EXPERT COMMENTARY

Help Teens Develop Strong Sense of Self

When providing care for troubled adolescents, a series of progressive steps can be undertaken. Such interventions prove helpful for many teenagers. But for others, things don't get better, and community intervention begins.

BY MICHAEL S. JELLINEK, M.D.

The teenager might be transferred to a special classroom or continuation school. Behavior might bubble over to one or repeated emergency department visits. The teenager might be admitted to an inpatient psychiatric ward, or law enforcement might be involved because of substance use, violent behavior, or criminal acts.

Eventually, the family might ask you about whether they should consider a placement out of the community in a specialized school or camp to see whether a change of setting and a tightly structured environment might help. Often, parents at this point are frustrated, angry, hopeless, guilty, and even punitive.

Encourage the family to ask several questions, including: Have family interactions become so strained as to become at least temporarily estranged? Are resources available for boarding school tuition or an Outward Bound–type experience? Perhaps most importantly, can such a move be cast as an opportunity for a fresh start for all—rather than as a punishment?

A rancorous history of punishment and push back can seriously jeopardize the possibility that such a placement will be successful, particularly if it is viewed by the teenager as the final straw in a pattern of attempted control by the parents. After having been repeatedly grounded, deprived of allowance and driving privileges, removed from activities, and perhaps even thrown out of school, a teenager whose behavior continues to escalate is unlikely to differentiate between punishment and treatment. He or she is likely to resist any imposed authority or intervention.

Despite all of their alienating behavior, teenagers do not want to face being rejected and considered worthless.

A key step, then, is to get the family and the teen to acknowledge that nothing they've tried so far is working. You might be in a unique position to frame the conflict as a shared problem demanding a shared response. Made in the context of love and caring, decisions should have the goal of making the teen's life better.

Sometimes families have trouble stepping back and seeing that they are in a mutual choke hold that needs to be loosened for any positive solutions to emerge. Such discussions might recast the decision as an opportunity, rather than a forced march to the next level of teen purgatory.

If finances are a problem, then broach the idea of their proposing a cost-sharing arrangement. Such a suggestion might be welcomed by a school district unable to meet the educational needs of a disruptive teen, or an insurance company that has already paid for a hospitalization or two.

In some cases, an ultimatum from the court system or school might make the decision less of a choice. Still, families often have some choice in the setting or location of a residential program offered as an alternative to incarceration and/or a criminal record. When helping a family decide what school or camp makes sense for a given teenager, try to help the parents let go of old angers and presumptions and consider what is best for their child. Automatically deciding on the most restrictive setting might be interpreted as punitive and counterproductive.

Emphasize that the decision about what to do should be a thoughtful one. An educational specialist, psychologist, or psychiatrist experienced in school placements can make recommendations based on cost, structure, goals, program duration, and professional support. As a physician, it's important that you are confident that any potential school or camp has enough professional expertise to ensure the teen's physical safety and emotional well-being.

The long-term goal is for a teenager to establish a firm sense of self. Treatment should continue when teenagers return home and include family therapy that allows for rebuilding of trust and accommodation of revised perceptions of the teen's new reality. ■

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EXPERT COMMENTARY

A Farewell to Consultation Codes

A brand new year has begun, and that, as usual, means brand new surprises from our friends at the Centers for Medicare and Medicaid Services.

This year's big surprise: The CMS has decided that it will no longer pay for consultations in either outpatient (99241-99245) or inpatient (99251-99255) settings.

BY JOSEPH S. EASTERN, M.D.

This decree has caused a great deal of protest, particularly from specialists who depend on consultations for most of their income. After all, we specialists should be appropriately compensated for the special expertise we provide.

It is hard to envision how eliminating consultation payments could be anything but detrimental to patient care. At the least, consulting physicians might feel less inclined to provide reports to referring physicians, which would substantially hurt coordination of care at a time when policymakers claim to be looking for ways to improve it.

Further objections abound; nevertheless, the decision has been made, and adjustments must be taken to accommodate it.

For office visits, the CMS expects consultation codes to be replaced with new or established visit codes (that is, 99201-99205 or 99212-99215). They have increased relative value units for those visit codes by 6% to soften the blow, but the difference will be substantially noticeable if a lot of consultations were billed last year.

On the inpatient side, admission codes (99221-99223) are to be used in lieu of consultation codes. The "true" admitting physician will use a new modifier (not yet published at press time) along with the admit code, while all consulting physicians will use the admit code unmodified. Physicians performing a lot of inpatient consultations should anticipate denials, appeals, and confusion as admitting physicians and consultants alike adjust to this change.

As usual, some commercial insurers will follow the CMS lead, while others will continue recognizing the consultation codes (which remain in the 2010 CPT book). This means a decision will need to be made about whether to continue billing consultations for non-Medicare patients whose insurers continue to pay for them. If this route is chosen, Medicare will provide secondary coverage, and will, of course, not pay its portion. So this situation needs to be recognized in advance.

It is probably worth reviewing some past explanation of benefits to determine how often Medicare is a secondary payer, and whether any extra revenue will be worth the extra vigilance and work involved.

Discussions on this issue have been widespread and heated, and opinions vary widely. Some specialists contend that they actually welcome the change because they will no longer need to worry about complying with the agency's confusing and ever-changing consultation rules.

Others are understandably concerned about a potentially significant loss of income. Do not be tempted, however, to bill for more services. The CMS is well aware of that tendency (they even have a name for it: "code creep"), and they will be watching.

If billing patterns change significantly, an audit can be expected; increased billings must be proved to be of medical necessity, not compensatory revenue generation. If increased billings cannot be proved to be medically necessary, abuse or fraud charges will come. In an audit, remember, everyone is guilty until proven innocent.

Billing patients directly for consults has been proposed as a way to recover lost revenue. If consults are no longer covered by the CMS, then physicians have reasoned that they should be able to use a "noncovered service" code (such as 99199-GA) and have Medicare patients sign an Advance Beneficiary Notice (ABN).

This signifies their understanding that Medicare will not pay for the service, the same procedure used for noncovered cosmetic services. It is not clear, however, if this is permissible by the CMS.

Another proposed counterstrategy is to bill Medicare for a new patient visit and add a "surcharge" for consultative care that is billed directly to the patient (again using a National Supplier Clearinghouse [NCS] code and an ABN). This would be considered a "priority service," analogous to "concierge services" offered by some internists. No one knows whether the CMS (or the patients) would go along with this option, either.

Even proponents of such strategies admit that they are speculative and untested; I would not advise attempting them without a careful legal review with an experienced health care attorney.

No matter how individuals choose to deal with the loss of consultation codes, I believe physicians should continue sending reports to referring physicians even though they will not specifically be paid for them. Doing what is best for patients should always be the top priority. ■

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