIE, STEP-BP and STAR-D are important steps in sorting out our beliefs from our knowledge.

These and other studies are important to help produce evidence to guide practice. A recent letter in *Psychiatric Services* by Mark Ragins, MD said, "I hear a great deal of talk about evidence-based practice" and "research-informed clinical treatment." An increasingly frustrated group of effective clinicians urge "practice-based evidence" and "clinically informed research."

But didn't Benjamin Rush use practice-based evidence to convince himself that purgatives and zealous bleeding led to cures? It was claimed that at least six thousand of the inhabitants of Philadelphia were saved from death by Rush's bleeding and purging; during the Yellow Fever epidemic of 1793. Didn't Walter Freeman use practice-based evidence to convince himself that lobotomy was on the cutting edge of modern science?

When we prescribe a new medication and patients improve, especially if we are more aggressive with the dosing, is our research "n" big enough to have that experience be our practice guide? How do you know?

Medical historians have noted that many of the leaders of their times, who were later proven wrong, had considerable hubris. Excessive pride and arrogance can block one's openness to new knowledge. Feeling ignorant is not a comfortable experience for doctors, good students that we have been. Inno-

vation does take courage and self-confidence, but keeping in perspective what we *really* know will allow us to better serve our patients by keeping us open to evidence guiding our practice to what *really* helps.

Material re: W. Freeman from *The Lobotomist: a maverick medical genius and his tragic quest to rid the world of mental illness*, by Jack El-Hai and re: B. Rush from *Psychiatric News Online* by Lucy D. Ozarin, M.D.

**COMING SOON!**

## **ONLINE MEMBERSHIP DIRECTORY FOR 2007**

A new and improved Membership Directory is coming! Please watch for a letter requesting updates to your contact information. To create easy access and current information to all members, PSV will offer the membership directory online in early 2007. In order to have accurate information, please note any changes to the member information that we now have and return to PSV, 2209 Dickens Road, Richmond, VA 23230-2005. If you have any questions, please contact Andrew Mann at 804-565-6325 or via email at [andrew@societyhq.com](mailto:andrew@societyhq.com).

### **PSYCHIATRIC POSITION AVAILABLE**

**Norfolk Community Services Board** is seeking a full or part-time Psychiatrist for Community Outpatient Clinic. Must be licensed to practice Psychiatry in Virginia. Board Certification is preferred with relevant experience treating adults with serious mental illness and co-occurring disorders. We are also interested in candidates experienced in evaluating and treating children and adolescents, including the seriously emotionally disturbed. Excellent benefits package; salary commensurate with experience.

Apply to: Norfolk Community Services Board, 248 W. Bute Street, Norfolk VA 23510 or call (757) 441-5300 if you require special assistance. On-line application at [www.norfolkcsb.org](http://www.norfolkcsb.org). EOE M/F/D/V. Background check required.



# IN THE NEWS

## MEET YOUR NEW ASSOCIATION MANAGER



**Andrew Mann** over from Sandra Peterson, managing the day-to-day operations of the society. Before coming to Ruggles, I worked for Visual Aids Electronics as Regional Sales Manager. While there, I worked with Sandra as well as with many other state associations, to plan their audio visual needs for conferences, seminars and meetings. Sandra has been instrumental in steering me in the right direction and I will continue to stay in touch with her to make the transfer as seamless as possible. I look forward to working with the Board and members of PSV. Please feel free to call me at 804-565-6325 or email me at Andrew@societyhq.com.

### A Message from the President

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consider doing so as soon as possible. Your contributions have an immediate and direct impact. Also, the more active voices we have in our society, the better we are able to respond to the multiple issues we face. Please consider becoming more actively involved by letting any of the Board members know of your interest. We can't blame our professional organizations for not meeting our needs if we don't become involved. The society is all of us; and the PSV is one of the most responsive and open of organizations - open to ideas and open to participation of our members, even if you've never been active before.

## THE PSYCHIATRIC SOCIETY IN LOCAL MEDIA EVENTS

By Jose Nieves

Last time I wrote, I described the difference between "earned" and "paid" media and the importance media coverage has to the Psychiatric Society and Psychiatry in general.

Education, advocacy and establishing a leadership position in mental health related issues in the commonwealth among media venues are some of the most compelling reasons for us to get involved and seek opportunities.

Dr. Kathleen Stack, DFAPA recently participated in two "earned" media outlets. Recognized for her expertise in Addiction Psychiatry in the Tidewater area, she was asked to join a panel for a month long substance abuse series featured in the *Daily Press*, a large circulation east coast of Virginia newspaper. Readers were asked to forward

questions and Dr. Stack, along with a panel, provided answers. The questions ranged from the early symptoms of substance abuse, treatment alternatives, prognosis and the support of loved ones suffering from substance abuse. She has also participated in a WHRO 89.5 Public Radio program, "Hear Say" which aired on August 17, 2006 from 12 until 1 pm, taking live questions from the public, with Addiction Psychiatry again being the topic.

This kind of involvement in local media events helps the Psychiatry Society build a relationship with local reporters and radio hosts and can certainly help in cases when we may need to "set the record straight". It also demonstrates our interest and goodwill to educate the public in matters of mental health and helps demystify psychiatry in general.

## WELCOME TO OUR NEW MEMBERS



### Members in Training

Jatinder Babbar.....Roanoke  
 Andrea Bandfield.....Suffolk  
 Matthew Barrett.....Charlottesville  
 Scott Beach.....Charlottesville  
 Jozef L. Bledowski.....Charlottesville  
 Jorge A. Castro-Alvear.....Charlottesville  
 Christian T. De Filippo.....Norfolk  
 Reynald S. Ferraz.....Roanoke  
 Nicole Dirienzo.....Charlottesville  
 Laura Goldhar.....Charlottesville  
 David Hamilton.....Charlottesville  
 Elizabeth Johnson.....Charlottesville  
 Amaresh B. Khandat.....Richmond  
 Sachin N. Mehta.....Salem  
 Sarah Neely.....Charlottesville  
 Niels C.S. Nielson.....Charlottesville  
 Sujatha Ramamurthy.....Charlottesville  
 Sukhpreit K. Sohi.....Roanoke  
 Ying Ming Zhang.....Roanoke

### Permanent Inactive

Janet Lee Walters.....Portsmouth

### General Members

Julia Ailabouni.....Midlothian  
 Young Hoon Bae.....Harrisonburg  
 M. Angela Catolico.....Richmond  
 Kimberly T. Ellis.....Williamsburg  
 A. Kwasi Foluke.....Portsmouth  
 Bankole A. Johnson.....Charlottesville  
 Omar Manejwala.....Williamsburg

Brett Sharp.....Roanoke  
 Christina Truman.....Norfolk  
 Erica Bradshaw.....Virginia Beach  
 Sandra Carty.....Richmond  
 Meredith R. Cary.....Charlottesville  
 Veronica L. Harsh.....Charlottesville  
 Omar K. Hasan.....Roanoke  
 Samia Sabeen.....Charlottesville  
 Anwar Hossain.....Richmond  
 Jessica K. Irvine.....Richmond  
 Nelson Monroy.....Painter  
 Erica Bradshaw.....Virginia Beach  
 Meredith R. Cary.....Charlottesville  
 Veronica L. Harsh.....Charlottesville  
 Omar K. Hasan.....Roanoke  
 Anwar Hossain.....Richmond  
 Jessica K. Irvine.....Richmond  
 Noel B. Jewel.....Daleville  
 Naciye Kalafat.....Roanoke  
 Vladimir A. Karpov.....Virginia Beach  
 Tania Kees.....Rockville  
 Bruce M. Lovelace.....Palmyra  
 Martha M. Mann.....Warrenton  
 Melissa Moore.....Crozet  
 Maria Popovici Coica.....Roanoke  
 Stacey L. Rawis.....Richmond  
 Kevin R. Rosi.....Richmond  
 Elahe Sagart.....Roanoke  
 Madhanika L. Srirama.....Norfolk

## PSYCHMD PAC

How many times have you seen this strange word and wondered what it meant? The Psychiatric Medical Doctor Political Action Committee (PsychMD PAC) is the vehicle for continuing a strong psychiatric profession in Virginia. Now you must be asking yourself, "Well, why is that?" Because political activity through fundraising helps drive our influence in state government. Here is how it works and why it is so important for you to participate.

As you may know, money talks in politics. Elected officials are always campaigning and campaigning requires funding. In Virginia, it is completely legal to give as much money as you want to candidates, as long as it is fully and publicly disclosed. Our PsychMD PAC Board and staff in Richmond know who to support, when to support them, and how to do it most effectively within the spirit and letter of law. Still wondering how it works?

Because PSV is a non-profit organization, the society can lobby the General Assembly members, but cannot give money directly to political candidates. A separate organization, a political action committee or PAC, exists to complement and enhance advocacy activities. PsychMD PAC raises money from member psychiatrists in order to support candidates backing our commitment to better mental health services in Virginia. This support fuels the political cycle and gives professionals the opportunity to participate together.

Because Virginia laws regulate psychiatry practice guidelines, it is important that the profession maintain influential and healthy relationships with Delegates, Senators, and General Assembly candidates. Funding PsychMD PAC is an investment in your professional future.

If you have any more questions about PsychMD PAC, please feel free to contact our Advocacy Coordinators for information.

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## NATIONAL PROVIDER IDENTIFIER EFFECTIVE MAY 2007- BEGIN PREPARATIONS NOW

Submitted by Anthem Blue Cross and Blue Shield  
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Effective May 23, 2007, the Health Insurance Portability and Accountability Act (HIPAA) will require the transition to the National Provider Identifier (NPI) – 10-position, unique numeric identifiers. These standard NPIs will replace existing provider numbers – including Medicare, Medicaid and other physician identification numbers for health care professionals (including physicians and institutions). All health care providers who are HIPAA-covered entities must obtain NPIs to identify themselves when requesting reimbursement for health care services rendered.

### Help Ensure a Smooth Transition – Contact CMS Now to Obtain NPIs

With just under a year until the new NPI requirements are implemented, health care professionals are encouraged to obtain their new NPIs now from the Centers for Medicare and Medicaid Services (CMS) if they have not already done so. Visit the CMS Web site at <http://www.cms.hhs.gov/NationalProviderStand> or dial toll free at (800) 465-3203 to get started. The National Plan and Provider Enumeration System Web site is [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov).

One other way health care professionals can help ensure a smooth transition to NPI is to register their NPIs as soon as possible with insurance carriers with which they contract. By doing so, health care professionals provide vital information that insurance carriers need in order to process claims and issue accurate payments to health care professionals going forward once NPI is fully implemented. Many carriers are currently working collaboratively with the health care community to comply with the federal mandate and to ensure uninterrupted operations with these professionals.

### Assess System Capabilities Early

Preparation for NPI may also require health care professionals to assess and upgrade their existing systems or have discussions with their practice management vendors to ensure compliance with NPI requirements. In addition, testing is a key component of the NPI preparation process. A physician office or institution may be able to minimize problems by testing early with their vendors and any health insurance carriers. By making preparations in advance of the upcoming implementation, health care professionals can further ensure a seamless conversion to NPI, minimizing any potential payment disruptions in their operations.

### Become Familiar With NPI Terminology

As with any transition to a different process, new terms are common – such as NPI terms like enumeration, entity type 1 providers and entity type 2 providers. Enumeration refers to the process of obtaining NPIs during the application and NPI number assignment process. A health care professional who is an individual can apply for an entity type 1 NPI. This includes, but is not limited to, physicians and behavioral health professionals. An organization, such as a hospital, can apply for an entity type 2 NPI. The definition of an organization includes, but is not limited to, hospitals, residential treatment centers, laboratories and group practices.



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## THE POLITICAL VOICE FOR VIRGINIA'S PSYCHIATRISTS

PsychMD-PAC raises money from Virginia psychiatrists to fund General Assembly and statewide candidates who promote a better environment for psychiatric care delivery. Political contributions help offset the expenses of campaigns and allow psychiatrists to target our message to important decision-makers. With your support of PsychMD-PAC we can achieve our mission of educating candidates about our professional concerns.



**Yes! I will support my profession at the following level:**

\_\_\_ \$ 500 (Leadership Circle)

\_\_\_ \$ 250 (Advocate)

\_\_\_ \$ 100 (Member)

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Please mail completed form and contributions to:

**PsychMD-PAC**  
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28 North 8<sup>th</sup> Street, 2<sup>nd</sup> Floor  
Richmond, Virginia 23219

*Contributions are not tax deductible.*

## FROM THE BOARD OF DIRECTORS

*The following letter was sent to James Reinhard, MD, Commissioner of DMHMRSAS from the PSV Board.*

We are writing to support the concept of Transformation and Reinvestment promoted by the DMHMRSAS. However, on behalf of Virginia's citizens with psychiatric illness, we request that no additional state hospital beds be closed until they have been left vacant and thereby proven unnecessary.

We are greatly concerned about Virginia being on the American Psychiatric Association's Office of Health Care Systems Financing list of states with hospital bed shortages. They note that, "On many nights there are no crisis psychiatric beds available in the entire state. Patients have gone to jail, been transferred out of state, or been released inappropriately." Despite this caution from the American Psychiatric Association, the DMHMRSAS continued with state bed closures as part of then Governor Warner's Reinvestment Plan.

We have also heard from our colleagues who work within the Community Service Board system throughout the state. They have addressed their concerns about the critical need for additional resources for the ongoing efforts of the CSB's to develop facilities and programs to keep patients in treatment in their local communities, thereby, to the extent possible, limiting the need for hospital admissions in centralized facilities. Establishing an even more functional community system with adequate crisis stabilization programs is costly and since these programs are a relatively new concept in Virginia, they will take several years to develop. Many of our members have considerable experience working with people in a psychiatric crisis and are willing to offer ongoing collaboration in establishing Crisis Stabilization Units.

Several of the members of the Board are, for better or worse, old enough to remember the publication in 1961 of *Action for Mental Health*; the document upon which the community mental health movement was founded. This document called for a shifting of funds from state psychiatric hospitals to community-based care. Also remembered is that the legislators who implemented this system seemed to have overlooked the last chapter of this document which emphasized that a considerable increase in funding would be required to achieve the benefits of this "transformation." Similarly, those on the Board who have been practicing psychiatry in Virginia for many years have seen again and again the political minuet of the cutting of funds for the state hospital system coupled with promises of increased funding for "community care" only to see the latter never fully materialize. At the same time, funding for the penal system, the "poor man's mental health system," never seems to diminish. It has been demonstrated repeatedly over time and geography that there is an inverse relation-

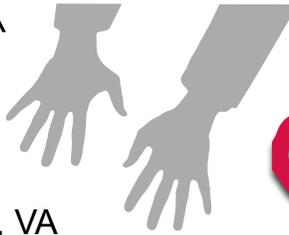
ship between the number of existent psychiatric beds and penal beds. While we fully agree with the goal of shifting care to the local community and to the least restrictive and effective alternative, we question how this can best occur.

The approach we have seen over the past 30 years seems to involve cutting inpatient beds and hoping "the system" in some way will absorb the patients. Meanwhile, managed care has cut the private funding of mental health care from ten percent of health care expenditures to less than two percent. As the forty community services boards in Virginia have developed, much progress over the years has been made in serving people in the community. Even without closing a state hospital, over the years the daily census has been able to decrease. However, the combined public and private psychiatric beds are now at a critical level below which it is not safe to go without considerably more progress and development in the community sector. Therefore we are writing to ask for a hold on further bed closure.

As an example, when clinicians treat patients with anorexia nervosa, they try to establish at the beginning of treatment that they have no power to take away the patient's anorexic behaviors, but working together, they may be able to make the behaviors less necessary. Similarly, the most humane way of closing public hospital beds is by making them less necessary; having the community-based public/private system meeting the needs of citizens with psychiatric illness so that there are consistently unused hospital beds – and then closing them. This, of course, should be done "honestly," not by making regulations that refuse admission to patients clearly in need of care, or making the gatekeepers those who have a proprietary stake in refusing admission. Is this perhaps a public sector recapitulation of managed care?

By and large, most of our patients are neither wealthy nor in positions of power and if they are, they tend to not want their illnesses made public. Additionally, too many of our patients do not vote and certainly do not vote as a single issue bloc. They therefore have a very weak voice with legislators. While politics is indeed "the art of the possible" in truth psychiatric medicine as a profession, and our professional organizations, will always be advocating for policies and expenditures that will not be popular with the politicians. And yet, that is exactly what our patients need us to be doing and to be doing well.

Again, while we emphasize the broad support among the members of the Psychiatric Society of Virginia for the concepts of Transformation and Reinvestment promoted by the DMHMRSAS, we also feel compelled to request that no additional state hospital beds be closed until they have been left vacant and thereby proven unnecessary. We do not see how this Transformation and eventual Reinvestment can safely and compassionately take place without a temporary duplication and therefore an increase of resources.



# ANXIETY, CONFLICT & TRAUMA

## MEETING HIGHLIGHTS



The 2006 Fall Meeting opened with a Friday night reception at the Omni Charlottesville. At that reception, Sandra Peterson, the outgoing Executive Director of the Psychiatric Society of Virginia, was honored by PSV President Lawrence J. Conell, MD. Dr. Conell presented Sandra with a beautiful glass plaque as thanks for her hard work. Delegate David Toscano, representing the Charlottesville area, was also in attendance.

Saturday morning, attendees joined their peers for breakfast roundtables on hot topics such as ethics and legislative updates. Next on the program, Dr.

Conell welcomed the group and introduced Jonathan David, MD who presented on new treatments in the field of anxiety and PTSD.

PSV's annual business meeting was held during lunch.

After lunch, Gregory O'Shanick, MD, spoke on the *Evaluation and Management of Traumatic Brain Injury: What a Practicing Psychiatrist Needs to Know*. The final session was presented by Steve Brasington, MD, on distressed professionals.

The Spring Meeting will be held March 23-24, 2007 at the Sheraton Richmond West in Richmond, Virginia.





PSV WOULD LIKE TO THANK OUR SUPPORTERS AND EXHIBITORS FOR AN EXCELLENT 2006 FALL MEETING

LEVEL 1 SUPPORTER

Reception Sponsor SEPRACOR

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Forest Pharmaceuticals
Pfizer Inc.
Takeda Pharmaceuticals
Wyeth Pharmaceuticals

# AREA V COUNCIL & AMERICAN PSYCHIATRIC ASSOCIATION ASSEMBLY NOVEMBER 2 - 5, 2006 • MEETING REVIEW

By John Shemo, MD, DFAPA  
Ram Shenoy, MD, DFAPA

The Area V Council meeting was held again in Washington, DC, just prior to the APA Assembly meeting in order to conserve finances. Ram, for this meeting, served on Action Paper Reference Committee IV, *Defining/Supporting Professional Values*. I continue to serve on the Assembly Rules Committee and on the Steering Committee for the APA Practice Guidelines. We have recently completed reformulations of the Obsessive-Compulsive Disorder and Alzheimer's Disease guidelines and have begun work on the Bipolar guidelines. Currently, the Steering Committee is attempting to do yearly updates, published as *Watches*, on each of the guidelines and to do complete rewrites of each guideline at about five-year intervals.

During this Assembly meeting, we had a lengthy report on issues of Medicare reimbursement. To summarize this briefly, when the reimbursement codes were developed, there was an attempt to crosswalk the 908xx codes with the E&M codes used in most of medicine. However, the overall reimbursement system is set up as something of a zero-sum game. The E&M codes are being increased again for next year, and to compensate, the 908xx codes are going to be reduced by about 10 percent. The attempts to maintain crosswalk parity between these sets of codes apparently has been entirely sacrificed. Thus, a primary care physician will be paid significantly more for seeing a patient with psychiatric illness for one-half hour or one hour than will a psychiatrist using 908xx codes, despite less training/experience in the evaluation and treatment of the psychiatric illness. It was pointed out that the decrease in reimbursement for the 908xx codes, given the requirement of "expenditure neutrality," is further driven by the fact that other specialties keep coming out with "new" procedures for which they get to develop new codes that can be valued de novo without the need to negotiate

an increase.

It was also warned that psychiatrists put themselves at risk if they bill for more than three 90862 codes in an hour or maybe four, if they can prove that they do all the notes/paperwork at a different time than the period in which the patient is seen.

It is noted that psychiatrists can use E&M codes, and that with E&M codes, the time specified can encompass all the time spent on patient care, not just "face-to-face" time. Unfortunately, there remains great uncertainty about what will satisfy Medicare in terms of documentation. Either the 1995 or the 1997 standards can be used, but both are painfully vague. We could, as a district branch, look into having a member of the APA Committee on RBRVS, Codes and Reimbursement do a presentation at an upcoming PSV meeting.

In Oklahoma, the pediatricians recently sued the Medicaid carrier on the basis that the carrier had not fulfilled its contractual obligation to provide care for indigent children by offering rates of reimbursement so low that practitioners could not afford to see these children. The suit was won by the pediatricians and Medicaid reimbursement was increased, including the rate for child psychiatric services.

It was also noted that in some states, patients are being pushed to go on disability (federal funding) rather than being put in recovery programs in community mental health centers if not being on disability leaves them on state funded medical coverage.

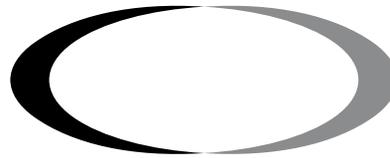
The issue of the poor reimbursement rates for psychiatric services paid by Cigna in Virginia was discussed. It was pointed out that Cigna's rates may, in fact, be in violation of the terms of the agreement Cigna made with Judge Merino in the Florida District Court requiring adequate reimbursement rates as part of a settlement Cigna made to not be involved in the RICO lawsuit. The

Managed Care Liaison Committee of the Psychiatric Society of Virginia had contacted Cigna during the summer about these extremely low reimbursement rates. Cigna's reimbursement rate for 90807 is 73% of the Medicare rate and its reimbursement rate for 90801 is 58% of the Medicare rate. In reply, Cigna stated that these rates were under review, but otherwise were very avoidant of directly answering questions about reimbursement rates for other medical services in Virginia or in other states. We will be readdressing this issue with Cigna before the end of this year.

Given that the representatives for the Uniform Services District Branch are in Area V, we had a lot of discussion about post-traumatic stress disorder and the Iraqi war. The military psychiatrists did discuss how little press coverage the high incidence of PTSD in Iraqi war veterans has received. They discussed their sense that an aspect of this high incidence is that the Iraqi war has lasted longer, thus far, than World War II, and that the soldiers keep getting redeployed. Many are currently on their third deployment. They pointed out their view that the military is not being adequately supportive of treatment for PTSD. They discussed the paradox that soldiers with major physical injuries have a lower incident of PTSD because this group gets early consultation and ongoing psychiatric care while hospitalized for their physical injuries. It was pointed out that 1,300 IED's (improvised explosive devices) were set off in Iraq in a recent 90-day period and that 35 percent of deaths are due to these devices. One and a half million military personnel have been deployed so far to Iraq or Afghanistan. Thirty-four point six (34.6) percent of the deployed have sought mental health care within one year of return. Unfortunately, many community mental health centers will not treat these returned veterans

*Continued on page 12*

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### MEETING REVIEW

*Continued from page 10*

because, in their jurisdictions, PTSD is not statutorily defined as a “serious and persistent mental illness.” Currently, 180 wars are occurring worldwide.

The finances of the APA continue to look strong. We currently have increased to 37,783 members. Eighteen point nine (18.9) percent of the APA budget comes from dues, greater than 50 percent comes from publishing, and 28 percent comes from the annual meeting. The APA spent \$6.4 million last year on advocacy funding, by far the largest component of discretionary spending. The APA did undergo an audit last year. No management letter of deficiencies was issued. Only 20 of 400 nonprofit organizations reviewed last year had this clean an outcome.

The heart of the Assembly is the consideration of action papers. At this meeting a paper was passed addressing the issue of managed care pharmacies

pushing patients to change their medication regimens without disclosing the pharmacies’ profit motive. On average, pharmacies have a greater mark-up and profit on generic medications that they do on brand medications.

Other passed papers addressed issues of Medicare, Part D drug plans, patient suicide as an occupational hazard for psychiatrists, an annual award for medical schools who have a large percentage of graduates entering psychiatric residency programs, providing the APA practice management guide free to third or fourth year members-in-training, and a format for collaborative care with nonpsychiatric practitioners. Several papers focused on internal governance issues of the APA.

A paper on medical marijuana was defeated, in large part because of questions and unease about the motives of the author.

Ram and I remain extremely open to any feedback from PSV members about the functioning of the Assembly or the APA in general, and we are more than willing to discuss potential initiatives or action papers. Our Assembly positions exist to both represent and serve the PSV membership.

**SAVE THE DATE!**

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MEETING**

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