A Brief Overview of Mild Traumatic Brain Injury for Psychiatrists

Dr. Lyn Turkstra, Ph.D., Professor, Department of Communication Sciences and Disorders, Department of Neurological Surgery and Neuroscience Training Program, UW Madison
Dr. Eric Heiligenstein, MD, Clinical Director, Psychiatry, University Health Services, UW Madison

In this article, we review the definition and epidemiology of mild traumatic brain injury (aka concussion), typical signs and symptoms, and the typical recovery patterns and risks. We also consider psychiatric morbidity associated with concussion, and provide suggestions for management of psychiatric sequelae.

Mild traumatic brain injury (mTBI) is defined as an injury to the brain in which the individual has a loss of consciousness of 30 minutes or less, alteration of consciousness for less than 24 hours (e.g., feeling “foggy”), post-traumatic amnesia from a moment to 24 hours, and normal CT or MRI (1). Post-traumatic amnesia, which is sometimes referred to as post-traumatic delirium or confusion, is a state in which the person has no new conscious learning (anterograde amnesia), and thus appears confused because he or she is not updating memory for events since the injury. The prototypical example is the football player who has his “bell rung” and runs to the huddle of the opposing team.

Tables 1 and 2 summarize the typical signs and symptoms of concussion (1). Based on our experience at the UW-Madison College Concussion Clinic, we would add to the late symptoms a re-emergence of earlier symptoms that were thought to have resolved, when the student is academically or physically stressed (e.g., when studying intensively for exams and getting insufficient sleep) or when environmental demands increase (e.g., in a distracting classroom environment or with more complex subject material).

About 90% of individuals with mTBI will have returned to baseline levels of neuropsychological test performance within three months, but an estimated 5-10% are at risk for long-lasting cognitive and psychological impairments. There also is growing concern about individuals who initially appear to recover, but might still be at risk for delayed cognitive consequences, particularly individuals with a history of multiple concussions. These concerns have been prompted by reports of profound cognitive morbidity in aging athletes who sustained concussions earlier in life. Fears about long-term cognitive effects were highlighted by a recently published surveillance study from the Centers for Disease Control (2), which revealed that NFL players had a four-times higher risk of developing dementia or ALS than those in the general population, despite having lower overall mortality rates. Athletes in speed positions were at particular risk, compared to offensive and defensive linemen, adding support for the notion that running into relatively stationery objects at high speeds is bad for the brain. Unlike previous reports of chronic traumatic encephalopathy from autopsy samples in donated brains (e.g., (3), the CDC report surveyed all 3, 439 athletes who played football from 1959 to 1988, and thus is a more accurate reflection of true prevalence.

Table 1: Common signs of acute concussion

- Vacant stare (befuddled facial expression)
- Delayed verbal and motor responses (slow to answer questions or follow instructions)
- Confusion and inability to focus attention (easily distracted and unable to follow through with normal activities)
- Disorientation (walking in the wrong direction, unaware of time, date, and place)
- Slurred or incoherent speech (making disjointed or incomprehensible statements)
- Gross observable incoordination (stumbling, inability to walk tandem/straight line)
- Emotions out of proportion to circumstances (distracted, crying for no apparent reason)
- Memory deficits (exhibited by the athlete repeatedly asking the same question that has already been answered, or inability to memorize and recall 3 of 3 words or 3 of 3 objects in 5 minutes) Any period of loss of consciousness (paralytic coma, unresponsiveness to arousal)
Concerns about concussion in youth athletics led to the passage of Wisconsin Act 172, which went into effect July 1, 2012, and mandated the following:

(3) At the beginning of a season for a youth athletic activity, the person operating the youth athletic activity shall distribute a concussion and head injury information sheet to each person who will be coaching that youth athletic activity and to each person who wishes to participate in that youth athletic activity. No person may participate in a youth athletic activity unless the person returns the information sheet signed by the person and, if he or she is under the age of 19, by his or her parent or guardian.

(4) (b) A person who has been removed from a youth athletic activity under par. (a) may not participate in a youth athletic activity until he or she is evaluated by a health care provider and receives a written clearance to participate in the activity from the health care provider.

The definition of “health care provider” is deliberately broad, to encompass not only physicians but also qualified trainers and nursing staff who are likely to be on site during sporting events. Act 172 means that health care providers – including psychiatrists – must be aware of the signs and symptoms of concussion, typical methods for evaluating those signs and symptoms, and criteria for return to play.

Table 2: Symptoms of concussion

- Early (minutes and hours)
- Headache
- Dizziness or vertigo
- Lack of awareness of surroundings
- Nausea or vomiting
- Late (days to weeks):
  - Persistent low grade headache
  - Light-headedness
  - Poor attention and concentration
  - Memory dysfunction
  - Easy fatigability
  - Irritability and low frustration tolerance
  - Intolerance of bright lights or difficulty focusing vision
  - Intolerance of loud noises, sometimes ringing in the ears
  - Anxiety and/or depressed mood
  - Sleep disturbance

General recommendations for diagnosis and treatment of persistent symptoms following TBI

Psychiatrists should assess and monitor persistent cognitive and emotional symptoms following mTBI. For those patients with a recent mTBI a careful differential diagnosis should be considered. Psychiatrist should evaluate the risk of mental health disorders and that the emergence and maintenance of symptoms might be influenced by maladaptive psychological responses to the injury (Table 3). Given their prevalence and potential effects, all patients with persistent symptoms following mTBI should be screened for mental health symptoms and disorders, including the following:

- depressive disorders, particularly 1-3 months post-injury;
- anxiety disorders, including PTSD;
- irritability, emotional lability, or...
Persistent symptoms can be nonspecific and frequently not connected to the brain injury. Many adults present for evaluation of ADHD yet do not have the typical childhood or adolescent history consistent with the disorder. One should always screen for head trauma when any patient presents with complaints of poor attention or work/academic problems related to cognitive problems. A large percentage will have a history of mTBI rather than an “atypical ADHD”.

A selective serotonin reuptake inhibitor is recommended as the first-line drug treatment for mood and anxiety syndromes after mTBI. However, in some cases the combination of sedative, analgesic, and antimigraine effects from a tricyclic antidepressant might be particularly desirable, although these agents are generally considered second-line options. CBT has well-established efficacy for treatment of primary depression; as such it is appropriate in the treatment of mood symptoms following mTBI. Individuals with PTSD following mTBI should be offered a trial of trauma-focused CBT. The need for concurrent pharmacotherapy should also be assessed, depending upon symptom severity and the nature of comorbid difficulties (e.g., major depression, prominent somatic symptoms, severe hyperarousal, and sleeplessness, which all might limit psychological treatment).

When there are persistent cognitive complaints, the psychiatrist should make efforts to formally screen for cognitive deficits typically associated with mTBI. Aspects of cognitive function most commonly affected by mTBI are attention and concentration, information processing speed, and new learning, which readers will identify as symptoms of many other conditions. Thus, current practice recommendations focus on the clinical interview as the key screening tool. Interview guidelines are available for free download through resources such as BrainLine, the website for service members and veterans sponsored by the Defense Veterans Brain Injury Consortium (http://www.brainline.org/content/2009/06/tbi-screening-tool.html), and the Centers for Disease Control (http://www.cdc.gov/concussion/HeadsUp/physicians_tool_kit.html). Consideration should be given to potential comorbid diagnoses that could be present and have the potential to influence cognition, such as anxiety, depression, PTSD, pain, fatigue, sleep disturbance, or acute stress disorder.

Neuropsychologists are an integral part of mTBI management, and may be involved from the early stage of screening to full assessment of cognitive functions for those with persistent cognitive symptoms. While there are no current evidence-based guidelines for the timing or extent of neuropsychological assessment after mTBI, epidemiological data suggest that cognitive evaluation will most likely benefit those with problems persisting beyond 3 months, given that the majority of patients will recover within that time.

Management of mTBI

Given the rapid rate of recovery for most individuals with mTBI, the clinical rule of thumb is to begin with education, normalization of symptoms (e.g., reassurance that symptoms are typical of mTBI and that most people recover within a few weeks), and environmental modifications (e.g., to improve sleep hygiene). The management framework is that this is a well, healthy individual who requires some assistance to return to everyday activities, and not the chronic disease model associated with moderate-to-severe TBI. To use a Department of Defense phrase borrowed from Home Depot, the management philosophy in mTBI is, “You can do it, we can help.” Normalization and a well-being framework are critical in the mTBI population, as these patients have intact metacognitive skills and new, mild cognitive impairments and thus are particularly vulnerable to self-scrutiny and over-emphasis on deficits. If cognitive problems persist for longer than 3 months, it is appropriate to progress to more active interventions such as training in compensatory cognitive strategies.

For those with persistent cognitive problems, there is strong evidence that rehabilitation of cognitive impairments is effective, and patients with chronic cognitive complaints should be referred to a speech-language pathologist or occupational therapist for treatment. Cognitive rehabilitation for mTBI focuses on teaching compensatory strategies to support cognitive functioning in everyday contexts, as there is no evidence that direct remediation of cognitive impairments...
continued from page 3

(e.g., “memory training”) is effective or generalizes beyond treated tasks. As in other aspects of mTBI management, and indeed TBI management in general, there are no formal criteria for practicing cognitive rehabilitation; at minimum, the person should have experience with this population and familiarity with published evidence.

Pharmacologic augmentation of cognitive domains is an expanding area of research. Presently there is evidence to support the use of psychostimulants in various aspects of attention, processing speed, and vigilance, in the subacute phases of recovery. There have been minimally positive results for enhancing function, memory, and other executive function deficits. There is less research for their effects on chronic deficits although they are commonly used in practice. An important guideline in both situations should be the documentation of deficits by testing prior to the prescription of medication in order to define to the patient what is possibly remediable and what is not. Preliminary evidence for the role of dopaminergic agents in improving attention and other cognitive deficits is encouraging.

There is limited evidence (due to a lack of research) for the role of SSRIs for treatment of post-TBI depression and beta-blockers for control of agitated/irritable behavior. A need exists to clarify the role of psychopharmacology in post mTBI patients. We need to better understand the recovery process and clarify the characteristics of who might benefit from treatment.

By recognizing signs and symptoms and implementing appropriate management strategies, psychiatrists can play a critical role in ensuring that patients with mTBI receive appropriate assessment and intervention, and return to work and community life as quickly and smoothly as possible.

Heads Up: Brain Injury in Your Practice
CDC concussion management toolkit for physicians:
http://www.cdc.gov/concussion/headsup/physicians_tool_kit.html


---

CPT 2013, Coding Changes

Christopher Christian, MD, Outpatient Psychiatrist, Froedtert Health Medical Group, Menomonee Falls WI
Justin Schoen, MD

As you know, there will be tremendous changes to how we code and bill the psychiatric services we provide. Excellent summaries have been published by the American Psychiatric Association in their “CPT Crosswalk”. The APA also has two excellent video presentations, one on an overview of the coding changes, and a second on the nitty-gritty of how to do E&M coding. For more information see the APA website’s CPT clearinghouse at:

In brief, every psychiatric code an outpatient psychiatrist uses right now is being abolished. In my practice, we utilize 90801 for every 60 minute intake, and follow-ups with 90862, 90805, or 90807 depending on time spent with the patient (15, 30, 45 minutes respectively). 90801 is being cross-walked to two new codes, 90792 with medication services (this is essentially a “psychiatrist” or “prescriber” intake code) and 90791 for no medication services (The “psychologist” or “social worker” intake code). Our current 90801 yields 2.8 RVU’s while the new 90792 will yield 2.92. The bigger change is that psychiatrists can now use “E&M” coding for both intakes and follow-ups. (Technically, we’ve been able to use E&M for both for some time, though few have taken advantage of it, and some insurers were slow to allow it). These E&M codes are what all other physicians in primary and specialty care use for outpatient intake and follow-up appointments, and inpatient H&P and follow-up interviews. Until now a patient presenting to her PCP for depression and started on an SSRI after an interview and cursory examination would have been coded by him under E&M while an identical patient presenting to your office with a similar history and exam would have been coded 90801 by you, with different reimbursements and documentation.
requirements. Level 4 and 5 new patient visits (99204/99205) yield 2.43 and 3.17 RVU’s respectively, while the 90792 yields 2.92, nearly as much as 99205 without the same stringent documentation requirements. Therefore, I believe under most circumstances it will make sense for outpatient psychiatrists to utilize the 90792 intake code nearly exclusively. One important note is that under the new rules, a “new patient visit” now means a patient that has not been seen by you or by any other psychiatrist in your practice within the last 3 years. If for example the patient has been seen by your partner 2.5 years ago, they must be billed as a follow-up. 90862 is being completely disbanded. A new 90863 code has been created for medication management (in conjunction with psychotherapy) by a prescribing psychologist; it is imperative to note that 90863 cannot be used by psychiatrists at any time.

A new “add on” code 90785 has been created for Interactive Complexity. Historically used as a stand alone code by child psychiatrists and psychotherapists to capture the added complexity of interacting with children, they have been expanded to include other situations where communication is more complex (e.g. interpreter, hostile/resistant patient necessitating collateral, etc). They are an “add on” code meaning they cannot be billed in isolation. They can be added on to an intake 90792 code, to any psychotherapy code, along with group therapy 90853, or as a second add on to E&M Psychotherapy (for instance a 99213 + 90833 + 90785). The interactive add on code cannot be billed as an add-on to E&M alone, or to the new crisis codes 90839/90840. Please see the excellent one page handout by the APA / AACAP available on the APA’s CPT website. http://www.psychiatry.org/File%20Library/Practice/Managing%20a%20Practice/CPT/Interactive-Complexity-v2-REV-11-4-12.pdf

In addition there is now a crisis psychotherapy code 90839 for up to 60 minutes of crisis psychotherapy. Each additional 30 minute block of time beyond is eligible for an add on code of 90840. 90840 cannot be billed without 90839. 90839/40 cannot be billed with interactive complexity.

\[
\text{continued on page 6}
\]
These E&M codes have specific documentation requirements in three domains (History, Exam, Medical Decision making), and through a (somewhat complicated) algorithm arrive at one of five “levels of service”. 99211-99215 are follow-up E&M codes for established patients (more on that later), and 99201-99215 are initial intake E&M codes for new patients. There are additional codes for inpatient visits, which are similar but not covered here. Those of you who do psychotherapy will likely be using an E&M code plus a second modifier code that specifies how much of the visit was performing psychotherapy. For instance you might bill an E&M level 3 plus a modifier for 30 minutes psychotherapy. Under the new guidelines 16 minutes of psychotherapy is sufficient for the 30 minute code. Check with your coding department and the APA for more details. I’ll focus the remainder of this article on E&M coding itself, which is likely the most daunting change for psychiatrists to adapt to. Since most of my practice is outpatient, the examples used will be for outpatient visits, though the general principles are equally applicable to inpatient visits.

Components of E&M

E&M is composed of three key elements: History, Exam, and Medical Decision Making (MDM). Each note you generate for a patient encounter can be scoured by a coder (or by you first, hopefully!) to gather which “level” each of the key elements reaches. Each component has one of four possible levels (Problem focused to Comprehensive for History and Exam, Minimal to High for MDM). There are grids showing which levels are required for which codes available on the APA website; refer to that or contact your coding department for more information. Each of these levels of a given key element would support a certain E&M code. For instance a Comprehensive history would support a 99215 (level 5 follow-up visit). The key to remember is that new visits require 3/3 elements (the lowest element makes the grade) for a given level, whereas for established follow-up patients it’s 2/3. For instance, a “Comprehensive History” plus a “Comprehensive Exam” plus “Moderate Medical Decision Making” would support a 99204 (level 4 H&P) due to the lowest element choosing the level, whereas the same documentation in a follow-up would be a 99215 (level 5 follow-up) due to the 2 out of 3 element rule. The take home point is that by examining your documentation for each of the 3 key elements, the final billing code can be accurately assigned.

History

A history is composed of four parts: Chief Complaint (required for all notes), HPI (history of present illness), ROS (review of systems), and “PFSH” (Past, family, social history). Every note requires at least a chief complaint and one point of HPI. Please note that not including a chief complaint renders your note insufficient by E&M standards, no matter how voluminous the rest of the HPI and Exam is. A chief complaint is usually the patient’s own words but can also be stated as “follow-up for depression”. Just writing “follow-up” is insufficient.

History of Present Illness: SIG-E-CAPS is not enough

You can document many paragraphs of information on the patient’s depressive symptoms, and still not hit an “extended” HPI necessary for a Level 4 or 5 history despite spending the same amount of time and cognitive effort. An extended HPI consists of a chief complaint with 4 “elements” which include:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs and Symptoms

A thorough HPI that includes all eight SIGECAPS (sleep, interest, guilt, energy, concentration, appetite, psychomotor slowing, and suicidal ideation) elements and nothing else actually gives you just one “point” for HPI elements for “Associated signs and symptoms”. An HPI that includes some of SIGECAPS but also describes the depression itself with some of the above HPI elements (“depressed mood began 3 months ago, is worse in the morning, was triggered by job loss, has associated SI/sleep disturbance/appetite loss) will then meet E&M coding criteria for an “extended” HPI and allow you to reach for Level 4 or 5 if you’ve done an appropriate amount of work. You already ask these questions in some way or another, the key is effective documentation to match the work you’ve put in.

ROS: You do it, so write it

For a 99213, you are required to have one point of ROS. Sometimes this can be divined by a generous coder from the text of your HPI, but it’s best to separate it out. You can’t count any psychiatric symptoms in the ROS since that’s what your HPI is for (no “double dipping”). We all ask at least one point of ROS every visit anyway as part of checking for side effects or further elucidating somatic aspects of psychiatric illness, though we often fail to document it. For instance each of the following lines would count as a point of ROS:

- Constitutional: no weight or appetite change (good to ask each patient every time)
- CV: no Palpitations (anxiety patients, stimulant patients)
- Resp: no shortness of breath (anxiety patients)
- GI: No nausea or diarrhea (I ask most patients on SSRI’S)
- Integumentary: no rash or photosensitivity (asked of Lamictal patients among others)

continued on page 7
Neurologic: headaches, balance issues
There are many other, very clinically appropriate examples of ROS questions that we are already asking but just not documenting. I’ve been told by our coding department that unfortunately sexual dysfunction counts as “psychiatric” ROS and not GU, even physical aspects of sexual functioning such as lubrication and erection.

PSFH: a bit of a disclaimer
Psychiatry is more Past, Family, Social History (PSFH) focused than most other specialties, but we again just need to document clearly and ideally separately. One point of PSFH is needed for 99214, zero for 99213. If you’ve asked the patient and there are no changes, a dated disclaimer would count: “No change in past family or social history since 10/02/2012”, provided your note dated 10/02/2012 (most likely the H&P) includes a full PSFH. Alternatively you could simply write “no alcohol or illicit drugs” (one point), “newly diagnosed with lupus” (one point), etc. My coding department strongly discourages writing “PSFH” as an abbreviation within your note, but seems ok with me writing out “No Past, Family, Social history changes since MM/DD/YYYY”. Check with your coders for documentation advice.

Exam
When you read E&M handbooks, make sure you’re looking at the 1997 “Single System Guides”. The APA has a nice chapter on E&M single system coding in PDF format. In brief, whereas a primary care doctor doing an H&P on a new intake would probably do a full exam of all major organ systems, doctors are allowed to do focused but complete “Single System Exam” per the 1997 guidelines and still reach a higher level exams. Please review the APA’s chapter on this for all the “bullet points” that exist for psychiatry. Much of your current mental status exam (though not all) will count as a bullet point. A level 3 follow-up needs 6 bullets, level 4 needs 9 bullets, level 5 needs 100% of the possible psych bullets along with Appearance, 3 Vital signs, and either Gait/station described or muscle exam. In practice, I anticipate it would be hard to get a “Comprehensive” psychiatric exam (which includes much of the Folstein Mini-Mental exam) routinely, outside of the initial intake (where many of us already do partial or full Folstein plus vitals), or in certain specialized clinics (e.g. geropsychiatry) where memory and other MMSE aspects are routinely tested. However with attention to documentation, a “Detailed” exam would be reachable for many patients.

Medical Decision Making
MDM looks pretty odious on the surface but is manageable once you understand how it applies to psychiatrists. It gets its own page of algorithm just for this one component. It is comprised of three criteria, A, B, C. A is essentially the number and status of diagnoses. B is Risk. C is Data. Each level is rated, and again the best 2/3 applies to the overall level of MDM reached.

In brief, you’ll probably rarely go high on Criteria C and can probably ignore it in favor of Criteria A & B. Doctors who independently perform or review tests get extra points on criteria C. The ones that are relevant to psychiatry are ordering a lab test (antipsychotic labs for instance) gets 1 point, reviewing old records gets 2 points.

Criteria A counts the number and status of relevant diagnoses. For instance a patient’s diabetes wouldn’t count, unless you’re the primary one treating it. If a patient has known bipolar disorder and is worse today (2 points) you’d have “low” risk. Clearly documenting each specific diagnosis and status is very important. For instance, I might forget to clearly mention “alcohol dependence, in full sustained remission, stable” as a second or third diagnosis in the assessment but clearly documented “still sober 3 years” in the HPI. Documentation of all psychiatric illnesses and plainly stating whether they’re stable, improving, or worsening is something we should have been doing all along anyway.

Criteria B is more favorable: Each visit you prescribe medication you automatically qualify for “moderate”. You might qualify for “High” if the problem is a “psychiatric illness with potential threat to self or others”, according to a handout put out by the Wisconsin Medical Society. This is obviously an ambiguous statement and should be clarified with your coding department as to what standard they suggest.

Killing Time
Until now most psychiatry CPT codes were explicitly or at least implicitly based on time. In our practice we use 90862 to code for a 15 minutes visit, a 90805 to code for a 30 minute visit, and a 90807 to code for a 45 minute visit. The E&M rules upend this completely. Although you will find associated time amounts for each visit, these are really only applicable if you code “based on time”. This event is triggered if >50% of the time is documented to be spent on Counseling or Coordination of Care. Counseling explicitly excludes psychotherapy. Examples would be a 25 minute visit with a bipolar patient in which 13 minutes or more spent on teaching about or discussing the diagnosis itself (aka psychoeducation), the treatment options, teaching family members, calling or writing his PCP to coordinate treatment of his atypical-induced high cholesterol, etc. In this situation you would be able to bill 99214 (Level 4 follow-up) without the typical documentation needed to support it, provided you documented clearly the 50% condition. But for most visits you will likely no longer be basing the code itself on time, but rather on the documentation (and thus hopefully the “cognitive labor”). For instance you could spend 20 minutes gathering (and documenting!) a “Detailed” history about a
patient’s manic symptoms, do a “Detailed” exam, and reach a
99214. Conversely you could spend 40 minutes on the same
patient, do an even more thorough history and exam, but not
document clearly, and only be able to bill a 99213 as a result.
So in a sense, “time” is not very relevant anymore—it’s all in
what you do and what you document.

Conclusions
Most outpatient psychiatrists will choose to use the 90792
intake code over E&M. For follow-ups (where E&M is required),
most of your visits will be Level 3 or 4 (99213 or 99214). There
should be very few Level 2 follow-ups unless you have issues
with implementing the changes in documentation (for instance
forgetting to put an ROS into every note). It will be hard to
reach Level 5 follow-ups in the absence of a thorough exam
(a full MMSE exam at the visit with vitals) or High Medical
Decision Making (acutely suicidal patient for instance), which
probably will be infrequent for most outpatient psychiatrists.

It makes sense for your practice to begin preparing now for the
new codes. Your billing department should verify with each
insurer that they are aware of and will accept the new codes.
Many psychiatrists have contracts with insurers that limit
them to the 90801/etc, which will no longer exist. You should
skim all APA provided handouts and if you are not comfortable
with E&M start by watching the APA’s video lecture on the
topic (which also provides Continuing Medical Education
credits). Then, design your own template that captures the
key E&M elements. I suggest focusing on History and Physical
exam at first for your follow-ups (since you only need 2/3) as
these are more intuitive than the MDM component. Make
sure your template includes a CC, HPI (4 elements ideally),
ROS (only 1-2 points needed depending on the code chosen),
documented PFSH, and a mental status exam that uses the form
and language from the “bullet points” of the single system
exam. For instance, commenting on the gait of the patient
is something you might not do now but certainly observe.
Practice writing some notes in the E&M format. Ask yourself
what level you would have hit. Your target should be 99213
or higher, since that (as of now) roughly corresponds to the
90862. 90863 should not be billed for by a Psychiatrist, Nurse
Practitioner, or Physician Assistant (all of whom will bill E&M).
Your more complex patients could hit 99214 or even 99215.
Once you’re comfortable with history and exam, start working
with MDM. Count the number and stability of diagnoses and
whether you’ve prescribed medications, and see how that affects
your code. Creating a template or decision tree may help you
rapidly and accurately decide which code you’ve reached. If
you work in a larger institution with coding support, ask them
to audit a few of your notes now. This will help you be ready
come January 1, and avoid having payment denied due to poor
documentation.

---

2013 Integration Innovator Awards

**Wisconsin Nicotine Treatment Integration Project (WiNTiP)**

In 2012 WiNTiP introduced “Integration Innovator Awards”
as a mechanism to recognize and encourage stakeholder
organizations to take initial steps to integrate the treatment of
tobacco dependence. WiNTiP is pleased to announce that the
Integration Innovator Award program is being expanded. For
2013, two categories of awards will be made: Two organizations
will be awarded up to $10,000 each to fully integrate the
treatment of tobacco dependence into their clinical work,
while five organizations will receive up to $4,000 each to take
concrete steps toward full integration. Proposals are due January
15, 2013. For full details regarding eligibility and timeline as
well as application information visit:

More than just medical professional liability insurance...

Attention Wisconsin Psychiatrists:

NEW RATES!

SAME GREAT PROTECTION!

Find out why switching your medical professional liability insurance coverage to The Psychiatrists’ Program will provide you with a comprehensive insurance program and might even save you some money. Contact us today for your personalized quote!

You need a medical professional liability insurance program that is more than just a policy. To safeguard your practice and reputation, you need a full-service program that includes proactive risk management resources and strategies, offers expert advice on call, and boasts a proven claims defense record. Anything else is risky business. That’s why you should trust The Psychiatrists’ Program.

- More than 18,000 psychiatric claims handled
- $50,000 administrative defense coverage at no additional charge
- Coverage for forensic services and telepsychiatry
- In-house risk management, free CME seminars, online resources and toll-free helpline
- Occurrence and claims-made policies available*
- Premium discounts - and much more!

www.PsychProgram.com | TheProgram@prms.com | (800) 245-3333 ext. 389 | twitter@PsychProgram

*may vary by state
Clinical Psychiatry in the News, In Brief:

LAWMAKERS AGREE ON REVIEWING FIREARM ACCESS FOR PEOPLE WITH MENTAL ILLNESSES (from the AMA Morning Rounds 12/19/12)
The Wall Street Journal (12/19, A6, Fields, Jones, Subscription Publication) reports that in the wake of the Newtown, CT shootings, political leaders in Congress from both sides of the aisle have agreed that legislation on firearm access for people with mental illnesses should be revisited. For the past 42 years, Federal laws have prohibited the sale of firearms to those “adjudicated mentally ill or involuntarily committed.” The problem with expanding this definition is that it will interfere with patients’ rights to privacy. An existing National Instant Check System, run by the Federal Bureau of Investigation, depends upon records sent to it by the states. However, a 1997 ruling by the Supreme Court held that states’ contribution to the database were strictly voluntary.

Trend toward deinstitutionalization scrutinized. The Treatment Advocacy Center’s E. Fuller Torrey, MD, a psychiatrist, and Doris A. Fuller, in an opinion piece for the Wall Street Journal (12/19, A19, Subscription Publication) titled, “The Potential Killers We Let Loose,” argue that improperly treated mental illness, not the easy availability of guns, is at the root of the epidemic of mass shootings. The authors tie this to a dramatic decrease in the number of places available at psychiatric institutions, from 559,000 fifty years ago to 43,000 today.

Expert: Even psychiatrists struggle to pinpoint who may turn violent. The National Journal (12/19, Quinton, Subscription Publication) reports, “Studies show that even people who have been diagnosed with a serious disability -- like schizophrenia -- are only slightly more prone to violent behavior than the general population.” In fact, “even psychiatrists struggle to pinpoint who could turn violent. ‘We are really terrible at anticipating behavior, or predicting behavior. There’s no theory -- in psychology or psychiatry -- that gives us a good basis or framework’ to predict what will cause a young person to act violently, said Dr. Victor Schwartz, medical director at suicide-prevention group The Jed Foundation.”

Associating mental disorders with extreme violence may fuel stereotypes, experts say. The PBS NewsHour (12/19, Marder, Kane) “The Rundown” blog reports, “Associating mental illnesses or disorders with extreme violence without real evidence can add stigma to already stigmatized conditions and fuel harmful stereotypes, mental health experts say. It’s irresponsible, said Dr. Ken Duckworth, a child and adolescent psychiatrist and medical director for...the National Alliance on Mental Illness, adding that when catastrophic things happen, people often look for a psychiatric diagnosis.”

COLORADO GOVERNOR PROPOSES MENTAL HEALTH FUNDING PACKAGE (from the AMA Morning Rounds 12/19/12)
The Denver Post (12/19, Booth) reports that Colorado Gov. John Hickenlooper proposed measures to broaden the discretion of mental health professionals in deciding whether persons with mental illnesses should be committed if they pose a threat to themselves or others. At the same time, he proposes allocating an additional $18.5 million annually for mental-health funding with the idea of opening a mental-health crisis hotline, adding psychiatric beds, establishing walk-in centers, improving transitional mental healthcare, and the immediate entry of information about court-ordered mental-health holds into firearm registries run by the Colorado Bureau of Investigation. Reuters (12/18, Coffman) quotes the governor, who stated, “No single plan can guarantee to stop dangerous people from doing harm to themselves or others.” He added, “But we can help people from falling through the cracks.” The governor’s proposals would need to be approved by the state Legislature. Hickenlooper said his proposal balances the protection of the civil liberties of people with mental illnesses while bolstering public safety.

The Denver (CO) Business Journal (12/19, Sealover, Subscription Publication) reports that the governor said his proposals “would help hospitals by keeping some mentally ill patients out of overcrowded emergency” departments. However, the “Colorado Hospital Association (CHA) leaders said afterward that the effort, while helpful, doesn’t address a major issue facing mental health today: A state accounting rule that allows facilities to bill for treatment of physical- or mental-illness symptoms -- but not both at the same time.”
ESCITALOPRAM GENERIC EXCLUSIVITY:
Teva pharmaceuticals granted 180 days exclusivity for first generic form of escitalopram.

USPTO EXTENDS SCHIZOPHRENIA DRUG’S PATENT PROTECTION:
Reuters (9/25, Cohen) reported that the US Patent and Trademark Office granted BioLineRx’s request to extend the patent it holds for BL-1020, a novel schizophrenia treatment. The biopharmaceutical development company said the USPTO granted a nine-year extension to its existing patent protection for BL-1020, making it valid until 2031. At present, BioLineRx is performing a Phase II/III trial with a primary goal point of enhanced cognition among patients with schizophrenia; and the company expects to release the results of the trial next year.

TREATMENT FOR SOCIAL WITHDRAWAL IN AUTISM?
Science Translational Medicine (Berry-Kravis EM et al., 2012) published an article demonstrating considerable improvement in social behavior through administration of arbaclofen in subjects with fragile X syndrome and symptoms of autism. In their randomized, double-blind, placebo-controlled crossover study of 63 subjects, showed considerable benefit in social engagement through ABC-Social Avoidance scale scores, suggesting a possible medicinal approach to a key symptom of autism and autism spectrum disorders.

BENZODIAZEPINES INCREASE RISK OF DEMENTIA:
BMJ published a cohort study involving 3,777 community-dwelling people aged 65 or older (Billioti de Gage S et al., e-pub ahead of pring). The authors showed that new use of a benzodiazepine increased the risk of dementia dramatically (hazard ratio of 1.6; 95% confidence interval, 1.08-2.38).

AUTISM IN DSM-5:
Research published in the American Journal of Psychiatry (Huerta et al., 2012) indicates that, contrary to earlier reports, most children currently diagnosed with pervasive developmental disorders in DSM-IV will continue to have that diagnosis under DSM-5. In the evaluation of 4,453 children with DSM-IV diagnosis, 91% were identified with DSM-5 criteria.

ADHD IN ADULTHOOD:
A study (Archives of General Psychiatry, Klein et al., 2012) of 135 males with ADHD and 136 without, followed for 33 years, showed worse educational, occupational, economic and social outcomes, including more divorce, for those with ADHD diagnosis as children. In addition, higher rates of antisocial personality disorder and substance use disorders were noted, but not higher mood or anxiety disorders.

EXERCISE AND NEUROPROTECTION:
In a cohort study of nearly 700 seniors in their 70’s, Gow et al (Neurology 2012) found that increased exercise was associated with less cortical atrophy and fewer white matter lesions. Of course, causality could not be inferred.

ADHD AND AGE:
According to the work of Zoëga et al., (Pediatrics 2012), in a nationwide study of nearly 12,000 children in Iceland, the younger the relative age within a class, the lower the standardized test scores and the greater the likelihood of being prescribed medication for ADHD. This underscores the findings we reported on in our first clinical corner nearly a year ago in which a cohort study of over 900,000 Canadian children found that the youngest children in their classes were over 30% more likely to be diagnosed with ADHD than those born nearly a year earlier. The lead author of that paper published in CMAJ, Richard L. Morrow, expressed concern that immaturity may be misdiagnosed as a mental health issue as a result, going so far as to express concern in the press that we are medicalizing a subset of a normal developmental range of behavior.

SUBSTANCE ABUSE ON THE RISE:
Reuters (10/23, Seaman) reported that US diagnoses of alcohol and drug problems increased by 70% between 2001 and 2009, according to a study published online Oct. 22 in the Archives of Internal Medicine.

Psychiatry In Wisconsin:

WISCONSIN PRESCRIPTION DRUG MONITORING PROGRAM TAKES EFFECT JANUARY 1:
The PDMP is a statewide program that collects information about controlled substances and other drugs that have a substantial potential for abuse that are dispensed to patients in Wisconsin. The PDMP discloses the information to users who are legally authorized to obtain the information.
Mental Health Policy News:

NATIONAL SUICIDE PREVENTION STRATEGY:
The Obama administration announced a national strategy to prevent suicide, coinciding with suicide prevention week. The story was picked up by the AP (9/11) stating that the administration is “urging a new focus on preventing suicides, especially among military veterans - and is beefing up the nation’s crisis hotline to help.” The Federal government “announced...it will boost staff by 50 percent at the national hotline - 1-800-273-TALK - that's open to military and civilians alike. It provided $55.6 million for state and local programs, and highlighted Facebook features that link distressed users to counselors.

Mental Health in the Popular Press:

DEPRESSED MOMS = SHORT KIDS?
A journal Pediatrics article (Surkan et al., 2012 on line) based on longitudinal data found that children whose mother’s became depressed in the first 9 months following birth were more likely than their peers to be short for their age by preschool.

ABOUT 84% OF HUMAN GENES ARE ACTIVE IN THE BRAIN:
According to research published in Nature (Hawrylycz MJ et al., 2012) over 80% of the human genome is expressed in the brain, a vast majority of the over 20,000 genes in the human genome, underscoring the complexity of neuroarchitecture and human neurodevelopment.

SLEEP DEPRIVATION AND DESYNCHRONIZATION:
CNN reported (10/18) that recent research using resting state fMRI showed reduced coordination of activity in the default network during rest in sleep deprived subjects.

SSRIS AND STROKE:
Many news outlets picked up on a journal Neurology (Hackam and Mrkobrada) meta-analysis of 16 studies including about 500,000 individuals, showing an increased risk of hemorrhagic stroke with SSRI use. This risk translated to one in 10,000 for anyone taking an SSRI for a year, with highest risk in the first weeks and months of starting the medication.

BAD FOOD = BAD BRAIN?
CNN (10/19, Wilson) reported in “The Chart” blog that research by Timothy Verstynen and others (presented at the 2012 Society for Neuroscience conference) suggested that bad food choices can result in poor brain function. This was inferred by fMRI connectivity analysis of data during Stroop Task performance (word color mismatch) in which “overweight and obese participants’ brains showed more activity during difficult questions, suggesting they were working harder to get the same answers.”

TREATING ADHD LOWERS CRIME RATES?
The AP (11/22, Marchione), Bloomberg News (11/22, Kitamura), The Los Angeles Times (11/22, Bardin) and CNN, among other sources, reported on Swedish study appearing in the New England Journal of Medicine on November 22nd which showed that of those 16,000 men and 10,000 women aged 15 and older and diagnosed with ADHD, those taking medications for ADHD had a 32 percent lower (in men) and 41 percent lower (in women) crime rate over a four-year period.

HALF OF DEPRESSED TEENS RECOVER WITH TIME ALONE

PHYSICAL ACTIVITY IN SENIORS = HEALTHIER BRAINS?
USA Today (11/26, Lloyd) reported on a study presented at the annual meeting of the Radiological Society of North America which found that “people who burn off the most energy have healthier, younger brains compared with adults who do less.” The study reportedly used magnetic resonance imaging to scan the brains of 876 seniors finding that “those who burned the most calories had 5% more gray matter.”

CONVERSION THERAPY IN THE COURTS:
According to multiple news sources on 11/27 and 11/28, courts in New Jersey and California are addressing lawsuits involving the practice of providing therapy to ‘cure’ homosexual urges. In New Jersey, a counseling group was charged by four gay plaintiffs under the state’s Consumer Fraud Act of committing “deceptive practices.” In California, practitioners of conversion therapy are seeking to block a state law banning the treatment by “claiming that the ban is an unconstitutional infringement on speech, religion and privacy.”
Why would you choose anyone else?
Join your colleagues who have chosen
the APA-endorsed insurance program that best serves their needs.

The ONLY APA-endorsed Medical Malpractice Program

www.APAmalpractice.com

- Superior protection provided by a financially secure global carrier rated “A” (Excellent) by A.M. Best and has admitted capabilities in all 50 states
- Great low rates available as well as no surcharge for claims
- Years in APA’s prior program count towards tail coverage
- Fire Damage Legal Liability Coverage included
- Information Privacy Coverage (HIPAA) included
- Coverage for Telepsychiatry and ECT is included at no additional charge
- Interest Free Quarterly Payments and Credit Card Processing are available
- 10% Claims Free Discount if you have been claims free for the last ten years
- 10% Discount for New Insureds who are claims free for the last six months

American Professional Agency, Inc.
Toll Free: 1-877-740-1777

Underwritten By
Allied World Assurance Company
News from APA

ADVANCING MINORITY MENTAL HEALTH AWARDS
The American Psychiatric Foundation is now accepting applications for its 2013 Awards for Advancing Minority Mental Health program. This program recognizes psychiatrists, mental health professionals, and mental health programs and organizations that have undertaken innovative and supportive efforts to either raise awareness of mental illness in minority communities, or improved the quality of care or availability of treatment for underserved minority populations. Applications must be mailed and postmarked by February 4.

MINORITY FELLOWSHIPS PROGRAM INVITES APPLICANTS DEADLINE - JANUARY 30
Psychiatry residents are invited to apply for APA’s Minority Fellowships Program. The fellowships provide educational opportunities, not only to minority residents, but to any resident interested in providing quality and effective service to minorities and the underserved. The fellowships provide the funds necessary for psychiatry residents to experience a specialized educational program specifically geared toward building leaders in psychiatry to improve the quality of mental health care for the following federally recognized ethnic minority groups: American Indians, Native Alaskans, Asian Americans, Native Hawaiians, Native Pacific Islanders, African Americans and Hispanics/Latinos. The fellowship program is also designed to involve the resident in the work of the association and to give APA the perspective of young psychiatrists. Learn more about the APA/SAMHSAfellows, APA/SAMHSA Substance Abuse fellows and the APA/Diversity Leadership fellows on the APA fellowship page. Complete the fellowship application form found under “For Psychiatry Residents” and select which fellowship you wish to apply for. Or, you can complete the Minority Fellowship Application online located here. The application deadline is Jan. 30. All applicants are welcome to apply regardless of race, ethnicity, gender, national origin, religion, sexual orientation or disability. If you have any questions please contact Marilyn King at (703) 907-8653 or mking@psych.org.

TRAVEL SCHOLARSHIP FOR MINORITY MEDICAL STUDENTS DEADLINE - JANUARY 31
The Travel Scholarship for minority medical students supports travel and related costs for approximately 10 medical students to attend the APA Annual Meetings held in May each year at various locations. The travel scholarship application deadline is January 31. Complete the application on the Minority Fellows page posted under “For Minority Students.”

WEBINAR ON COVERAGE OF STATE EXCHANGES
Each legislative session advocates for psychiatry seek to influence the content of state and federal laws. Being able to craft meaningful state and federal laws requires knowing how existing state and federal laws interact with each other. These legal principles are often referred to as “Conflict of Laws.” You can watch the webinar hosted by APA’s Deputy Director of Regulatory Affairs, Julie A. Clements, J.D., M.P.P., legal counsel for The New York State Psychiatric Association, Seth P. Stein, JD and Rachel A. Fernbach, JD, and APA District Branch Executive Directors Beverly Dupuis of the Massachusetts Psychiatric Society and Wilma Cooley of the Tennessee Psychiatric Association.

American Psychiatric Association to Recognize the Newest Distinguished Fellows

Congratulations to these WPA members who were recently elected to the status of Fellow of the American Psychiatric Association:

Ned Kalin, MD
Erik Knudson, MD
Edward Krall, MD
Vani Ray, MD
John Schneider, MD
Theodore Weltzin, MD

They will be honored at the 2013 Convocation of Distinguished Fellows, during the Annual Meeting in San Francisco, CA. The ceremony will be held on Monday, May 20, at 5:30 p.m., in Exhibit Hall D, Exhibit Level at the Moscone Convention Center.
Save the Date for the 2013 WPA Annual Meeting

The 2013 WPA Annual Meeting will be held March 14-16 at the Fluno Center in Madison, Wisconsin. For more details please visit the WPA website at www.thewpa.org.

Confirmed presenters include:

JOHN OLDHAM, MD, MS
Immediate Past President, American Psychiatric Association
Senior Vice President and Chief of Staff, The Menninger Clinic
Professor and Executive Vice Chair of the Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine

DAVID KATZELNICK, MD
Chair of the Division of Integrated Behavioral Health and Associate Professor, Mayo Clinic

ROBERT N. GOLDEN, MD
Robert Turell Professor in Medical Leadership
Dean, University of Wisconsin School of Medicine and Public Health
Vice Chancellor for Medical Affairs, University of Wisconsin School of Medicine and Public Health

JEREMY A. LAZARUS, MD
President, American Medical Association
Clinical Professor of Psychiatry, University of Colorado Health Sciences Center

ANDREW S. POMERANTZ, MD
National Mental Health Director, Integrated Services Office of Mental Health Services
VA Central Office, Veterans Health Administration

PATRICK T. HAMMER, MSA
President and Chief Executive Officer, Rogers Behavioral Health System

WILLIAM HENRICKS, MBA, PHD
Chief Operations Officer, Rogers Partners in Behavioral Health

Recovery of Records Following a Disaster

Written by Professional Risk Management Services, Inc., Manager of The Psychiatrists’ Program

- To the extent that you are able, secure what remains of your records to avoid the possibility of a confidentiality breach.

- Consider taking photos of the damaged area.

- Keep copies of any insurance claims filed.

- Keep newspaper clipping of event leading to destruction.

- Ascertain which patient records were affected. Do you have a separate patient list you can access?

- Begin reconstruction of files. Clearly note that it is a reconstruction to avoid suspicion should there be discrepancies between your new file and records that may have been previously released.

- Be candid with patients and let them know that you are having to reconstruct files. Have them complete new history forms.

- Consult your state’s PMP to determine what medications you have been prescribing and in what dosages.

- If records are damaged, rather than completely destroyed, consult your state licensing board to determine their requirements for maintaining damaged records if any.

Professional Risk Management Services, Inc.
1-800-245-3333
Email: TheProgram@prms.com
Visit: www.psychprogram.com
Twitter: @PsychProgram
Wisconsin Psychiatric Association
563 Carter Court, Suite B
Kimberly, WI 54136

Wednesday, January 9 • 4-6 p.m.
WPA Webinar: Update and Overview of CPT 2013 Billing Changes for Psychiatry
For more information about this event please visit www.thewpa.org.

March 14-16, 2013
Wisconsin Psychiatric Association 2013 Annual Meeting
Fluno Center • Madison, WI

May 18, 2013
NAMI Walk - Greater Milwaukee Veterans’ Park on Lincoln Memorial Drive
For more information about this event, please contact:
Peter Hoeffel
peterh@namigrm.org
414-344-0447

Mayo Clinic Health System in Eau Claire, Wisconsin seeks two BC/BE Adult Psychiatrists for primarily outpatient positions. Call of 1:7. Outpatient unit attached to 20 bed inpatient unit. Inpatient unit is covered by daytime Psychiatric Hospitalists Monday through Friday.

Mayo Clinic Health System is a family of clinics and hospitals serving over 70 communities in Iowa, Wisconsin and Minnesota. Eau Claire, metro area of 99,000, is home to the 11,400 students at the University of Wisconsin-Eau Claire. Located 90 minutes east of Minneapolis, Eau Claire is a family friendly community with the cost of living below the national average, a low crime rate and strong public schools.

Contact Cyndi Edwards:
800-573-2580, fax 715-838-6192, or edwards.cyndi@mayo.edu. EOE