The Pennsylvania Psychologist

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Important Notice About Act 31

As a result of Act 31 of 2014, starting in 2015 all licensed health care professionals must receive a minimum of two (2) hours of continuing education in child abuse recognition and reporting as a condition of their licensing renewal. This continuing education program must be approved by the Pennsylvania Department of Public Welfare and their respective licensing board specifically as fulfilling Act 31 requirements.

In addition, Act 31 requires that all new licensees should have three (3) hours of education in child abuse recognition and reporting in order to receive a license. These programs must be approved by the Department of Public Welfare. Continuing education courses can be used to fulfill this requirement. It is our understanding that the Office of Children and Youth (of the Pennsylvania Department of Public Welfare) will have such continuing education programs available later in 2014.

Courses for Licensing Renewal

PPA has created a home study CE course and has submitted it to the Department of Public Welfare and the Pennsylvania Department of State for approval. We have not yet received word back concerning whether this program has been accepted. Also, we understand that the Department of Public Welfare is planning to offer free online CE programs that could also meet this requirement, although we have no data on that program at this time. Furthermore, over the next year we expect that many other continuing education providers will receive approval to offer similar courses. However, all of these approved courses must have a basic curriculum that has been submitted to and approved by both the Department of Public Welfare and the Department of State. PPA has requested that, after the first renewal period, the Office of Children and Youth allow for more flexibility in the curriculum so that psychologists may take advanced courses that expand their knowledge base and allow them to provide a higher quality of services to children. However, at this time, there will not be a major difference in the content presented in these courses.

PPA has created a home study CE course and has submitted it to the Department of Public Welfare and the Pennsylvania Department of State for approval.

The two hours will count toward the 30 hours required for licensing renewal. PPA has presented its opinion to the State Board of Psychology that any course that fulfills Act 31 requirements should count toward the 30 hours required for licensing renewal, even if it is not provided by an APA, AMA, or other approved CE provider. We have not yet received confirmation of this opinion from the State Board, however. At this time, we do not know if this will count toward partial fulfillment toward the ethics requirement. PPA has requested that the State Board of Psychology not count Act 31 credits as fulfilling the ethics requirement.

Psychologists who hold credentials from the Department of Education may have fulfilled this requirement if they took a similar course approved by the Department of Education. Act 31 allows the licensing board to exempt certain professionals at their discretion. At the present time, the State Board of Psychology is providing no other options by which psychologists can exempt themselves from this requirement.

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The Pennsylvania Psychologist
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2014/15 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

March 19 and 20, 2015
Spring Continuing Education and Ethics Conference
DoubleTree Hotel Monroeville
Monroeville, PA

June 17–20, 2015
Annual Convention
Hilton Harrisburg
Harrisburg, PA

Contact: judy@papsy.org

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IMPORTANT NOTICE ABOUT ACT 31

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PPA has requested that, after the first renewal period, the State Board of Psychology allow limited exceptions, such as for persons who do not practice psychology in Pennsylvania.

Reporting Act 31 Credits

Psychologists must complete 30 hours of continuing education every renewal period. At the time of licensing renewal, psychologists verify that they have completed the required continuing education and will be subject to random audits to ensure that they have fulfilled their obligations. Failure to complete the required continuing education can subject psychologists to disciplinary actions by the State Board of Psychology.

The reporting for this mandatory training program differs from the reporting for ordinary continuing education. All licensees must demonstrate before their licenses are renewed that they have fulfilled their Act 31 requirements by completing an approved program. The CE provider then must submit certain information to the Department of State (the oversight department for the State Board of Psychology) that includes first and last name, last four digits of their social security number, date of birth, and license number. Every continuing education provider who is authorized to fulfill the Act 31 requirements must receive this information from the licensee who takes this course. Licensees who fail to provide this information will not be recorded as having fulfilled their Act 31 requirements and will not be allowed to renew their licenses. There are no exceptions.

Summary

Starting for license renewal in 2015, psychologists (and all other health care professionals) must take a two (2) CE course in child abuse recognition and reporting. This course must be one approved by the Department of Public Welfare and the Department of State (the oversight body for the State Board of Psychology and other health care licensing boards). The reporting process for Act 31 differs from the reporting process for other continuing education for the State Board of Psychology in that every psychologist must have verification that they took an approved course on child abuse before their licenses can be renewed.

In addition, all new licensees must receive three (3) hours of instruction in child abuse recognition and reporting from a program approved by the Pennsylvania Department of Public Welfare. We are confident that courses will be available by late fall 2014 to meet these requirements. PPA will publicize more information about Act 31 requirements as it becomes available.

Child Abuse: An Ethical Dilemma

Manuscript for Patricia M. Bricklin Student Ethics Award

Rachel Cornelius

Rachel Cornelius

Current statistics from the CDC suggest that 1 in 5 children will experience abuse during childhood (Center for Disease Control, 2012). With frequency rates elevating, most psychologists will be faced with an ethical dilemma involving child abuse. Moreover, with statistics indicating that child abuse is underreported, it is imperative for psychologists to gain competence through building a knowledge base of rules, laws, and ethical standards related to mandated reporting (Children's Bureau, 2013).

Mandated reporting presents a unique ethical issue for psychologists because of the inherent conflict the situation holds. While psychologists are ethically obligated to maintain confidentiality, the presenting safety concerns of the children experiencing the abuse require that psychologists ensure the safety of their child clients. Despite the legal mandate in the state of Pennsylvania to report suspected child abuse, an analysis of 2011 reports suggests that mental health clinicians are underreporting (Children's Bureau, 2013).

Psychologists presented with child-abuse situations often feel torn in how to respond. While it may be their legal duty, there are ethical concerns related to confidentiality and access to treatment. As far back as 2002, the American Psychological Association (APA) has noted that mandated reporting situations are "gray" in relation to the ethics code (Behnke & Kinscherff, 2002). The APA posits that even in states where the psychologist may not be mandated to report, filing the report may represent the best ethical response (Behnke & Kinscherff, 2002). The APA suggests that the psychologist determine a course of action through reviewing state laws, collaborating with a colleague and reaching out to child protective services, broad guidelines that leave room for bias and ultimately foster inconsistencies in reporting (Behnke & Kinscherff, 2002).

Psychologists presented with child-abuse situations often feel torn in how to respond.

Since mandated reporting laws emerged, there have been debates among psychologists as to the value of these laws and their impact on the psychological community (Behnke & Kinscherff, 2002). Lawrence and Robinson Kurpius (2000) speak to the lack of guidance for psychologists, noting that a failure to report child abuse is among the most frequent breaches of the law for psychology professionals. Brown and Strozier (2004) conducted a review of outcomes, noting that the majority of the cases reported for child abuse had either no therapeutic change or a positive change. Despite this finding, the authors noted that many professionals do not complete reports due to a belief in "absolute therapeutic confidentiality" (Brown & Strozier, 2004, p. 49). Jenkins (2010) notes that clinicians maintain a duty to do no harm and, therefore, confidentiality should be superseded by mandated reporting. Johnson (2002) noted concern with a decline in the level of completed reports, hypothesizing that this underreporting stems from a lack of consistent definitions and a lack of effective training.

Faced with these inconsistencies in the research, psychologists turn to the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2002) for guidance. In reviewing the principles of beneficence/nonmaleficence, fidelity/responsibility, integrity, justice and autonomy, psychologists find themselves with additional conflicts as to whether to complete a report (APA, 2002). In addition, while multiple ethical standards apply (1.02, 2.01, 2.03, 3.04, 4.01, 4.02, 4.05, 4.06, 10.01), they also provide conflicting information on whether to file a report (APA, 2002). For further guidance psychologists would reference the Child Protective Services Law (CPSL), only to find unclear and at times extreme definitions as to what abuse is and what is considered reportable (CPSL, 1999).

The nature of the law within Pennsylvania along with a gray ethics code creates significant complications for psychologists working with children. While psychologists may want to file reports to proactively protect children, the law often does not mandate these reports. Furthermore, while the CPSL may not be applicable, the psychologist may still feel ethically obligated to file a report. It is recommended that psychologists take the following steps to assist them in determining the best ethical course of action.

First, the psychologist should critically examine the situation and review the law to assess if the situation meets the standard of including a victim (under age 18), a perpetrator, and a defined act of abuse. If these qualifications are met, the psychologist must complete the report. If they are not, the psychologist should review his/her personal background, ensuring s/he is not exhibiting personal bias. The psychologist should self-explore what his/her childhood was like, the type of parenting received, and what s/he judges as positive parental qualities. If biases

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CHILD ABUSE

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are uncovered, s/he should ensure they are removed from the decision-making process.

Next, the psychologist should consider best and worst case scenarios of making/not making the report. Within this analysis, s/he should weigh the risks to the child, carefully assessing for any immediate safety concerns and concerns for imminent risk. The psychologist should consider alternative plans such as safety planning and development of an acceptable discipline techniques plan. The psychologist should consider whether there are more appropriate therapeutic interventions and services available to address the identified parenting concerns. These may include specialized treatment such as family therapy or other forms of family-based services that would strengthen positive interactions within the family. The psychologist should also explore natural supports within the community such as support groups, anger management groups, natural community supports, utility assistance and parenting classes.

Upon completion of this analysis, if the psychologist feels that a report should still be made, s/he should consult a colleague considered an expert within the realm of child abuse situations. This collaboration should be utilized to determine whether the psychologist and colleague reach the same decision regarding filing a report. If still uncertain, the psychologist should contact Childline and ask for advice. After assessing all factors, the psychologist should make a final reporting decision and fully document the evaluative process.

Although child abuse is a prevalent issue across America, laws regarding mandated reporting are unclear and little empirical evidence is available for best practice methods in handling suspicions of child abuse. For mandated reporting to occur consistently and effectively, there must be guidelines for

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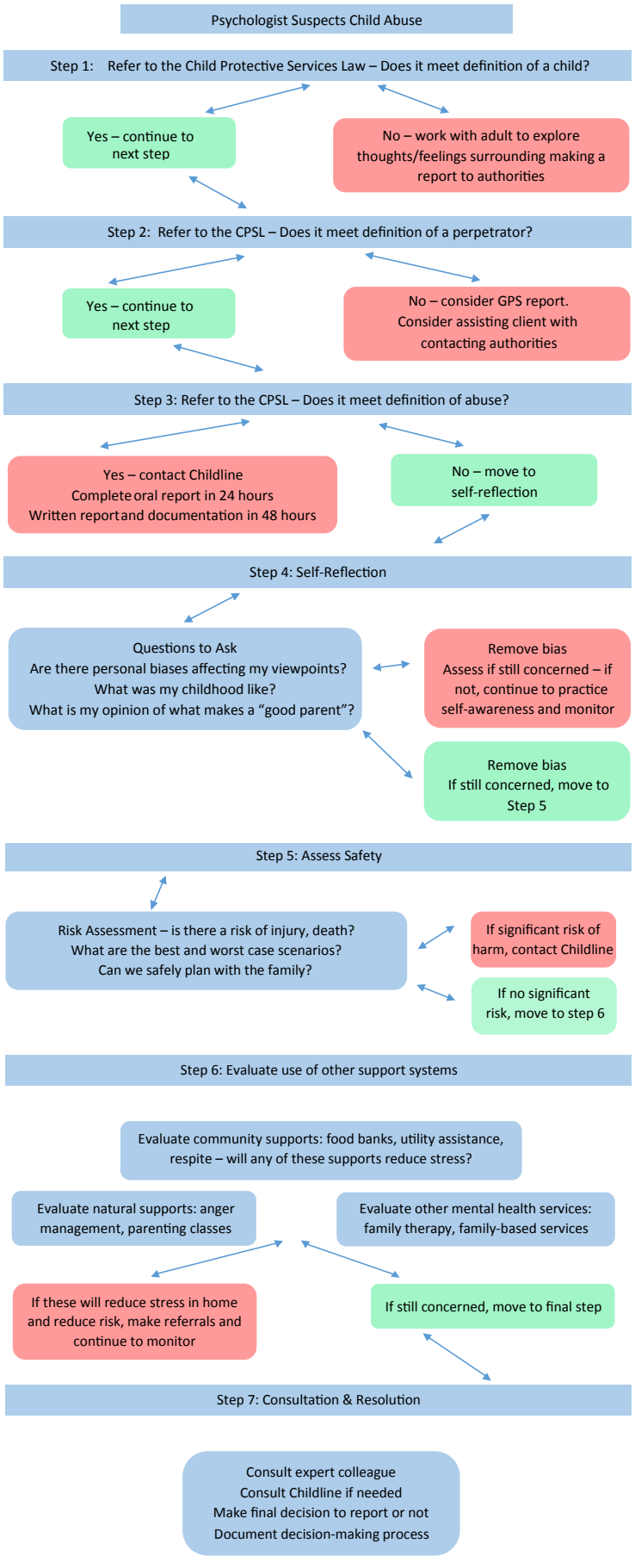
PROPOSED CHILD ABUSE REPORTING ETHICAL DECISION-MAKING MODEL



CHILD ABUSE

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ethical decision-making when faced with suspicions of child abuse.

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Understanding Moral Values in Psychotherapy

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Psychotherapy is not a value-free experience; hence, morality plays a role in the helping relationship. The psychologist's role in psychotherapy inherently entails more power in the relationship. Therefore, to work in their patient's best interest, psychologists need to remain aware of the power imbalance and their potential influence on the belief systems and values of our patients. All psychologists have the ability to influence their patients in many ways, including the domains of morality, values, and ethics.

In terms of psychotherapy training, psychologists need to be aware of their moral beliefs as these apply to a variety of topics in psychotherapy. Patients come to psychotherapy with diverse beliefs and backgrounds, so psychologists need to be open to the diversities of modern American life. Psychologists also need to be aware of their limits of what is acceptable versus unacceptable in terms of their patients' thoughts, feelings, and behaviors. Psychologists and patients who have congruent belief systems rarely discuss how their synchronous values work toward a positive outcome, although congruence between the value systems of clients and psychologists is correlated with successful outcomes in psychotherapy (Beutler & Bergen, 1991). Furthermore, research supports the idea that patient values shift toward psychologist values during therapy (Williams & Levitt, 2007). This finding is a less obvious result of psychotherapy, and typically not a planned goal of therapy.

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However, when the values and morals of psychologists and patients are misaligned, the therapeutic relationship may be in jeopardy, depending on the psychologist's reaction to or tolerance for discrepant views. If the psychologist and the patient each bring differing belief systems or models of morality into therapy, how do psychologists balance their notions of morality with that of their patients? What can be done to keep psychologists from inappropriately trying to impose their value system on the patient during the course of psychotherapy?

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UNDERSTANDING MORAL VALUES

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The first step in understanding how morals shape the psychotherapeutic relationship is by heightening our awareness of how our values affect our work. Patients commonly discuss moral dilemmas in psychotherapy, such as considering ending a marriage, contemplating end-of-life issues with a parent, having an extramarital affair, or deciding whether or not to reveal his gay identity to his wife. Less common types of moral conflicts may occur such as when a patient intends to acquiesce to an arranged marriage with extreme inequalities in gender roles, or when a patient says that she is considering entering into a polygamous marriage (in a country where such marriages are legal). In each case, the patient arrived at the therapy session with a moral issue as the topic of discussion.

Except when the situation involves an imminent danger of serious harm to self or others, the psychologist needs to allow the patient to retain moral responsibility for the decision-making process. Psychologists need to refrain from directly expressing their value systems or inserting their morality in therapy. "If I were you, then I would...." is the beginning of a psychologist inserting his or her morality into the therapeutic dialogue. Of course that does not mean that psychologists should avoid discussing the issue. It is quite appropriate for psychologists to direct patients to consequences of the decision that they may not have considered, or have considered only perfunctorily. However, usurping a patient's moral agency is a significant boundary crossing in psychotherapy. Some psychologists may view it as benevolent, as it solves the patient's dilemma; however, allowing and encouraging the patient to struggle with weighty moral issues is an important part of emotional growth. Working with moral problems can be frustrating and time consuming, as these are typically complex, uncomfortable, and emotionally-charged issues. Often the moral issues raised in psychotherapy are subtle or nuanced. Consider the following example:

During the course of a session, the patient reveals that he regularly takes off from work even though he is not suffering mentally or physically. The patient rationalizes his behavior as "taking a mental health day." He openly admits that he lies to his employer about why he did not show up for work.

In this less glaring example of right and wrong, if the psychologist agrees overtly or tacitly with the patient's moral choice or action, then the choice or action is reinforced. A psychologist who gently expresses concern about the patient's action opens an opportunity to explore or clarify the patient's belief system. In exploring beliefs, the psychologist may suggest other forms of reflection, such as journaling, for the patient to clarify his value system. This type of intervention needs to be used skillfully, as the goal is not to induce shame or humiliation. Rather, the psychologist encourages contemplation to promote awareness of values, morals, and choices.

Different dynamics may become salient during psychotherapy sessions when psychologists become sensitive to the moral implications of patient issues. For example, a psychologist may question a missed opportunity for discussing moral beliefs, like a patient describing a punitive tirade toward a subordinate at work who received "her just deserts." A psychologist may become aware of overtly reinforcing deceitful behavior, as illustrated above. Or, a psychologist may recognize how a patient's negative self-statements are anchored to a moral intolerance for individuals who are helpless or weak-willed. In these clinical situations, understanding how morality plays into life choices and interpersonal relationships is important.

In this series of articles, we have tried to highlight the connection between psychology and morality. We hope that psychologists can become attuned to their moral values and how these play out in obvious or subtle ways in their daily work. Furthermore, the more comfortable we are about highlighting and discussing moral issues that permeate psychotherapy, the greater the likelihood that we are being respectful of our patients and working toward providing the best care possible.

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Psychologists Must Be Certain They Comply With Medicare's Documentation Requirements

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In 2001, the U.S. Office of Inspector General conducted a random review of claims submitted for outpatient mental health services under Medicare Part B, and the results of this survey showed that one of the most problematic areas for providers of mental health services was documentation. Approximately one third of the outpatient mental health services provided to Medicare beneficiaries were either medically unnecessary, billed incorrectly, rendered by unqualified providers, undocumented, or poorly documented. Sixty-five percent of services were insufficiently documented because medical records lacked critical information about patients' conditions and details of the care provided (Department of Health and Human Services, 2001).

This is not to suggest that the services were provided fraudulently. Most of the services billed for were probably medically necessary. However, in the event of a post-payment review, Medicare would disallow payment primarily because of the lack of adequate documentation.

One reason why there may be so much confusion on how to properly document for Medicare is that the Centers for Medicare and Medicaid Services (CMS) has not established a national medical review policy that assesses the appropriateness of claims submitted for mental health services. Instead, CMS contracts with local Medicare Carriers to establish local coverage determinations (LCDs) based on Medicare coverage and documentation guidelines. These LCDs describe the medical criteria that must be met for a particular mental health service to be considered medically necessary and appropriate. They also specify criteria for satisfactory documentation of mental health services. In Pennsylvania, Novitas Solutions is the local Medicare Carrier that develops Pennsylvania's LCDs.

Since documentation seems to be the most common problem for billing for psychotherapy and psychological testing, here are the guidelines set forth in Pennsylvania's LCDs that a psychologist should follow when documenting for mental health services under Medicare:

Psychological and Neuropsychological Assessment and Testing

Medical record documentation maintained by the psychologist must indicate the medical necessity of the psychological and/or neuropsychological testing including the following:

- a suspected mental illness or neuropsychological abnormality or central nervous system dysfunction
- referral information and/or the initial evaluation that determines the need for and types of testing
- the time involved and whether this is initial testing or follow-up
- previous testing by the same or different provider, and efforts to obtain previous test results
- the tests administered, scoring and interpretation
- treatment recommendations

If the testing time exceeds 7 hours, documentation that indicates the medical necessity for this extended testing must be submitted with the claim. (Retired Medicare Policy V-6B)

Psychiatric Therapeutic Procedures (Individual, Group and Family Psychotherapy)

The ICD diagnosis codes for mental and/or medical disorders must be coded to the highest level of specificity for coverage by Medicare. Medical record documentation maintained by the provider must indicate the medical necessity of the psychotherapy (individual, group, and family) including the following:

- the presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to significantly alter baseline functioning;
- the time spent in each psychotherapy encounter;
- documentation that therapeutic interventions, such as behavior modification, supportive interaction, and discussion of reality were applied in an attempt to produce therapeutic change;
- the patient's capacity to participate in and benefit from psychotherapy;
- the estimated duration of treatment in terms of number of sessions required; and
- the target symptoms, the goals of therapy and methods of monitoring outcome, and why the chosen therapy is the appropriate treatment modality either in lieu of or in addition to another form of psychiatric treatment.

There is no absolute rule on what constitutes a good note as the review will focus on the complete medical record. For example, it may not be necessary to document the patient's capacity to participate in and benefit from psychotherapy in every note (although frequent notation of that may be indicated when the patient has a dementia or where their capacity to participate or benefit is questioned).

All documentation must be maintained in the patient's medical record and available to the contractor upon request. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)).

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MEDICARE'S DOCUMENTATION REQUIREMENTS

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The record must include the physician or non-physician practitioner responsible for and providing the care of the patient. The submitted medical record should support the use of the selected ICD code(s). The submitted CPT/HCPCS code should describe the service performed.

The medical record documentation for psychotherapy must be clear and concise.

Psychotherapy services are not considered to be medically reasonable and necessary when they primarily include the teaching of grooming skills, monitoring activities of daily living, recreational therapy (dance, art, play), or social interaction. Psychotherapy services should not be reported for ADL training and/or social interaction skills.

The medical record documentation for psychotherapy must be clear and concise. Statements such as "supportive psychotherapy given" is not adequate. A clear and detailed description of what the psychotherapy entailed and how it is addressing the presenting problem of the patient should be evident. Time spent in each psychotherapy encounter should also be delineated.

The patient must have the capacity to participate actively in all therapies prescribed, except for family therapy without the patient present (code 90846). To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist (except for family therapy without the patient present, and where interactive psychotherapy is necessary).

Family psychotherapy (90847) primarily involves the treatment of the patient's condition, and not the treatment of each family member's problems. Therefore, this code represents a complete family session, payable only for the patient. This code is not to be used for the other family members involved in the family psychotherapy.

Family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient's condition. The term "family" applies to traditional family members and "associates." Associates may be live-in companions or significant others. Examples are as follows: 1) When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (CPT 90847) and 2) Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847). Counseling principally concerned with the effects of the patient's condition on the individual being interviewed would not be reimbursable as part of the physician's personal services to the patient.

For group therapy, progress notes should indicate the degree of patient participation, interaction with group members and leader, the reaction of the patient to the group, and the group's reaction to the patient. The medical record should also reflect the changes or lack of changes in patient symptoms and/or behavior as a result of the group psychotherapy.

For an acute problem, there should be documentation that the treatment is expected to improve the health status or function of the patient. For chronic problems where the possibility of recovery is low, there must be documentation indicating that stabilization or maintenance of health status or function is expected.

These LCDs can be downloaded from the local Medicare Carrier's Web site at www.novitas-solutions.com.

Examples of Poor Documentation

Sometimes the psychologist's notes are only one or two sentences long and give little description of the presenting problem, the treatment modality, or the progress of the patient to date. A note simply stating that "the patient appears to be doing better" would probably result in denial of payment in the event that the records of a psychologist were reviewed in a post-payment review.

Additional Pointers

Here are some additional pointers for conducting psychotherapy with a patient:

- If the patient is suffering from dementia make sure that you document how the patient is benefitting from therapy. Medicare will allow payments for patients with dementias who have co-existing psychiatric disorders. However, in the event of a post-payment review, greater scrutiny will be given to patients with dementias. You should be certain to document that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in treatment.
- Make sure that all of your notes do not state the same thing. Example: "Saw the patient today and she is feeling better." Although the post-payment review will look at each note in context of the total treatment, there should be enough documentation in each note so that the reader can determine the general substance and content of the session.

Here is an additional pointer for conducting psychological testing with a patient:

- At least one standardized and individually administered psychological test must be given to the patient for this session to be billed as psychological testing. Behavioral assessments alone do not qualify as psychological testing, although the behavioral assessments may be used to supplement the data from standardized testing.

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Philadelphia Behavior Therapy Association

PBTA

Zindel Segal, PhD

Mindfulness Based Cognitive Therapy for the treatment of Mood Disorders

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Drexel University

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Douglas Woods, PhD

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Arcadia University

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Cory Newman, PhD

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2/21/2015 9:00 AM - 12:00 PM

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This program provides three (3) hours of CE

APA APPROVED SPONSOR

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Katherine Dahlsgaard, PhD

Introducing the New Anxiety Disorder: Selective Mutism

3/2/2015 6:30 PM - 8:30 PM

Drexel University

This program provides two (2) hours of CE

Jeffrey Greeson, PhD

Why is Mindfulness Training Helpful across so many Psychological Disorders?

4/14/2015 6:00 PM - 8:00 PM

TBD

This program provides two (2) hours of CE

Classifieds

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Allegheny Health Network

Allegheny Health Network's Department of Psychiatry announces three positions available for clinical psychologists. Areas of specialization include:

General psychology	**Health psychology**	**Neuropsychology**
Preference for candidates who are experienced with mood/ anxiety disorders or couples/ family therapy.	Preference for candidates who are experienced working in a multidisciplinary settings including pain management.	Preference for candidates who are experienced with head trauma and concussion.

In addition to clinical service:

- A faculty appointment in the Department of Psychiatry, Temple University is available.
- Teaching opportunities include didactic training and supervision of doctoral internship psychology trainees and psychiatric residents.

See our webpage at http://www.ahn.org/specialties/psychiatry/ for more details. Successful candidates must have completed APA approved graduate training and be licensed in Pennsylvania. Send a letter of application along with vita and three letters of recommendation to Anthony Mannarino, Ph.D., Vice Chair, Allegheny Health Network Department of Psychiatry, East Commons Professional Building, 8th Floor, Pittsburgh, PA 15212.