Many of AACAP’s advocacy efforts extend beyond legislation. These new Advocacy Updates will include legislative, regulatory, and other advocacy activities that AACAP and our regional organizations are working towards.

This issue includes:

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**Loan Forgiveness for Child and Adolescent Psychiatry Residents Passes as Part of the Healthcare Reform Bill**

For years, AACAP has advocated for many of the provisions adopted in the *Patient Protection and Affordable Care Act (PL 111-148)*. In late 2008, AACAP leadership developed our health care reform principles from current AACAP policy. Our three overall principles are:

1. Mental Health Coverage for All Children and Adolescents
2. Improved Coordination and Integration between Health Care Services
3. Strengthening the Child and Adolescent Psychiatry Workforce

These principles, and the specific elements included within, were at the forefront of our advocacy efforts for the last 15 months. You may recall that increasing the number of child and adolescent psychiatrists has been a priority for the AACAP since 2002. We are happy to say that two provisions of AACAP’s legislation “The Child Healthcare Crisis Relief Act” are included in the final healthcare reform bill. Those provisions will provide:
• loan repayment of up to $35,000 per year to child and adolescent psychiatric residents who agree to work in underserved areas after graduation, and
• grants to graduate schools to help develop and expand child and adolescent mental health programs.

A special thank you to our members, Greg Fritz, M.D., Wun Jung Kim, M.D., Tom Anders, M.D., and Jess Shatkin, M.D. who lead our effort on workforce issues.

H.R. 3590 also has many of the other principles AACAP has been advocating for, such as:
• health coverage for all children, including mental health and addiction services, coverage for early intervention and prevention treatment, a ban on pre-existing condition exclusions, and the elimination of lifetime coverage limits;
• extending the 5% bump in payment rate for psychiatric services, through the end of 2010;
• increased funding for community mental health centers;
• grants for co-location of primary and behavioral health care services; and
• grants to establish depression centers of excellence.

For a comparison on how AACAP’s healthcare reform principles stack up to the provisions in the law, please [click here](#). While the law is not perfect and it does not include everything child psychiatrists and patient groups want, it is a step forward to providing mental health coverage to millions of children and adolescents. We will continue to fight for improvements in the healthcare system through the regulatory and legislative processes.

**AACAP Advocates for Tennessee Kids**

BlueCross BlueShield of Tennessee (BC/BS TN) and its behavioral health partner, Magellan Health Services, [wrote to their healthcare providers](#) recently regarding the increasing use of atypical antipsychotic medications for children and adolescents. Within their letter they: 1) misrepresented an article published in *JAACAP* on the use of antipsychotics for young children as official AACAP policy, 2) suggested that second generation antipsychotics have no demonstrated efficacy for any disorders in children and require prior authorization, and 3) now also require a failure of psychosocial intervention before any consideration of off-label use is allowed. AACAP was alerted to these new requirements and the misrepresentation of AACAP policy. [We responded with a firm letter](#) to BC/BS TN and Magellan Health Services requesting “a retraction of Magellan’s letter on antipsychotic use in children within 30 days of your receipt of this letter stating: (1) the article in *JAACAP* does not represent the policy of the AACAP and (2) that the AACAP does not, directly or indirectly, support the policy articulated by BlueCross BlueShield of Tennessee and Magellan Health Services. We also ask that you review your policy on second generation antipsychotic medications and consider the best community standards of care as presented by the AACAP in any future changes.” We included AACAP’s “Practice Parameter on the Use of Psychotropic Medication for Children and Adolescents” (September 2009) and the

AACAP received a response from BC/BS TN, including a retraction to their providers correcting the misrepresentation of AACAP policy. AACAP, with our Tennessee regional organization and local members, continues to dialogue with BC/BS of Tennessee regarding their additional policy requiring prior authorizations for antipsychotics and the use of off-label medications. **If you hear about any insurance policy changes that create disincentives or limit access to care, please contact our Clinical Practice Department at 1-800-333-7636, and, with our Work Group on Healthcare Access and Economics, we will work with you to address these concerns.**

**Juvenile Justice Delinquency Prevention Act Approved in Senate**

The Juvenile Justice Delinquency Prevention Reauthorization Act (JJDPA) passed the Senate Judiciary Committee and is scheduled for a floor vote in May. Important provisions in the bill include:

- funding for training, technical assistance and consultation to develop coordinated dependence and delinquency system plans for early intervention and treatment;
- requiring state plans to address mental health and substance abuse screening, assessment, referral, and treatment for juveniles;
- expanding the jail removal requirement to keep youth awaiting trial in adult court out of adult lock-ups;
- identifying and reducing racial and ethnic disparities among youth who come into contact with the juvenile justice system; and
- establishing a uniform method of data collection and technology used to evaluate data on juvenile recidivism.

While untitled, the House is working on language similar to JJDPA, and the mental health and juvenile justice communities are actively calling for Chairman George Miller (D-CA) to move the bill through the Education and Labor Committee before this summer.

On March 11, the Healthy Families and Communities Subcommittee, held a hearing on “The Challenges Facing Girls in the Juvenile Justice System.” With the increase of girls in prisons, there is concern that the juvenile justice system is not adequately prepared to deal with the situation and is in need of better understanding the events that bring girls to law enforcement, the court system, and to jails. The expert panel before the Committee included a family court judge, a juvenile rights advocate, and a probation officer. The most compelling testimony was given by Rachel Carrion, a young woman who was a victim of sexual and substance abuse in the juvenile justice system. She provided a personal account of her experiences, demonstrating the need for greater data collection on domestic and family chaotic events that lead to girls involvement with the criminal justice system. Francine T. Sherman, Juvenile Rights Advocacy Project at Boston
College Law School, testified that girls, more often than boys, are arrested for distressed family situations and have been victims of sexual assault. Citing studies, she added that a history of abuse is “probably a more powerful predictor” of delinquent behavior for girls than for boys and because of that abusive history, girls may be linked to mental health issues such as depression and anxiety disorders, or may demonstrate more aggressive behavior. Finally, the subcommittee examined confinement conditions, mental health, victimization, and public safety. Linda A. Teplin, M.D., Professor of Psychiatry and Behavioral Sciences at Northwestern University, testified that girls have significantly higher odds than boys of having affective disorders such as major depression, anxiety disorder, and substance abuse. In fact, she stated, girls have higher rates of comorbid disorders, making their treatment much more difficult than boys. Members of Congress learned that these issues have a significant impact on how and if a female inmate is successfully released from prison and will be ready for any re-entry programs. The archived webcast of the hearing can be found here.

**Elementary and Secondary Education Act Reauthorization and the Positive Behavior for Safe and Effective Schools Act**

The House is expected to reauthorize the Elementary and Secondary Education Act (ESEA) and has held a series of hearings on the legislation. Both Chairman Kildee (D-MI) and Ranking Member Michael Castle (R-DE) highlighted the need for more funding in schools for ADHD, autism, Down Syndrome, and other intellectual disabilities. AACAP and other mental health organizations are hoping to amend the Positive Behavior for Safe and Effective Schools Act (HR 2597), to the ESEA. This bill will expand the use of school-wide positive behavior supports in order to create a climate that is advantageous to learning, reducing discipline referrals, and improving student academic outcomes. Provisions within the bill include:

- language that calls for teachers and school administrators to have subject matter knowledge, teaching skills, and an understanding of social or emotional, or both, learning in children and approaches that improve the school climate for learning;
- support for programs that prevent violence in schools, prevent the illegal use of alcohol, tobacco, and drugs, and involve parents and communities in the school programs and activities;
- the creation of an Office of Specialized Instructional Support Services within the Department of Education to administer, coordinate, implement, and ensure adequate evaluation of the effectiveness of programs and activities concerned with providing specialized instructional support services in schools, delivered by trained, qualified specialized instructional support personnel; and
- the definition of “specialized instructional support personnel” as school counselors, school social workers, school psychologists, and other qualified professional personnel involved in providing assessment, diagnosis, counseling, educational, therapeutic, and other necessary corrective or supportive services as part of a comprehensive program to meet student needs.
Native American Child and Adolescent Health Highlighted in Congress

On March 23, 2010, AACAP member Dr. Thomas McInktosh Jones joined the American Academy of Pediatrics’ Committee on Native American Child Health for a day of advocacy on Capitol Hill in Washington, D.C. Dr. Jones enjoyed a day of successful meetings with his members of Congress. He also met with AACAP’s Congressional Fellow, Dr. Andreea Adiaconitei, and Representative Jim McDermott (D-WA), the only child and adolescent psychiatrist in Congress.

The Senate Committee on Indian Affairs held a hearing on “the Preventable Epidemic” of youth suicides in Indian Country on March 25. Native American youth suffer suicide rates over three times that of the general population—the highest rate of suicide in any population in the country. The hearing examined the epidemic and the need for early detection efforts and increased mental health resources in tribal communities. The hearing also featured representatives from successful suicide prevention programs and explored ways to replicate the success of these programs throughout Indian Country. The written statements of the panelists can be read [here](#).

Visit Your Representative and Senators at Home!

Congress is on its annual Spring recess from March 29 through April 9. Take this opportunity to make an appointment with their local offices to talk about child and adolescent psychiatry issues. This District Work Week is intended for members of Congress and Senators to return home and meet with constituents about federal and local issues. AACAP staff will help you arrange the appointment and provide you with the materials you need for your meeting! To find your elected officials, visit AACAP’s Advocacy website at [http://capwiz.com/aacap/home/](http://capwiz.com/aacap/home/).

COME TO AACAP’S ADVOCACY DAYS 2010

Join AACAP for its annual Advocacy Days on Capitol Hill, May 6-7, 2010. This extraordinary event will bring another opportunity to network with child and adolescent psychiatrists, parents, and patients on the latest issues of importance and concern to the field.

- Learn how to advocate at the federal and state level.
- Hear about the latest policy issues and regulations.
- Make valuable connections with decision-makers and leaders.

This is your time in Washington, DC to have your voice heard on healthcare. By speaking with your members of Congress, you will raise awareness for children's mental health issues and help our leaders better understand the serious needs of children and families. There is no better way for child and adolescent psychiatrists and families to effect change! For more information, please visit [www.aacap.org/cs/advocacy](http://www.aacap.org/cs/advocacy) or contact Karen Davis at kdavis@aacap.org or (202) 966-7300 ext 128.
Assisting Members with Using Electronic Medical Records

The adoption and implementation of Electronic Health Records (EHR) and Electronic Medical Records (EMR) technology by health care professionals has become a major policy effort by the Federal government to improve quality and efficiency within the health care system. **AACAP has begun an initiative to assist members in understanding the legislation and regulations surrounding EHR and EMR programs and how they will affect child and adolescent psychiatrists.** We recently submitted comments to the Center for Medicaid and Medicare Services on the implementation of the EMR in Medicaid and Medicare programs and made recommendations for clarification and changes assist our members in private practice. In order to help AACAP members understand how physicians might be affected, a Q and A has been created to help guide you through the legislation. We will continue to inform you on changes and clarifications to the regulations that will allow you to make informed decisions to better suit the needs of your practice.

### Changes to Consultation Codes

The Centers for Medicare and Medicaid Services (CMS) announced that Medicare will no longer reimburse for the outpatient and inpatient consultation codes (99241-99245 and 99251 – 99255) as of January 1, 2010. **It is important to note that the consultation service codes are not being eliminated, however CMS will no longer reimburse for these codes. It is unclear at this point in time if private payers will follow Medicare’s policy.** This rule does not mean CMS will not pay for any consultations, but that consultations must be reported using different codes. Physicians should use the new patient, initial hospital care or initial nursing facility care evaluation and management (E/M) code appropriate for the designated setting. Office consultations should be billed as office or other outpatient visit for the evaluation and management of a new patient (99201-99205). An inpatient consult should be coded using the initial hospital care codes (99221-99223). A consult occurring in a nursing/residential treatment facility should be coded using the initial nursing facility care codes (99304 – 99306). Any consultations done as a home service should be coded as a home visit for the evaluation and management of a new patient (99341-99345). If you have been using 90801 for your consults, you can continue to do that. Telehealth consultation G-codes (G0406-G0408) will continue to be reimbursed.

As with all evaluation and management services, the specific code selection should be based on the standard evaluation and management guidelines. The AACAP CPT Module, in addition to covering the specific psychotherapy codes, also discusses documentation of E/M codes. The AMA and other physician organizations have been lobbying CMS and Congress for a delay in the implementation of the elimination of the consultation codes. If there is a change in the policy or a delay in the implementation, AACAP will notify members. If you have questions on the change in Medicare policy or to get a copy of the CMS transmittal, please contact Jennifer Medicus at 202.966.7300 ext 137 or jmedicus@aacap.org. If you have ongoing questions about coding, reimbursement, third-party insurance or other issues, please contact Jennifer and stay
tuned for the 57th Annual Meeting preliminary program for sessions on CPT and reimbursement. Our experts will be there in New York to answer all of your coding questions.

**AACAP Prepares for Review of Child Psychiatric Codes**

The psychiatric CPT codes are up for review to determine the appropriate value of the codes. We are collaborating with the American Psychiatric Association and the American Nurses Association on this endeavor.

AACAP will focus on surveying the codes typically used by child and adolescent psychiatrists, the diagnostic codes (90801, 90802) as well as the psychotherapy codes with E/M and the 90862 code. The surveys measure the complexity of the work involved for the procedure, the time involved to do it, including the time spent prior to seeing the patients, the actual time spent seeing the patients, and the time spent after the patient visit is completed. The surveys also assess the stress involved in performing the procedure should an adverse event occur.

The review process requires random selection of members to complete surveys about the codes to be sent in late May or June. Upon receiving the survey, it may initially appear cumbersome or even confusing. However, it is crucial to complete and return these surveys. The results of these surveys directly influence the relative value units (RVUs) assigned to each of the psychiatric codes, which directly translate into reimbursement rates. If you have any questions, please contact the coding and reimbursement advisors, Sherry Barron-Seabrook, M.D. or David Berland, M.D., via AACAP staff, Jennifer Medicus at jmedicus@aacap.org.

If you have any questions, please let us know.
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