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THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

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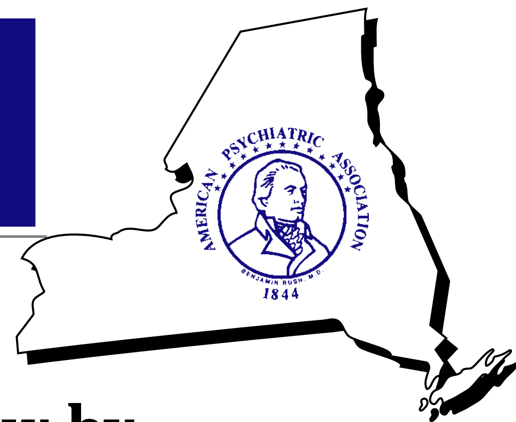

President's Message: The Next Wave in Managed Care – Fee Reductions

by Jim Nininger, M.D., President, New York State Psychiatric Association

At the end of 1998, NYSPA members were confronted by a "tidal wave" of fee reductions imposed by the big three behavioral managed care companies operating in New York State: Magellan, ValueOptions, and United Behavioral Health. These three companies that control access to treatment of mental illness for millions of New Yorkers sent out notices last December to their provider networks reducing their fee schedules between 15% to 40%, all effective as of January 1, 1999. In response to these unprecedented and simultaneous fee reductions and the consequent outrage from the membership, NYSPA took immediate and decisive action to protect the interests of our members and their patients.

Jim Nininger, M.D.

On November 11, 1998, the NYSPA Executive Committee held a special meeting by conference call and authorized the following plan of action:

- Get information to our members regarding their legal rights under their contracts with the managed care companies.
- Communicate our concerns to the three managed care companies regarding their actions and insist on full compliance with the provider contract and state laws.
- Contact appropriate state and federal government agencies and ask them to investigate the simultaneous fee reductions and the possibility of an illegal restraint of trade.

On December 4, 1998, NYSPA mailed out an Action Alert to every NYSPA member. This memorandum contained detailed information regarding the fee reductions and reviewed the specific provisions of each contract regarding members' options and rights under the their contracts. We explained what health programs were affected; how members could object to the fee schedule reductions, the rights of the managed care company to terminate their contracts if they objected and finally, how members could preemptively terminate their contracts.

On January 5, 1999, Seth Stein, NYSPA Executive Director and General Counsel, sent letters to Magellan, ValueOptions and UBH protesting the fee reductions. The letters focused on the impact of the fee reductions on patient access to care. Mr. Stein requested written assurances that the fee reductions would not be imposed on any psychiatrist who, in a reasonably timely way, objected to the fee reductions and that any actions taken to terminate psychiatrists from provider panels comply with requirements of state law. The letters also challenged the reductions as encouraging bifurcated treatment where the psychiatrist only provides medication and therapy is provided by a non-physician. NYSPA urged that the fee schedule be adjusted to encourage integrated treatment by a psychiatrist providing both medication and psychotherapy as the most cost effective and clinically effective form of treatment.

Finally, NYSPA is currently preparing letters to state and federal officials seeking an investigation to determine whether the simultaneous fee reductions resulted from improper collusive activities in restraint of trade.

Of course, we can simply mandate to "roll back" the fee decreases. Managed care companies are under increasing pressure to maintain their profitability. Reducing the cost of care by reducing physician fees is the simplest way to protect their "bottom line" and guarantee the ability to pay executive salaries and shareholder dividends. Each individual managed care company acting alone retains the right to set its own fee schedule and to reduce fees at its discretion. Such individual action is subject only to the forces of the market place and the willingness or refusal of providers to participate at the reduced fee levels. However, if managed care companies act in concert and conspire among themselves to drive down psychiatric fees, such conduct would violate federal and state antitrust laws. NYSPA will advocate for a government investigation of the simultaneous fee reductions and will continue its vigilance to respond quickly to make sure members are informed of their rights and aggressively pursue state and federal legislation to enhance patient protection, hold managed care companies liable for their decisions and improve patient access to care. ■

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Utilization Review by Managed Care Organizations: What You Need To Know About the New Law

The information presented below was provided by Vallencia Lloyd of the New York State Department of Health, Office of Managed Care, Bureau of Certification and Surveillance. It contains important points about Utilization Review by Managed Care Organizations, including mandated time-frames and appeal procedures –Ed.

Chapter 705 of the Laws of 1996 resulted in the enactment of Article 49 to the New York State Public Health Law which established detailed standards for the performance of utilization review (UR) activities by both managed care organizations (MCOs) and independent utilization review agents.

Registration Required For Some but Compliance Required For All

Article 49 requires all entities (except certified MCO's) conducting UR to be registered with the New York State Department of Health (DOH) or the New York State Insurance Department (SID). Those registering with DOH must renew their registration every two years. Although MCOs are exempt from registration as a utilization review agent, *they too must demonstrate compliance with Article 49* by obtaining DOH approval of their UR procedures. Required UR procedures are the same for both registered UR agents and certified MCOs.

Initial Medical Necessity Determinations

For services that require pre-authorization approval, the UR agent or MCO must make its determination within (3) three business days of receipt of the request for service. The determination must be made in writing and by telephone to the enrollee and their provider.

Subsequent Determinations

In the situation where approval is needed for continuing or extending an ongoing treatment, or to add services for an enrollee already under treatment, that determination must be transmitted by telephone and in writing to the provider within (1) one business day after receipt of all necessary information.

Requests for Reconsideration

If the UR agent or MCO makes an adverse determination with regard to pre-authorizing or continuing services, as noted above, without having discussed that determination beforehand with the member's prescribing provider, that provider can request a reconsideration of the determination. The reconsideration must be given to the provider within one (1) business day of the provider's request. The reconsideration is conducted by the enrollee's providers and the clinical peer reviewer making the adverse determination, or a clinical peer reviewer designated by the UR agent or MCO if the original one is unavailable.

Retrospective Determinations

Lastly, a UR agent or MCO can make a retrospective UR determination involving health care services which had previously been delivered and must provide that determination within 30 days of receipt of the necessary information to make a determination.

Emergency Services

It is important to note that emergency services are never subject to prior authorization nor shall reimbursement for emergency services be denied on retrospective review as long as such services were medically necessary to treat an emergency condition. The statute provides for a prudent layperson definition of an emergency condition in the determination of medical necessity.

Notices of Adverse Determination

All notices of adverse determination must inform the enrollee of the reasons for the decision, including clinical rationale, and instructions on how to initiate an appeal. In addition, all initial and appeal adverse determinations can only be made by a clinical peer reviewer. *The statute defines a clinical peer reviewer as a licensed physician who is in the same or similar specialty as the health care provider who is managing the treatment under review.* In the case of non-physician reviewers, it is a health care professional who is in the same profession and/or similar specialty as the healthcare provider who manages the treatment under review.

Appeal Time-Limits

An enrollee has at least forty-five (45) days after notification of an adverse decision to file an appeal and the MCO then has sixty (60) days to make a determination regarding the appeal. MCOs and/or UR agents must provide for expedited appeals for cases of continued, extended or additional health care services, or in cases where the enrollee's health care

[See Utilization Review on page 7]

Results are in!

As we go to press, the 1999 APA national election results were announced. Elected were the following candidates:

President–Elect - Dan Borenstein, M.D.
Vice-President - Paul Appelbaum, M.D.
Secretary - Michelle Riba, M.D.
Trustee-At-Large - Ann Maloney, M.D.
MIT Trustee-Elect - Sandra DeJong, M.D.
Area II Trustee - Herb Peyser, M.D.
Area V Trustee - Jack Bonner, M.D.

All proposed amendments were passed, with the exception of the proposed changes in the fellowship structure. Further details can be found in *Psychiatric News.*

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Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. The Bulletin is received by all 5,000 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. The Bulletin is published quarterly. Both classified advertisements and display advertisements are available. Please contact the managing editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

The opinions expressed in the articles or letters are the sole responsibility of the individual authors, and may not necessarily represent the views of NYSPA, its members, or its officers.

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From the Editor… Our First Anniversary

This issue marks the first anniversary of the new Bulletin. I would like to take this opportunity to thank the members of the Editorial Board, our contributors, and the executive committee of NYSPA for their support. Thank you readers for your thoughtful comments and suggestions. Our managing editor, Donna Sanclemente, and I look forward to another year of bringing you an informative and timely newsletter.

Leslie Citrome, M.D., M.P.H.

This past year has seen a lot of controversy regarding the future of our organization. While efforts to streamline costs are important, especially since reductions in cost can be translated to reductions in dues, there is no general agreement as to who will tighten their belts first. NYSPA was magnanimous in proposing a reorganization plan that would have saved APA some money but would have reduced New York State representation on the Assembly of District Branches. As events developed, it became clear that this reduction was minuscule compared to APA expenses in general, and in fact would have reduced local input into central activities, leading to even greater dissatisfaction on the part of the grassroots membership. The APA Board of Trustees, in their meeting in December 1998, made no real effort to downsize or reduce their costs. They did not set the example. The Assembly will meet again in May. This promises to be a lively topic of debate.

New York City politics brought Methadone Maintenance Treatment Programs to the headlines. Mayor Gulliani wanted to eliminate this treatment option as he believes that it perpetuates addiction, substituting one substance for another. Despite all the scientific evidence demonstrating real clinical and social benefit, the Mayor was steadfast. NYSPA was instrumental in sounding the alarm and mobilizing APA, ASAM, AAAP, and other associated groups to voice their concerns at all levels, city, state, and national. Ultimately, the mayor did back down. The evidence, and practical concerns, were simply overwhelming.

Managed care continues to be a major concern. Many of the articles in The Bulletin relate to this issue one way or another. NYSPA played a significant role in helping get the New York State Patient's Rights Bill passed, and is working with the Attorney General's Office in implementing it. Recently, NYSPA members received mailings from our Executive Director regarding fee reductions that were announced simultaneously by three major behavioral health managed care organizations. NYSPA is working hard to deal with this adversity. The Bulletin will continue to cover these issues. Your input, in the form of articles and letters, is very important.

By the time this issue is in your hands, the results of the national APA elections will have been announced (see box on page one.) It will be important to ensure that our national leaders are apprised of our local and State issues. I urge all of you to participate in this exchange of ideas, and have a voice in our future. ■

ANNOUNCEMENT

NYSPA Online Searchable Database Sports New Feature

We are pleased to announce that the NYSPA Online Searchable Database now includes "Yahoo! Maps" on a member's profile page. Yahoo! Maps provide a physical map of a member's primary office location as well as the ability to obtain detailed driving directions to the member's office from a visitor's location. Members with secondary office locations can look forward to a "Yahoo! Map" as well -- this feature will be available by the end of March.

If you have not yet signed up for the NYSPA Online Searchable Database, you may do so by signing up online at <http://www.nyspsych.org/members.html>. Alternatively, you can obtain a printed form by contacting the NYSPA office at (516) 542-0077.

LETTERS TO THE EDITOR

Letters to the Editor are welcomed but are limited to 750 words. The full text of all letters will be available on The Bulletin web site at <http://www.nyspsych.org/bulletin>.

An Open Letter to NYSPA Members

At last, we have some good news. On March 8, one of our antitrust cases, *Holstein vs GreenSpring*, will be in court in New York City before Judge Louis Kaplan a jurist we trust will see the merit of our case. We now hope to get beyond the procedural blockade managed care (MC) lawyers used to stall our cause for over two years.

Our case in NY is part of a gathering antitrust storm in courts across the country. *Stephens vs CMG* is being sent to the US Supreme Court for a review of Judge Wood's twisted decision that contravene past Supreme Court policies on antitrust law. Within weeks, other plaintiffs may wish to bring additional suits in other courts.

At times, the question is raised as to what can be gained by these antitrust actions. The answer is: the same relief being sought in the Microsoft case or in the case of the retail pharmacists where several defendant companies agreed to pay $700 million and change their anti-competitive business practices. In plain English, this suit doesn't need us as much as we need it.

Our psychiatric membership has felt demoralized by MC management for profit. Taking MC companies to court makes sense because without recourse to justice businesses simply won't change what is profitable to what is right for the community. Our antitrust suit is meant to force that change with the threat of billion dollar damage awards and court ordered changes. They feel our hot breath and know it is only a matter of time.

In January, while I was campaigning for trustee in the New York State, I contacted thousands of you asking you to call to participate personally in the New York suit. Many of you are already individually named plaintiffs as are the New Jersey Psychiatric Association, the American Association of Private Practice Psychiatrists (AAPPP) in which I am a Director, and our parent, the American Psychiatric Association. Now, we need wholesale NYSPA membership participation. Five thousand physicians and their patients are an important lobby.

Joining the suit gives the message to the court that this is our battle and not simply a protracted case. The court is reasonable when it refuses to go against a popular tide. We in NYSPA must show up with all the resources of our organization and a public outcry for help against business practices that are crippling our ability to help our patients.

We are not alone. In addition to our membership and our patients, we have friends in the legislature. Our cause is being championed by Congressman Jerrold Nadler, Congresswoman Carolyn Maloney, New York State Senator Pete Grannis and New York State Assemblymen Jim Brennan and Richard Godfry. They came to a NYCoDB legislative brunch in December and spoke stirringly about the need for expanded and unfettered psychiatric treatment for all our citizens.

We still face the problem of lost time, lack of a coherent strategy and concerted leadership. Our membership and our leadership are still in shock over the ongoing deterioration of our ability to treat our patients. The December "Magellan" letter by Seth Stein, showed that NYSPA is starting to work on a coherent strategy for the membership. We can expand on that initiative by our participation in this court action in March.

You need to know that after three years of investigation and the help of whistle blowers across the nation, we have more than enough facts to prove our antitrust case. And, as soon as we are firmly in court, you can be sure we will request judicial relief from the illegal practices that are defeating our ability to treat our patients.

Right now, as this letter goes to press, our president, Jim Nininger and other NYSPA members are working with Mr. Joseph Sahid, the lead lawyer in our suit, to see how NYSPA can join the suit, an action which will not cost us a single dollar. It is our moral and medical presence that is needed, not our money. Whether we join individually, as a District Branch or as NYSPA, all costs are being paid by the law firms that have undertaken this case.

We need courage, leadership and a unity of purpose to meet the challenges that are confronting us.

For information about the suit or how to join personally, I can be reached at: (212) 327-3055 or fax 212-737-8279 or e-mail edmd@iname.com

Edward M. Stephens, M.D.
APA Member since 1971

AREA II TRUSTEE'S REPORT

Reorganization and Other Matters

by Herb Peyser, M.D.

At the December Board meeting one could see the difficulties in moving the APA Strategic Plan from proposal to actuality. The Plan's goals are absolutely necessary. We have to restructure APA and make it more efficient and less costly. And lowering the dues will help retain and recruit members and make APA stronger and more able to carry out its mission. The main priority in that mission, given by the members, is advocacy, to fight the depredations of for-profit industry's managed care and return the conditions of the medical workplace to patients and physicians. To this end APA pursues legislative, regulatory, litigation and public relations initiatives, and the job of the Plan is to make APA more effective in carrying these out.

Herb Peyser, M.D.

Tightening Up the Belt

However, slimming down, tightening up, cutting expenditures and decreasing dues means cutting down on people, programs, projects, agencies and structures. But many of them have been developed for the same reason, for advocacy in one way or another, and they have strong constituencies devoted to them. Furthermore it means applying the same surgical principles to moving forward and creating new advocacy projects.

Obviously some of them are more critical than others, but as people rarely think that other people's projects are worth more than their own, tough prioritizing is needed from the center. People tend not to cut their own projects, so it is up to the Board. It would be good if the Board could set an example for the Assembly, Components, Area Councils, DBs, state organizations and central staff by cutting down on itself, its own projects, personnel and operating expenses.

The Board voted to stop subsidizing some distal Past Presidents attending Board meetings but that only pertains to ten years from now, and it did not cut any other membership on the Board. That might make it difficult to get the Assembly, Components, Area Councils, DBs, state organizations and staff to do much downsizing on their own projects and personnel.

At What Cost?

Many people feel strongly that downsizing member participation in APA governance and policy making is not the way to go. I agree. The cost to APA in loss of member interest, involvement and morale would be too great, and our attention should be directed more toward cutting projects and infrastructure than members. For example, increased use of telecommunications could lessen the cost of officer, governance, components and staff meetings and travel, and also decrease the necessity for some of the expensive centralized office space for the staff's work, with decentralization and regionalization of many staff and leadership activities.

Meanwhile it is difficult to see New York happily bearing the burden of the extreme decrease in DB and state organization autonomy as well as member participation and representation that was set out for us in the original version of the Strategic Plan. The impact on us of the severe cost cutting and centralization of control was seen to be far and away the heaviest of such burdens distributed throughout the APA, one not visited on any other DB, state organization, Area Council or other structure. Our joint Area VI (California) and Area II (NYS) position paper specifically called for cuts to be equitably distributed throughout the APA. We shall have to see what the Assembly does and how the Board deals with the Components in March before moving further with our own reorganization plans and accepting any cuts.

Reshuffling for Efficiency

The Board began rearranging the Committees and Councils in the Components in accordance with the Strategic Plan's priorities to increase efficiency, canceling some, splitting others, and limiting membership slots (but also limiting the number of positions anyone could hold so as to allow wider member participation while trying to decrease costs). There will be increased participation of allied organizations in Councils and Committees as we move toward integrating them with APA. The hard decisions regarding the Components were held over to March.

We have to be careful about membership morale. The beginning of a slow drop in membership reflects a general trend in all professional organizations. However, ours is not bad. The NYS Medical Society has lost almost 2,000 members in the past two years, so our decrease does not look bad at all. And yet there is talk among members and in some DBs about delinkage of the DBs from APA, a very dangerous road to go down (AMA did it and both the local and the central societies lost members). Yet one hears it from Texas, here in our Area Council and some DBs, elsewhere, and particularly in the Washington State Psychiatric Association.

The talk is not serious but reflects a mood. There is a lack of awareness on the part of the members as to what APA actually does for them, and here, what NYSPA does. APA has gone to a consulting firm for help in better getting the word out to the members as to its accomplishments, to communicate better with them, and also to help with its work with the DBs, to partner with them and to aid communication between the DBs themselves. There have been complaints that those in the center are not adequately responsive, not truly communicative. All this must be changed for this puts off members, and fewer members means decreased strength for advocacy.

Oldham's Proposal

Meanwhile APA has to go about its other business. The first draft of John Oldham's Task Force's Quality Indicators was reviewed and is in process. These will be clinically based and patient focused, and will help with evaluating care by health plans and organized systems of care.

There is further work in process in developing the new interactive voice response and voice-mail systems and the on–line bulletin board for advising members as to what is going on. Consolidation of staff and office activities (such as printing, billing, etc.) and getting the new Chief Financial and Information Officers on board should help move toward better organization and the saving of significant amounts of money.

Managing CME

A component is being developed to manage CME (the criteria of the accrediting agency, the ACGME, have become tighter). In addition to its educational value CME is one of APA's most significant sources of non-dues income, most noticeably at the Annual Meeting and the Institute for Psychiatric Services. There is concern over not having too much commercial support that might unduly influence the educational programs. Plans are being laid to work jointly with the DBs in regard to CME, and APA is looking into the use of the self assessment test, the Web, and CME for helping its members gain certification and recertification (among the specialties, we are the lowest in the percentage of Board certified members). Education is an important area for APA to be of use to its members, an APA priority just behind advocacy and membership.

APA continues to work with the other specialties in a problematic dialogue with AMA and its plans for its AMAP (Accreditation Program), dealing with credentialing, clinical performance, the environment of care, and possible requirement for 100% Board certification by, say, 2005.

Other matters included the approval of the Assembly's action paper against involuntary attempts to change sexual orientation, support for further work on tele-psychiatry (particularly helpful in prisons and rural areas), approval of the Delirium Practice Guidelines, support for free exchange of information between doctors and patients without doctors being subject to criminal or professional sanctions (this arose out of the US government's threats to doctors discussing medical marijuana use with their patients in California, although the Board has taken no position on medical marijuana use *per se*). Also it supported the necessary role of the Commission on Psychotherapy by Psychiatrists in reviewing Practice Guidelines before they are finally approved.

Budget Summary on Way

The budget summary will be published semi-annually in *Psychiatric News* and will be sent out in more detail to the Assembly Executive Committee, in the interests of increased accountability and openness of the APA. The number of international members is inching up towards 1000. The new 12–month (rather than 18–month) dues drop process has resulted in 1700 members still on the drop list, but every effort is being made to work with them and keep them in APA. The result of shortening the delinquent dues drop process, however, has been to increase APA's available funds at the moment.

Five DB Presidents-Elect addressed the Board, presenting some of the member and DB concerns noted above but also concerns with the cost and litigious quality of the ethics process, and concerns over ever mounting pressure from PAs, RNs and, particularly, psychologists for increased prescribing privileges.

Lastly, I would like to suggest that as the reorganization develops, if there are any problems, problems with the leadership or staff at the center or with NYSPA, call me. I'll help. ■

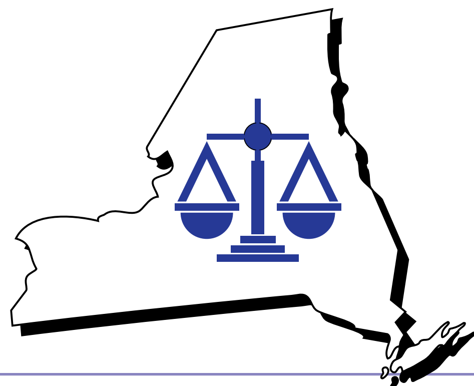
News from the District Branches

Legislative Brunch in Westchester County

The Psychiatric Society of Westchester (Westchester DB) held it's annual Legislative Brunch at the Crown Plaza Hotel in White Plains, New York on Sunday December 13, 1998. It was well attended by over 70 people including Congressman Gilman and Kelley and a representative from Congressman Lowey. In addition there were several state and county legislators present. A delegation from the Alliance For the Mentally Ill was there joining Westchester psychiatrists, and also the Executive Council from the New York State Psychiatric Association. Both congresspersons made a special point of noting that, despite the preoccupation of Congress with the impeachment activities, healthcare issues are of great concern in Washington. State and county legislators were very positive about the possibilities of making progress with parity legislation. They also were very interested in the formal remarks made by Dr. Villamena, Westchester DB President, Dr. Stabinsky, Westchester GR Rep and Dr. Perlman, Area II GR Rep as well as the informal discussion that took place at the tables during the lavish brunch set up by the Westchester DB - *Michael Blumenfield, M.D. Westchester Rep and Area II PA Rep. <Ronellan@aol.com>*

Public Forum in Rockland County

Despite the competition from the World Series, a capacity crowd turned out at the Public Forum on October 21, 1998 sponsored by the Mental Health Coalition of Rockland, of which the West Hudson Psychiatric Society (DB) is the lead agency. Speakers included Dr. Suzanne Vogel-Scibilia, a prominent psychiatrist from Pennsylvania who told of her personal struggle with bipolar disorder. Bouquets to Diane Polhemus, local consumer advocate and bridger at Rockland Psychiatric Center, who courageously shared her intimate and painful experiences on the road to recovery. Thanks to Mel Zalkin, clinical social worker and psychotherapist, who eloquently revealed the despair and suffering of the families whose loved ones have mental illness. We salute you all for letting us in on your lives and leaving us with so much hope. Thanks, also, to Commissioner of Mental Health Mary Ann Walsh-Tozer for her introductory comments and to County Executive C. Scott Vanderhoef who presented a declaration in honor of Mental Illness Awareness Week. – *Lois Kroplick, D.O., West Hudson Psychiatric Society PA Rep.*



Albany Report: Legislative Priorities for 1999

Barry B. Perlman, M.D.,
Chair, NYSPA Legislation Committee
Richard J. Gallo,
NYSPA Government Relations Advocate

As we prepare this article, the newly elected State Legislature has been in session for a month. The Legislature, along with everyone else with business at the Capitol, is trying to decipher the Governor's Executive Budget Request which, unlike prior years' discrete multi–bill packages, is lumped into a single voluminous document this year.

The overall legislative concerns for NYSPA in 1999 fall into roughly the same categories as last year's issues:

- The Executive Budget
- Parity
- Scope of Practice
- HMO Liability and other Managed Health Care Reforms
- Compulsory Psychiatric Hospitalization of Post–Incarcerated Sexually Violent Predators.

However, the similarities end there.

The Executive Budget is not so generous or benign toward health and mental health care as one might expect from the second year of budget surpluses that exceed $2 billion.

Parity for mental health coverage, despite significant progress last year in both Houses of the Legislature has major obstacles to overcome to win passage in the Senate.

The issue of who may diagnose and treat mental illness will be up for grabs again soon with the reintroduction of legislation to define and expand the scope of practice of several categories of "Mental Health Practitioners."

HMO liability legislation has already passed the Assembly but the Senate is certainly in no hurry to follow suit.

The Governor and the newly elected Attorney General have announced their combined, bipartisan support for legislation to compel psychiatric hospitalization of sexually violent offenders upon their release from prison.

The 1999-2000 Executive Budget Request

The overall budget for mental health services presented by the Governor is less troublesome in many respects than past years' budgets. For example, hospital based psychiatry is not singled out like in prior budgets for such things as targeted Medicaid caps on inpatient days. However, the budget is by no means benign with respect to psychiatry.

Of paramount concern to NYSPA is the Governor's proposal to eliminate Medicaid payments for Medicare deductibles and coinsurance for dually eligible enrollees where the Medicare payment is greater than the Medicaid fee.

The Governor has also proposed eliminating 18 "Office of Mental Health" psychiatric residencies currently funded by the State, in conjunction with OMH affiliation agreements with teaching hospitals.

Twenty–seven research program positions currently supported by the State's General Fund will have to be financed by outside grants and indirect cost recovery funds, or be eliminated.

The budget also proposes Medicaid cuts to hospitals totaling $511 Million some of which no doubt will fall upon hospital psychiatric departments.

Parity for Mental Illness Coverage

As noted above, one of the more encouraging legislative developments for psychiatry and the mental health community last year was the progress made on insurance parity legislation. The Assembly unanimously passed a broad parity bill introduced by Assemblyman James Brennan (D-Brooklyn) early in the session last year. In the Senate, parity legislation introduced by Senators Thomas Libous (R-Binghamton) was reported favorably from the Senate Insurance Committee (a first) to the Senate Rules Committee. Unfortunately, the Senate Rules Committee did not report the bill to the full house for a vote.

The progress being made on parity is due in large part to the dedicated grass roots and Albany-based efforts of the Mental Health Equality Not Discrimination (MEND) Campaign and the organizations it represents. The MEND campaign (of which NYSPA is a co-founder) is a coalition of more than 100 organizations urging enactment of mental health parity legislation. MEND members are busy again this year promoting insurance parity with legislators, the press, and business organizations.

Your legislator, especially your State Senators, needs to hear from you about the problems faced by people whose health benefits plan discriminates against mental illness.

Scope of Practice

In the closing days of the 1998 Session of the Legislature a major initiative was advanced and defeated that would have licensed a broad range of mental health practitioners including "mental health counselors," "creative arts therapists," "marriage and family therapists" and "psychoanalysts." The legislation also proposed to expand the scope of practice of currently licensed psychologists and social workers. The bill would have conferred upon all of the enumerated practitioners a scope of practice authorizing them to engage in activities presently reserved to the practice of medicine.

Although there are bills that have been introduced on the subject already this year, the operative legislation expected from the respective Chairmen of the Senate and Assembly Higher Education Committees is still being drafted as we go to press. The Medical Society of the State of New York and the New York State Psychiatric Association are resolute in their opposition to legislation granting to non-physician mental health practitioners practice activities for which a medical license has heretofore been required.

Managed Health Care Reforms

The hard fought and incremental process of re–balancing health care delivery in favor of the medical needs of consumers and the clinical judgments of their physicians is continuing in full force during the current legislative session.

Last year, the Governor signed into law a bill that assures patients and providers the right to an independent and external review of denials of coverage by health insurance companies and HMOs. Unfortunately, this important patient protection measure has limited applicability where mental illness is involved. Because of the exclusions and limitations on coverage for mental illness, the matter of appeal and review of an adverse determination is of questionable value if one has already exhausted their coverage.

As noted at the beginning of this article the State Assembly has already passed the HMO liability bill. A full court press by the broad-based Campaign for Quality and Choice, of which NYSPA is a member, is now underway to secure Senate passage of the bill. ■

We are Not Alone: Focus on MSSNY

by Barry Perlman, M.D., Chairman, NYSPA Legislation Committee, and Richard Gallo, NYSPA Government Relations Advocate

A crucial but unheralded component of NYSPA's government relations program is the building and maintaining of alliances. NYSPA comes together with many groups to promote a host of common legislative interests. Such alliances often help enable favorable legislative outcomes for Psychiatry. Among our most prominent friends and allies is the Medical Society of the State of New York (MSSNY).

When needed, MSSNY invests a considerable amount of its government relations' resources to NYSPA's legislative objectives. MSSNY invariably seeks NYSPA's guidance on all legislative matters that directly affect the practice of Psychiatry and routinely solicits our viewpoint on other public policy business affecting the practice of Medicine. Communications between our respective government relations' offices are open and frequent.

MSSNY's swift deployment of resources at the end of this 1998's legislative session proved invaluable to our securing the abrupt defeat of the most egregious mental health therapist licensing bill ever. In addition, MSSNY's commitment to NYSPA's initiative on Parity for mental illness in health care benefit plans was a driving force in 1998's development and subsequent victories of the broad-based Mental Health Equality Not Discrimination (MEND) campaign.

In view of MSSNY substantial record of support for organized psychiatry's legislative agenda in New York State it is disheartening to learn that only 12% of the psychiatrists in the State are members of MSSNY, while an average of 41.5 % of other specialists in the State are MSSNY members. As psychiatrists in New York State increasingly recognize the need for legislative and regulatory changes in order to protect their patients and their profession they must give more consideration to joining MSSNY along with NYSPA.

Recent changes in MSSNY's policy regarding recommending physicians for government panels and advisory groups further attests to the importance of MSSNY membership. The Governor's Office, as well as several state agencies — including the Attorney General's Office, the Department of Health, the Insurance Department, the Education Department and the Workers Compensation Board — seek the advise and counsel of MSSNY when recruiting physicians for important voluntary and paid posts. MSSNY in turn has called upon the specialty societies for recommendations and guidance in such matters. Dozen of psychiatrists now serving on important state panels came to be considered for such panels through this cooperative and informal process. However, MSSNY will no longer recommend or nominate physicians for government posts unless they are members of Medical Society. Some examples of where psychiatrists have been appointed with MSSNY's support are: the Medical Misconduct Board, the State Board for Medicine, the Patient Access to Records Review Panel, the Public Health Council, and the State Hospital Review and Planning Council, to name but a few.

MSSNY dues are $420 a year and it is not required that one join the AMA simultaneously. To join MSSNY you may call the MSSNY Membership Department at (516) 488-6100. We hope in the next year many more psychiatrists in New York State will become members of MSSNY. ■

Outpatient Civil Commitment in New York

by Howard Owens, M.D.

Dr. Owens is on the Editorial Board of the Bulletin and is active in the area of Psychiatry and the Law. He is Assistant Medical Director of the Forensic Psychiatry Clinic, located at the Criminal Court in Manhattan and is Clinical Associate Professor of Psychiatry at the NYU School of Medicine. He also has a private practice in general psychiatry. –Ed.

Howard Owens, M.D.

Psychiatrists in the State of New York may not be aware that for the past three years the state has been conducting a pilot project to evaluate the usefulness of out–patient civil commitment. This project has been operating out of Bellevue Hospital in New York City and is not yet available for general clinical use across the state. Depending on how the state legislature views the results of this project, it is possible that psychiatrists in New York may in the future have the option of outpatient civil commitment for the treatment of certain non–compliant patients.

In 1994 the state legislature authorized the establishment of a three-year program at Bellevue, which was to begin in July of 1995. The legislation establishing the program required that an outside evaluator be hired to study its effectiveness, and the City of New York contracted with Policy Research Associates, Inc. of Delmar, NY, to conduct this study. The final report from Policy Research Associates was published in early December 1998.

The pilot program was instituted at Bellevue under the leadership of Howard Telson, M.D. It provided for a prospective evaluation, with a control group, of the effectiveness of a court order on the treatment outcome of non-compliant out–patients. The patients in the study were drawn from the in-patient services of Bellevue Hospital and were required to meet the following criteria: (1) over age 17; (2) "suffering from a mental illness"; (3) incapable of surviving safely in the community without supervision; (4) lack of compliance with treatment that led to involuntary hospitalization at least twice in the past eighteen months; (5) unlikely to participate voluntarily in treatment because of mental illness; (6) in need of involuntary treatment in order to prevent relapse or deterioration which would likely lead to serious harm to self or others; and (7) likely to benefit from involuntary outpatient treatment. These criteria clearly defined a limited group of patients who would be eligible for the program. It is also important to recognize that the program was *not* designed to deal with patients who were identified as having a high risk for violence.

Patients who met eligibility criteria and consented to participate were randomly assigned to an experimental or control group. The experimental group were taken to court for a hearing to determine if they were suitable for outpatient commitment. The control group was discharged without a court order but with the same package of enhanced treatment services that was made available to the committed group.

Dr. Telson's Outpatient Commitment Coordinating Team consisted of himself as psychiatrist-director, two full time social workers, a secretary and a part time attorney. An additional part-time psychiatrist was added to the team in mid-1998. The Coordinating Team performed a variety of functions: initial assessment for inclusion in the program; formulation of a comprehensive discharge plan; presentation of cases to the court for commitment; and perhaps most important, the recruitment of clinical services in the community to provide the actual treatment to the patients, including in many cases residential treatment. In order to "sell" the program to community providers, Dr. Telson's group had to make clear to them that Bellevue Hospital would provide on-going back-up support in managing the referred patients. All the patients in the study (again, including those who were not under court order) received case management services. While the scarcity of certain community services was a problem, the Coordinating Team was generally successful in placing patients in the appropriate treatment. Sixty percent of patients were discharged to highly structured types of treatment, such as residential MICA programs or day treatment programs.

The results of the Policy Research Associates study were quite positive and yet ironic, since there was no statistically significant difference between the experimental and control groups when measured by acute or state rehospitalization, or in terms of the total days spent hospitalized during follow–up. Both groups benefited equally from the enhanced aftercare services provided, regardless of whether a commitment order was in place. For both groups there was a statistically significant reduction in rehospitalization over an eleven-month follow-up, compared to the year preceding the index admission. For the experimental group the proportion re-hospitalized went from 87.1% to 51.4%, and for the control group from 80% to 41.6%. There was also no difference in arrest rates (18% for experimentals and 16% for controls). The report concluded that the Coordinating Team made a substantial, positive difference in the post-discharge experience of both groups, by providing crucial functions in mobilizing treatment resources, and coordinat-

[See **Civil Commitment** on page 7]

Successful New York Meeting Spotlights APsaA Changes

by William D. Jeffrey, M.D.

Dr. Jeffrey is a Clinical Associate Professor at the New York University Medical Center Psychoanalytic Institute. He is Director of the Adult Outpatient Service of the Department of Psychiatry at Maimonides Medical Center. Dr. Jeffrey edits The American Psychoanalyst, the newsletter of the American Psychoanalytic Association, and has a private practice in Brooklyn. –Ed.

Over 800 attendees filled the Grand Ballroom of the Waldorf-Astoria to hear the Public Forum "Homophobia: Analysis of a 'Permissible' Prejudice" held December 18 at the Fall Meeting of the American Psychoanalytic Association.

The forum served as a milestone in the American's significant revision of its understanding of homosexuality. Once considered a symptom of serious pathology, it is now seen as a variant of human sexual behavior. The American has accepted many gay and lesbian candidates for training and has begun to appoint openly homosexual faculty and training analysts. "I am pleased that the American is sharing analytic thinking to help understand troubling social issues," commented Leon Hoffman, chair of the Committee on Public Information. "With this panel we are reaching out to the public, as we struggle with our own history."

Panelists were Professor Peter Gomes, Plummer Professor of Christian Morals, Harvard University; Nancy Chodorow, analyst and noted author; and Ralph Roughton, analyst and former chair of the American's Committee on Homosexual Issues. New York City Comptroller Alan G. Hevesi made the opening remarks. Paul Lynch chaired the panel. Barney Frank, congressman from Massachusetts, who was scheduled to attend but was unable to leave Washington because of the Clinton impeachment debate, wrote, "Your work against homophobia has been enormously important, and given the effort by the right wing to misuse psychoanalytic arguments to bolster their bigotry, your willingness to speak out in this way is enormously important to the country, and of great benefit to the victims of this prejudice."

The Public Forum highlighted broader, major changes within the APsaA. The Association has moved from a stance of anonymity to the public to an active involvement with significant political and cultural issues of our time. This shift is most prominently evidenced by the Association's current president, Robert Pyles. Pyles is one of the founders of the Coalition for Patient's Rights (CPR), an activist lobbying organization with special interest in issues of patient-therapist confidentiality.

These changes in the Association, now frequently called "the New American," were stressed by Past-president Marvin Margolis in his Plenary Address. "In response to the crisis in psychoanalysis, our Association has reinvented itself as a more welcoming democratic organization," he commented. "We have also begun to work more closely with other psychoanalytic groups. Local psychoanalytic alliances have become increasingly effective." Margolis, who emphasized democracy, openness and inclusion, summarized the multitude of areas in which the American has made extensive changes in these areas.

New York City Comptroller, Alan Hevesi, addresses the American Psychoanalytic Association at the Public Forum, "Homophobia: Analysis of a 'Permissible' Prejudice." Participants are (left to right) Paul Lynch, Peter Gomes, Nancy Chodorow, Ralph Roughton, and Leon Hoffman. Photo credit: Mervin Stewart.

Prominent New York psychoanalyst, Shelly Orgel, presented the Plenary Address, "Letting Go: Some Thoughts about Termination." Orgel considered termination as a vicissitude of the analytic situation containing the elements of the analytic process. He explored and widened Freud's views, in particular, termination's relationship to mourning and the permanence of the analytic transference. Finally, he presented meaningful vignettes from his own experience.

The trend to devalue analysis in general psychiatry was addressed in the Presidential Symposium "Psychoanalysis and American Medical Education for the Millennium: Recruitment, Teaching and Practice Building Opportunities in Medical Schools." The panel was introduced by Columbia's Herbert Pardes and chaired by Eric Marcus. Presenters were Janis Cutler, Burton Lerner, Steven Levy, Miriam Tasini, and Allan Tasman, president–elect of the APA. The panelists emphasized the importance of analytic humanistic values in the education of physicians in an age where economics has become such a malevolent driving force in the practice of medicine. The panel was co-sponsored by APsaA President Robert Pyles and American Psychiatric Association President Rodrigo Munoz.

The three major panels covered "Race in the Clinical Situation," "The Controversial Discussions: Fifty Years Later," and "Have We Changed Our View of the Unconscious in Contemporary Clinical Work?" Combining both educational and outreach functions were the well-attended Seminars for Students. The topics covered were the use of dreams in psychotherapy; viewing clinical material from three different theoretical perspectives; hate aggression and sadism in the countertransference; and boredom in therapy.

The 92 discussion groups continued to reflect the wide variety of topics in which an analytic perspective is of value. The groups varied from the traditional (dreams and termination phase), to the less traditional (intersubjectivity and Kleinian theory), to the unusual (sports and southern Asian literature).

"Art of Darkness: The Cinema of Roman Polanski" was the topic of the Workshop on Film. *Knife in the Water*, *Chinatown* and *Repulsion* were shown and discussed. Meet–the–Author, Robert Wallerstein discussed his book *The Talking Cures: The Psychoanalyses and the Psychotherapies.* Interested not only in the history of patients, but its own history, the Oral History Workshop, chaired by Nellie Thompson, continued its series on American women in psychoanalysis. Jerome Kavka discussed Helen Ross of Chicago and David Milrod discussed Edith Jacobson of New York City.

Winners of the psychoanalytic fellowship were announced at the meeting of members. These are outstanding individuals who are early in their career as mental health professionals. Chosen from the New York area were Luiz Gazzola, a PGY-5 fellow in public psychiatry at Columbia; Craig Katz, a PGY-4 resident in psychiatry at Columbia; Maurice Preter, a chief resident in the dual-board neurology–psychiatry residency at Albert Einstein; and Elizabeth Ann Danto, an assistant professor at the Hunter School of Social Work.

Paul Mosher, an Albany analyst who provided leadership in several key projects including important referencing works for the psychoanalytic literature, was given the first ever Award for Distinguished Service. Wilma Bucci, New York research psychologist was awarded honorary membership. Carol Hymowitz, a senior editor at the Wall Street Journal, was selected for an award for journalistic contributions. The Journal of the American Psychoanalytic Association prize went to Jennifer Downey and Richard Friedman for their paper *Female Homosexuality: Classical Psychoanalytic Theory Reconsidered.* The Menninger Prize went to J. Timothy Davis for his paper *Gone, but not Forgotten: Declarative and Procedural Memories of Early Relationships and their Contribution to Resilience.*

The next meeting of the American will be May 12 to 16 in Washington, DC. The American will meet again in New York City December 15-19, 1999.

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Civil Commitment

Continued from page 5

ing services. In the words of the Report "the assertiveness of the Coordinating Team in following up subjects (both controls and experimentals) ensured a level of continuity of care previously not experienced, either by providers or by patients." To cite only a single example, the team capitalized on having relationships with both Bellevue Hospital staff and outside agencies, such as the Visiting Nurse Service. This type of effort was apparently instrumental to the clinical success of the project.

Although there were anecdotal reports from clinicians who believed that a court order had been useful in keeping a particular patient in treatment, there was no statistically significant effect of the court order itself on the outcome of the experimental group. Various explanations for these results might be offered. In the first place, all patients were required to give informed consent to participate in the program. This factor created an element of self-selection, in the sense that patients who had some motivation to obtain treatment might be more likely to agree. When patients were brought to court, judges had difficulty understanding why commitment was even necessary, since the patient had already signed informed consent. At the same time the Mental Hygiene Legal Service also sought to ensure the patients' consent, perhaps with a view to secure enhanced outpatient services. During the study period there was only one patient for whom the MHLS successfully argued that commitment was unnecessary. The report suggests that the clinical and legal aspects of the Involuntary Commitment Program were continually conflated by all parties (including the patients, lawyers, judges, and clinicians), with the result that there was a loss of recognition of the difference between an initial consent to a discharge plan and a binding requirement to stick to it. As the program went along, the court hearings themselves were observed to become increasingly brief, less formal, and even perfunctory. One of the questions that remains to be answered about the project is whether the court hearings failed to convey to patients any significant mandatory or coercive message.

Another major problem was that the program initially had great difficulty negotiating with the New York City Police Department any procedure for picking up non-compliant patients, a job which the Police were reluctant to accept and skeptical about their legal authority to perform. Eventually, and only toward the end of the study period, an agreement was reached with the New York City Sheriff's Department to transport patients to Bellevue for immediate observation or hospital treatment. This problem may also account for the lack of discernible effect of the court order on clinical outcome.

On December 16, 1998 a public hearing was held regarding the effectiveness of outpatient civil commitment. At this point, the future of the concept is in the hands of the state legislature. Richard Rosner, M.D., Chair of NYSPA's Committee on Psychiatry and the Law has recommended that the Pilot Program at Bellevue and the Research Study of the program should be continued for an additional three years. At the present time there is insufficient data to determine if there is a group of patients for whom court–mandated treatment does improve compliance. An additional period of evaluation would permit the collection of more outcome data in an effort to answer the outstanding questions about the effectiveness of outpatient commitment.

One conclusion from the Pilot Program does seem clear, however, a conclusion which the average practicing psychiatrist might voice ruefully with a feeling of "I told you so": the Study demonstrates that an enhanced and aggressive program of community treatment does benefit de-institutionalized patients. The wisdom of Dr. Rosner's recommendation for further study of outpatient commitment really rests on two legs. First is the insufficiency of data to conclude the question as to whether the court order for commitment, in itself, is actually of any clinical benefit. The second point is that, even if the benefit is clearly demonstrated after further study, there would be significant problems in the implementation of an outpatient commitment law statewide. The clinical success of the Bellevue Pilot Program clearly resulted from the well-organized and consistent work of Dr. Howard Telson and his Coordinating Team. Any legislation designed to extend the program state-wide would have to provide for funding and for the necessary groundwork for the training and establishment of such teams across the state. Funds for the training of judicial and police agencies across the state would also be needed, so that the actual enforcement of commitment orders would be possible. Without such funding, leadership, organization, and training, an expanded outpatient commitment law would likely represent an empty promise. ■

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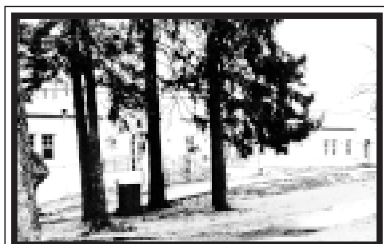

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Benefiting from Others' Suffering

By Anand Pandya, M.D.

Dr. Pandya was one of the four senior residents in psychiatry from the New York State Psychiatric Institute (NYSPI) who participated in the disaster response team for the 1998 Swissair crash. The residents assisted families and relief workers at both New York's JFK Airport and at the crash site in Nova Scotia. Moved by this powerful experience, these four residents have since formed a work group which seeks to organize a curriculum in disaster mental health for residents. Dr. Pandya is currently a chief resident at NYSPI and has recently served as co-chairman of the NYCoDB's Residents Committee. Dr. Pandya also chairs the MIT Committee of the Indo-American Psychiatric Association and serves as the recording secretary of NAMI-NYC METRO – Craig Katz, M.D.

After an unexpected trip to Halifax, Canada on Labor Day Weekend, my dominant, disturbing, recurrent thought was: "How am I going to use this experience?"

A few days earlier, a Swissair flight from New York City to Geneva crashed into the waters near Halifax, Canada and all aboard the flight died. The day after the crash, I was offered the opportunity to volunteer with the mental health response to this disaster coordinated by The American Red Cross and the New York City Department of Mental Health. I expected to spend a day at JFK Airport offering whatever kind of help I could to grieving family members, but midway through the day, I was offered the opportunity to fly to Canada with a group of family members.

I enthusiastically jumped on this opportunity and with this enthusiasm, my unease began. I knew that I would experience and learn more about normal and abnormal grieving in the next few hours than I had learned in three years of psychiatry residency. I could comfortably be excited about that. But I needed to examine other possible reasons for the excitement. The airport was a media circus, with a thicket of broadcasting antennae rising from the television station vans in the parking lot. I knew that my experience would interest my colleagues, my friends, my family, and almost anyone else. I could not have been more engaged in my job that day. I wanted to be as helpful as humanly possible. I was deeply moved by the grief I witnessed. But at times during that day, I felt that I had nothing to offer these families. On the flight to Halifax, I wondered whether I was there literally just for the ride.

While talking to other volunteers, I was reassured to learn that it was normal to feel peripheral. This type of grief work requires a 'light touch.' That evening, I hovered at a distance from a woman who fell to the ground crying. I thought that the few feet between me and her were a bad compromise between my desire to help and my desire not to intrude. I felt that I was intruding and not helping. Eventually, more experienced clinicians reassured me that in my ambivalence, I had stumbled on a fine execution of the 'light touch.' My distance gave space to grieve without abandoning the griever.

But my doubts that day were dwarfed by my feelings after returning home. I wondered how I was going to use this experience. My thoughts ranged from developing an APA workshop to calling my mother. When I did finally tell my mother, she was so proud that she arranged for an article about my experience in an Indian-American newspaper. I joined with three other residents who volunteered to form a group to make it easier for residents to participate in future disaster responses. (Any residents interested in this can get more information by calling me at (212) 213-6191.) And yes, I did use this experience to write a resident column for "The Bulletin."

But the question of how I was going to *use* this experience was itself deeply troubling. All psychiatrists use the suffering of others to earn their income and all residents use the suffering of others to learn. We want to enjoy our work but does that mean we enjoy seeing suffering?

When I finally articulated these doubts, I found that some of my fellow residents experience the same discomforts. One resident confided that he "freaked out" when he felt a "high" after a patient had a cathartic cry in a psychotherapy session. He had felt that they were making progress, breaking through defenses but the juxtaposition of his feeling of success with the patient's anguish was deeply disturbing.

I feel I have come to a difficult truce with this piece of countertransference. My excitement may be motivated by horrible things such as a need to feel important and it may be motivated by good things such as the sense that I am learning and developing my skills. Either way, I have to live with these feelings, and metabolize them without acting out on either the grandiosity or the subsequent guilt. In the end, this is how I used my experience in Canada. Yes, I learned about the 'light touch' needed to deal with grief. But I also learned about the 'light touch' needed to deal with what that grief raises in myself. ■

Utilization Review

Continued from page 1

provider believes an immediate appeal is warranted. Expedited appeals require a determination by the MCO or UR agent within two (2) business days.

Other Details

There are additional details to the UR requirements, such as maintaining confidentiality of medical records and not disrupting the delivery of services in the course of conducting UR, that have not been specified because of our attempt to limit this review to a summary of essential facts.

Where To Get More Information

Copies of the statute, Article 49 of the Public Health Law, can be obtained by contacting Jeanette Hill, Research Scientist II, Bureau of Managed Care Certification and Surveillance, Corning Tower Building, Room 1911, Empire State Plaza, Albany, New York 12237, (518) 474-4156. Questions you may have on this issue can also be directed to her attention. ■

The 1999 Medicare Highlights

by Seth P. Stein, Esq.

Last December, NYSPA sent out the eleventh annual Medicare update. Every NYSPA member received a 1999 Medicare memorandum and fee schedules for the localities where they practice. NYSPA is the only APA component that sends a Medicare update and locality fee schedules every year to every member. Highlights for 1999 are:

- This year will be the first year of implementation of a new methodology for assigning a "resource–based" practice expense value to each code. Under the new direction, HCFA was called upon to assess the cost in staff, equipment, supplies and expenses required in providing each CPT code in various settings. There are to be two separate Medicare fees based upon the site of the service. There is one fee for "Facility" sites of service (primarily inpatient) and a separate fee for "Non–Facility" sites of service (primarily office and outpatient). In the majority of cases, the higher practice expense value (and therefore the higher final Medicare fee) is assigned to the Non-Facility fee. When the service is provided in a hospital, a skilled nursing facility or hospital outpatient department, then a lower Facility practice expense (and therefore a lower final Medicare fee) is assigned to these services. HCFA justified imposing a lower practice expense for Facility services because in a Facility setting non-physician labor, supplies and equipment are typically furnished by the hospital or facility and not by the physician.
- Because of efforts by the APA to enhance the relative values assigned to the psychiatric codes, psychiatric fees will receive an average 4% increase in 1999. However, fees for some codes (e.g., 90805) are slightly less than last year because increases in relative values were offset by greater decreases in the Medicare conversion factor. Over the next four years, the new resource based practice expense methodology will be fully phased in and many psychiatric codes will have enhanced relative values.
- HCFA has adopted new regulations regarding private contracting and opting out of the Medicare program. In 1997, Congress amended the Medicare law to permit private contracting effective as of January 1, 1998. If a physician opts out of Medicare and enters into private contracts with patients, the physician is no longer subject to the Medicare limiting charge rules and may set a fee with the patient. While the new HCFA regulations do not change significantly private contracting procedures, HCFA has stated that it will issue its own sample documents for use by physicians who wish to opt out of Medicare. Unfortunately, HCFA staff do not expect the HCFA documents to be available until this summer or even later in the year. APA has retained legal counsel to update its private contracting documents and will post them on the APA web site (www.psych.org) shortly. The sample documents will also be posted on the NYSPA web site (www.nyspsych.org) as soon as they are available.
- Under new HCFA rules, Medicare services must be billed to the carrier and using the fee schedule for the locality where the service is actually provided without regard to the location of the physician's office. In the past, physicians could use the fee schedule for the locality where their office was located. Now, physicians who provide services at multiple locations must use the fee schedule for the locality where the patient actually receives the service.
- Medicare has not finalized guidelines for the documentation of CPT Evaluation and Management services (CPT codes 99xxx). The APA is working actively with the AMA to insure adoption of fair and workable documentation guidelines. There will be specific requirements for psychiatric services. The amount of documentation required will depend upon the level of E&M service provided. The greater the intensity of the service, the greater the level of documentation will be required. As soon as the documentation guidelines are finalized, they will be available on APA, NYSPA and Medicare websites. ■

NYSPA Calendar of Events

NYSPA Committees

Saturday, March 20, 1999 • 8:00 a.m. to 12 noon

Area II Council Meeting – Spring 1999

Saturday, March 20, 1999 • 1:00 p.m. to 5:00 p.m.

Sunday, March 21, 1999 • 9:00 a.m. to 12 Noon

NYSPA ECP Job Fair

Saturday, March 20, 1999 • 12 Noon to 3:00 p.m.

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