The Pennsylvania Psychologist

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REGULAR FEATURES

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PPA Makes Historic Move to New Location This Summer!

Bruce E. Mapes, PhD, PPA President, & Krista Paternostro Bower, CAE, Executive Director

After spending over 27 successful years in our current downtown Harrisburg location, the Pennsylvania Psychological Association is moving!

Following a yearlong review process, spearheaded by a corps of volunteers serving on the Board-appointed PPA Facility Task Force, the PPA Board of Directors purchased a new property at 5925 Stevenson Avenue in Harrisburg in May 2015 (Figure 1). "After careful deliberation with the Budget and Finance Committee, the task force realized that it would cost PPA substantially more money over the next 15 years to remain in our current building and renovate it than move to a new location," remarked Dr. Vince Bellwoar, facility task force chairman.

Dr. Bruce E. Mapes

Krista Paternostro Bower

Mirroring the size of our current office location at just over 5,700 square feet, the new PPA office condominium offers Class A office space on a second floor location within a clean, bright, well-maintained building and provides ample meeting areas and parking for staff and guests.

The new facility is located just 9 miles from our current property on Forster Street, just off of the Linglestown exit on Interstate 81 (Figure 2). "We considered a number of locations and, frankly, got very lucky with the one we found," remarked Dr. Bellwoar. "In business, timing can be everything, and our timing was just right!"

PPA's a dynamic, energetic, and creative staff now has a physical plant that can meet our current and future needs, and our volunteers are actively developing new initiatives. PPA is now positioned to remain a premiere state association meeting the needs of psychologists and psychology in Pennsylvania.

We would like to offer our special thanks and gratitude to the members of the PPA Facility Task Force who spent countless hours working over the better part of a year to make this happen! Members include:

- Vince Bellwoar, PhD, *Chair*
- Bruce Mapes, PhD
- Nancy Rogers, MS
- Thomas Whiteman, PhD
- David Zehrung, PhD
- Krista Paternostro Bower, CAE, *PPA Staff*

While we look forward to moving, we know that a lot of successful work came out of our current location at 416 Forster Street (Figure 3). We acknowledge our successful time in this space, and salute the hundreds of volunteers and staff who came through our front doors intent on making a difference for our organization and its members over the past three decades! We hope to carry forward in our new space with the same sense of accomplishment and achievement.

We are looking forward to exploring all of the exciting possibilities of our new facility with our PPA members. If you are ever in the area, please stop by to visit us in our new location!

Figure 1 PPA's new office building at 5925 Stevenson Avenue

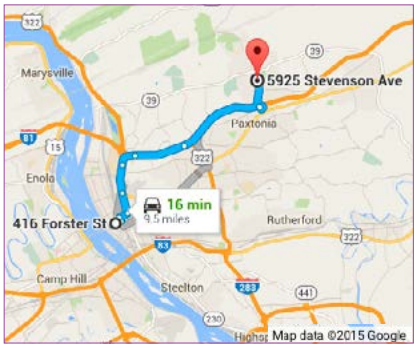

Figure 2 Distance between old *(left)* and new office

Figure 3 PPA's downtown Harrisburg location for the past 27 years

Where Do I File a Licensing Board Complaint?

Rachael L. Baturin, MPH, JD, Director of Legal and Regulatory Affairs

Rachael L. Baturin

Patients have a right to file a complaint against a psychologist who violates the Professional Psychologists Practice Act or rules and regulations that govern the practice of psychology in the Commonwealth of Pennsylvania. Patients often get confused about whom to contact to file a complaint. It is important for them to understand where they can file a complaint.

Complaints are filed with the Pennsylvania Department of State's Professional Compliance Office and not with the Pennsylvania Psychological Association. The Department of State is the state agency that houses the Bureau of Professional and Occupational Affairs, which provides administrative and legal support to 29 professional and occupational licensing boards and commissions. The State Board of Psychology (Board) is the licensing board that oversees the practice of psychology in the Commonwealth. The purpose of professional licensing boards is to protect the health, safety, and welfare of the public from fraudulent and unethical practitioners.

Specifically, Section 3.2 (4) of Act 52 of 1986, which is known as the Professional Psychologists Practice Act, provides that the Board has the power "to conduct hearings upon complaints concerning the violations of the provisions of and rules and regulations adopted pursuant to this act and cause the prosecution, impose civil penalties and enjoin any such violations." This section of the law allows the Board to prosecute psychologists who violate any of the provisions of the licensing law or its rules and regulations.

In contrast, PPA is a nonprofit trade organization that promotes the science and practice of psychology by supporting psychologists to meet the evolving needs of the public. PPA's mission is to (1) effectively communicate to the public, policy makers, and membership the value of evidence-based and ethical practice; (2) support the lifelong learning of competent and ethical psychologists; and (3) promote and connect our membership to foster a community of professional psychologists. PPA does not prosecute psychologists who violate any of the provisions of the licensing law or its rules and regulations.

Therefore, patients who want to file a licensing board complaint against a psychologist must file with the Pennsylvania Department of State's Professional Compliance Office. Patients can call the Professional Compliance Office hotline at 800-822-2113 (if calling from within Pennsylvania) or at 717-783-4854 (if calling from outside of Pennsylvania) to request the complaint form and then send it to the Professional Compliance Office at: Department of State, Professional Compliance Office, PO Box 69522, 2601 North Third Street, Harrisburg, PA 17106-9522, or download the complaint form from the Department of State's website.

Lastly, it is important for patients to understand that there are certain guidelines that the Department of State has for filing a complaint against a psychologist:

- The Department will not involve itself in a monetary dispute unless it involves an allegation that services were billed for but were not rendered—or if there is evidence of other billing or insurance fraud.
- The Department cannot act as a court of law to impose prison sentences or to order a person to make monetary restitution. This can only be achieved through the services of an attorney in a civil or criminal court proceeding.
- Decisions about whether to prosecute cases are constrained by the Professional Psychologists Practice Act and its rules and regulations, which set forth specifically enumerated offenses for which the Board may impose discipline on a psychologist. If offensive conduct or activity does not fit within any specifically enumerated offense, disciplinary action cannot be filed against the psychologist because the activity is not within the Board's jurisdiction.
- If you file a complaint, you may be required to attend a formal hearing and provide testimony in support of your complaint should a decision be made to file formal charges against a psychologist.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
As of May 1, 2015

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 21	Provides for assisted outpatient treatment programs in the Mental Health Procedures Act - Sen. Stewart Greenleaf (R-Montgomery)	Against	In Senate Public Health and Welfare Committee	N/A
SB 63 **HB 92**	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years - Sen. Stewart Greenleaf (R-Montgomery) - Rep. Kate Harper (R-Montgomery)	For	In Consumer Protection and Professional Licensure Committee	Passed House 4/21/15 (194-0)
SB 772 **HB TBA**	Updates the psychologists licensing law, eliminates certain exemptions, and modernizes the experience requirements - Sen. John Gordner (R-Columbia) - Rep. Marguerite Quinn (R-Bucks)	For	Introduced 5/1/15	Awaiting introduction
HB 64	Requires licensed psychologists to take 1 hour of continuing education in the assessment, treatment, and management of suicide risks - Rep. William Adolph (R-Delaware)	Against	N/A	Referred to Professional Licensure 2/25/15
HB 132	Provides Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee
HB 133	Act establishing a bill of rights for individuals with intellectual and developmental disabilities; and conferring powers and duties on the Department of Human Services - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee
HB 214	Increases oversight and accountability in Home and Community Based Services - Rep. Mauree Gingrich (R-Lebanon)	For	N/A	In Aging and Older Adult Services Committee

Information on any bill can be obtained from the Pennsylvania General Assembly website.

New Legislative Session Brings Hope for Passage of Psychological Practice Modernization Act

Justin Fleming, Director of Government Affairs

Justin Fleming

Greetings! I'm Justin Fleming, the new director of government affairs for the Pennsylvania Psychological Association (PPA). This new column in the *Pennsylvania Psychologist* seeks to inform you about what is happening with Pennsylvania's government, and how it affects you as a member of PPA.

The 2015–2016 legislative session is already historic, as the 2014 election marked the first time since 1854 that an incumbent governor running for re-election was defeated.

While Pennsylvanians went to the ballot box and elected a Democrat, Tom Wolf, as governor, the Republican majorities in both the Pennsylvania House (120–83) and Senate (30–20) grew larger. Most state government observers are predicting gridlock between the governor and the General Assembly, but that remains to be seen.

Regardless of the current construction of our state government, PPA is forging ahead with a major legislative initiative, the Psychological Practice Modernization Act (Senate Bill 772). The Psychological Practice Act hasn't been updated in nearly 30 years.

State senator John Gordner (R-Columbia) has once again agreed to be the prime sponsor of the legislation. The bill enhances public protection by giving the State Board of Psychology more authority to regulate those who lose their licenses to practice psychology; those who hold licenses in other states or under other boards; and professionals who lose their licenses in other states but want to practice in Pennsylvania. The bill also clarifies the scope of practice for psychologists by adding diagnosis. We have consulted the Pennsylvania Psychiatric Society regarding our language for diagnosis, and they have staked out a neutral position on the bill, which is good for PPA.

Other provisions of SB 772 include the elimination of the current exemption that permits hospitals and state, county, or municipal governments to allow persons to refer to themselves as psychologists or to perform activities unique to the practice of psychology without being licensed. Our findings are that the large majority of psychologists hired by those entities are licensed, but there are a few exceptions.

The bill also contains a generous grandfather clause that would eventually eliminate the exemption for unlicensed school psychologists to provide services in private practice. Those who are currently certified and employed may continue their work in private practice. We have worked extensively with the Association of School Psychologists of Pennsylvania in crafting this language, and they are supportive of this effort.

Finally, the legislation would eliminate the six-month waiting period for an individual to retake a failed licensing exam. This makes sense today, since exams are given much more frequently than semi-annually, which was the standard years ago. The licensing law requires a doctoral degree, two examinations (with passing grades), and 2 years of supervised experience. SB 772 would not change these requirements, but it would give applicants the option of getting 2 years of supervised experience before they earn their doctorate, instead of requiring 1 year of postdoctoral supervision. Several states (Ohio, Maryland, and Washington) have made this change already.

Regardless of the current construction of our state government, PPA is forging ahead with a major legislative initiative, the Psychological Practice Modernization Act (Senate Bill 772).

In addition to SB 722, PPA is following many other pieces of legislation that are of interest to you as members. For example, House Bill 92, sponsored by Kate Harper (R-Montgomery), would allow licensing boards the option to expunge disciplinary records of a technical nature after 4 years. We are also monitoring Senate Bill 21, which provides for assisted outpatient treatment programs in the Mental Health Procedures Act. As of now, we have concerns related to patient rights for involuntary commitment, but we'll continue to work with Senator Stewart Greenleaf (R-Montgomery) in the hope of reaching a compromise.

A new legislative session is always full of promise, and I pledge to work every day to advance the standing of psychological practice in Pennsylvania. If you would like to help in our efforts, or need more information, please contact me at 717-232-3817, justin@papsy.org, or find me on Twitter @PAPsychGA!

Medicare 2015: An Early Career Psychologist Perspective

Patricia J. Fox, PsyD

Dr. Patricia J. Fox

Thomas, a 73-year-old man with a long history of depression, was one of my first clients when I opened my private practice in 2012. He was referred by his pulmonologist for a course of cognitive-behavioral therapy to treat his insomnia. He was also my first Medicare client.

I had decided to do my own billing and was still learning the language and process of insurance. In addition to accepting insurance plans such as BlueCross, Highmark Blue Shield, Aetna, and Optum/UBH, I elected to accept Medicare because I wanted to work with older adults.

Initially, I completed the CMS-1500 claim form by hand and submitted it via snail mail to Novitas Solutions, the administrator for Medicare claims. I examined the first Explanation of Benefits form, attempting to determine how much I had been paid and if I had to collect coinsurance. Though I found the process frustrating and time consuming, I really enjoyed working with Thomas and continued to accept Medicare clients.

I soon learned that Medicare reimbursement seemed to be under a constant threat of cuts. One reason for the cuts is sequestration, which is "A governmental mechanism that involves a series of spending cuts required by the Budget Control Act of 2011, which are aimed at reducing the deficit (The Medicare Newsgroup, n.d., para. 1). Consequently, payments to Medicare providers were cut by 2% beginning April 1, 2013 (The Medicare Newsgroup, n.d.).

The other reason for cuts is the Medicare Sustainable Growth Rate (SGR), which is a "system designed to control the costs of Medicare payments to physicians" (Frotenot, Brandt, & McClellan, 2015, para. 4). The SGR was put in place via the Balanced Budget Act of 1997.

The SGR is "layered" on top of a system known as the physician fee schedule. This system pays physicians for volume of services rather than value or quality of care. The SGR was an attempt to control the cost of the volume of services. No cuts were necessary until 2003, and Congress has since enacted 17 "doc fixes," or patches (Fix Medicare Now, 2015). The cost of these patches is now over $169.5 billion.

I was discouraged when I learned about these numerous cuts and assumed that opting out of Medicare was the easiest solution. However, as I got more involved in advocating for psychology, via my participation in PPA's Leadership Academy and the American Psychological Association's State Leadership Conference, I learned that psychologists could, and should, have a strong voice in halting these cuts.

Reductions in Medicare rates are not just a problem for those psychologists who are dependent on third-party reimbursement. According to Sam Knapp, "commercial insurers often base their reimbursement rates on a percentage of Medicare rates" (Knapp, 2014).

Likewise, cuts in reimbursement rates don't just affect psychologists in independent practice. Psychologists who practice as fee-for-service providers may find it difficult to find clients who will pay their full fee out of pocket if their insurance company typically pays $50 for a session.

The salaries of psychologists working in institutions may be reduced if those institutions use private practice incomes as a yardstick for salaries. Seasoned psychologists, who often practice beyond the traditional retirement age of 65, may elect to offer more lucrative services, like consulting, rather than accept reduced insurance reimbursement.

The psychologists most likely to be impacted by these issues are students and early career psychologists (ECPs). Student loan debt has increased significantly for the new generation of psychologists. This perfect storm of increased debt load and decreased reimbursement may force new psychologists to leave the profession. Knapp (2014) labeled the decline in Medicare rates the "snowball effect" because of the impact on the profession and the potential for reducing mental health services to the community.

I was discouraged when I learned about these numerous cuts and assumed that opting out of Medicare was the easiest solution. However, . . . I learned that psychologists could, and should, have a strong voice in halting these cuts.

Now the good news: In a rare bipartisan decision, the U.S. House of Representatives voted on March 26, 2015, to repeal and replace the SGR formula (Government Relations Staff, 2015). The bad news, however, is that the Senate won't take up the legislation until returning from a 2-week recess on April 13, 2015. This means that psychologists will see a 21% reduction in payment on or after April 1.

You can find a series of articles about Medicare on PPA's website under the heading Psychologists, then Practice Resources, then Insurance Articles. For example, if you are considering becoming a Medicare provider, read "The Basics of Medicare" by Rachael L. Baturin. Or, if you are considering opting out, be sure to read "Properly Opt Out of Medicare." Access to these articles is one of the perks of membership.

Finally, you can learn more about Medicare's 2015 Physician Quality Rating System (PQRS) and earn 1 hour of CE credit by reading an article and taking the quiz on PPA's website.

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How to Enroll as a Medicare Psychologist[1]

Gordon I. Herz, PhD, Forward Psychology Group, Madison, WI

Dr. Gordon I. Herz

One cannot work extensively with older adults without working with Medicare. Contrary to popular belief, I have found Medicare to be one of the easier third-party payer systems to work with. In an effort to encourage colleagues to treat older adults and dispel myths about Medicare, a number of years ago I wrote the "Top 10 Reasons Medicare is Better." Many still apply:

1. Medicare will accept "any willing provider" who is a "clinical psychologist," defined by Medicare as a person who "(1) holds a doctoral degree in psychology, and (2) is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive and therapeutic services directly to individuals." This is Medicare Specialty 68, which allows psychologists to provide diagnostic and treatment services to Medicare beneficiaries.
2. The fee structure is objectively determined based on the technical skill required for a procedure, risks to patient and practitioner, and cost of providing the service, moderated by geographic region. Unfortunately Medicare reimbursement has since become caught up in congressional wrangling.
3. Fees tend to be higher for psychologists than under many managed schemes.
4. Over time reimbursement has tended to increase or remain stable, though it is slipping relative to inflation.
5. Fees are public information, so you can plan for your practice.
6. Medicare is nondiscriminatory toward psychologists, who are reimbursed at 100% of the physician fee schedule.
7. Preauthorizations and reauthorizations are not required.
8. Using correct ICD and CPT code combinations is the key requirement for billing. In addition to testing and psychotherapy, the health and behavior codes allow psychologists to treat the full range of physical health conditions in which psychological factors are salient—and reimbursable.
9. Intrusiveness for the clinician is minimal, and patient privacy is maximal. No paperwork is required beyond what is good clinical practice and within clearly established documentation guidelines.
10. It is a good and necessary thing for psychologists to be taking care of seniors.

Getting Ready to Enroll as a Provider

You will need to identify a physical location where you will be providing services. You may not simply provide a mailing address to enroll. The location where you have payments sent (your "billing address") may be different from the location where you provide services. You will also need to indicate on the application where you store patient health-care records.

All payers are now required to obtain a National Provider Identifier (NPI). Click here to apply for an NPI online. The NPI is "information neutral." Other than identifying you, it carries no information about what state you are in, your specialty, when you applied, or similar data. I received my NPI within 24 hours of applying online.

Enrolling

Visit Centers for Medicare & Medicaid Services (CMS) to access and download the forms. This is your key online resource. The Enrollment Applications page will tell you which form(s) you need, but here are some guidelines.

- If you are applying as an individual for the first time with an NPI that is not related to a corporation, you will submit form 855I, Application for Physicians and Non-Physician Practitioners. This will establish you as an individual practitioner with Medicare.
- If you are incorporated and will use the corporation NPI or TIN (taxpayer identification number) to apply (e.g., as an LLC, PC, SC, Inc., PLLC, or similar entity), you will submit form 855B and information about the corporation, such as where it is located, who the owner is, and where reimbursement checks are to be sent. You also will submit the 855I to establish yourself as an individual practitioner. Additionally, you will submit form 855R, Application for Reassignment of Medicare Benefits. This "reassigns" payments back to the corporation.
- If you are applying as a psychologist in a group that already has been established with Medicare and has a group number under which you will bill, you will submit 855I to establish yourself with Medicare and 855R to reassign reimbursement to the group.
- You may also need to submit form CMS460, the Medicare Participating Physician or Supplier Agreement, which defines and is the agreement with Medicare to accept "assignment."

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[1] A longer version is available on Dr. Herz's website and was also published in *The Independent Practitioner: Bulletin of Psychologists in Independent Practice*, Summer 2006, Vol. 26, No. 3.

The Medicaid "Loophole"—A Potential Benefit for Children With Severe Disabilities

Timothy L. King, PhD, drkingtesting@gmail.com

Dr. Timothy L. King

Perhaps the most underpublicized but still well known (at least by school psychologists and school social workers) potential benefit for children with serious disabilities is the Medicaid "Loophole." The provision was so named because it allows children who meet the criteria for a physical or intellectual disability under Supplemental Security Income (SSI) to receive Medicaid, also known as Medical Assistance (MA), irrespective of their parents' income or assets. Children must be 18 years of age or younger and not eligible for other MA categories.

According to information provided online by the Pennsylvania Department of Public Welfare, the majority of disabilities that meet SSI, and potentially Loophole, criteria fall within the following disabilities: attention-deficit/hyperactivity disorder, autistic spectrum disorder and other pervasive developmental disabilities, mood disorders, organic mental disorders, multiple body dysfunction, hearing impairment, intellectual disability disorder, and communication impairment associated with neurological disorder. Children who are found eligible are entitled to full Medicaid benefits. Some services such as physical therapy do not have a co-pay, while others such as outpatient psychotherapy apparently have a fixed co-pay. Other services may have a co-payment on a sliding scale, based on the MA fee for the service.

Psychologists working with individuals or families whose children may qualify for the above coverage should advise them, according to the above information, that they need to apply through their local county assistance office or by going to the COMPASS website. Individuals who are referred for support for psychological and/or developmental conditions should be encouraged to keep in mind that they will need, in addition to the paperwork required for the application, written documentation of an Axis I diagnosis. Parents should also be encouraged to write, in large letters: "MA for Disabled Child Only—Handbook Section 355.4" or "Loophole"—at the top of their application, according to school social workers who have assisted parents in applying for the support.

Unfortunately, like most benefits that fit the axiom "too good to be true," the above Medicaid benefits reportedly do not come easily, even for those children who are deemed eligible to receive them. More specifically, experienced school social workers who worked informally with this author on this article described both personal (in seeking support for their own children) and professional (based on reports provided back to them by parents they were attempting to assist) chronologies of frustrating experiences surrounded with hours of completing forms (sometimes every 3 months, 6 months, or 12 months) on every child in the families for whom they were seeking support.

In addition, the above social workers indicated that the cycle of filing the forms and then receiving no response; making follow-up calls and hearing, "We'll get back to you," and then receiving no phone call; and being told "you make too much money" can reportedly occur so frequently that many parents become "worn down" and simply "give up."

Thus, psychologists working with families whose children could potentially derive benefit from the Medicaid Loophole are encouraged, based on the background information gathered informally by this author, to advise parents that the road to obtaining financial support under this provision is likely to be a long one, potentially surrounded by frustration and feelings of not being heard by county assistance office staff. Thus, this author was advised to not only encourage parents to "not give up," but also to, if necessary, contact their local and state representatives for assistance in obtaining initial and follow-up Loophole coverage for their children.

New Resources Available to Improve Geropsychology Competency

Maureen E. Sweeney, PsyD, maureensweeney@msn.com

Dr. Maureen E. Sweeney

In December 2014 the American Board of Professional Psychology (ABPP) recognized board certification in geropsychology. This achievement highlights the consolidation of geropsychology as a specialty field of practice (Molinari, 2015). An essential component of the development of geropsychology as a specialty practice was identifying the attitudes, knowledge base, and skill competencies required for competent geropsychology practice. The 2006 Pikes Peak National Conference on Training in Professional Geropsychology defined these domains of competency and developed six core components of training in professional geropsychology for graduate, fellowship, and postlicensure levels of training. In addition, the Pikes Peak Conference established the Council of Professional Geropsychology Training Programs (CoPGTP) (Karel, Molinari, Emery-Tiburcio, & Knight, 2015).

Although the most recent surveys indicate that as few as 3–4% of psychologists identify geropsychology as the primary focus of practice, as many as 39–69% of psychologists report working with at least a few older adults (Hoge, Karel, Zeiss, Alegria, & Moye, 2015). Postlicensure training in geropsychology is self-guided based on need and interest. The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool is a useful starting point to self-evaluate competency domains of geropsychology practice. This instrument is available for free download at GeroCentral.

One significant concern raised by many PPA members is related to Medicare billing. This is also one of the Pikes Peak skill domains of professional geropsychology. Knapp, Behrendt, & Baturin (2015) have recently published both an article and a CEU to help strengthen our understanding of the Physician Quality Reporting System (PQRS). This information can be obtained from the PPA website. The Norris (2015) handbook includes everything and anything you have ever needed to know about psychology and Medicare billing practices. This document includes numerous free Internet resources about everything a psychologist will need to know about Medicare. Another useful Medicare resource is the first PQRS Registry designed for psychologists that can be accessed through the APA website (Nordal, 2015). Additionally, the GeroCentral website contains useful information about Medicare and resources to seek additional training related to Medicare billing practices.

One significant concern raised by many PPA members is related to Medicare billing. This is also one of the Pikes Peak skill domains of professional geropsychology.

Further, one of the Pikes Peak skill competency domains includes competencies in consultation and training in the areas of "consultation to families, professions, programs, health care facilities, legal systems, and other agencies/organizations that serve older adults," as well as our ability to design and use effective models of service delivery for this population (Karel, Molinari, Emery-Tiburcio, & Night, 2015). The CoPGTP website offers information about many affordable web-based training programs related to geropsychology clinical practice. For example, these include Older Adults and Mental Health (8 CEUs), Fundamentals of Healthy Aging: A Biopsychosocial Perspective (3 CEUs), and A Comprehensive Approach to Establishing Mental Health Practice in LTC Settings (1 CEU). These are just a few examples of the many affordable geropsychology web-based training programs offered through this website.

The APA website offers individuals 24 hours of unlimited on demand access to database searches and printing of APA journal articles for just under $12. Also, for just under $12 any one APA journal article or book chapter can be purchased online. This benefit and pricing is the same for APA members and nonmembers.

Geropsychology is a rapidly developing field of practice. This may be in reaction to our changing payer systems, changing long-term care systems, and the changing and unique clinical needs of the aging population. Further, the newness of developing geropsychology topics that require problem solving, innovative treatment model development, collaboration, as well as research, advocacy, policy, and law development are emergent and copious. Consequently, psychologists who wish to learn more about geropsychology or to become instrumental in the shaping of the development of geropsychology services are encouraged to connect with one or more of the organizations that partner with the GeroCentral website. These organizations include APA Division 12/II, APA Division 20, CoPGTP, PLTC, and the APA Office on Aging. Links to these organizations can be found at GeoCentral. For more information about the Pikes Peak training model, see the chapter by Karel, Molinari, Emery-Tiburcio, and Knight (2015) that discusses in detail the training model, the identified geropsychology competency domains, and strategies to implement the training model at the internship, fellowship, and postlicensure levels of training.

Continued on page 10

NEW RESOURCES AVAILABLE TO IMPROVE GEROPSYCHOLOGY COMPETENCY

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Special thanks to Jeanne Slattery for her guidance with and editing of this article.

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HOW TO ENROLL

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- Do not be intimidated by the apparent length of the applications. The 855I packet is 31 pages, but less than half requires information and even fewer pages will likely apply to you. The information requested is straightforward, and the instruction pages actually are intelligible.
- Submit your application to the Provider Enrollment Unit of your local carrier, not directly to CMS.
- Medicare now requires practitioners to receive payments by electronic funds transfer. You will complete and submit form CMS-588 for this purpose.
- While most of this information is generic, application requirements may vary among the regional Medicare administrators so verify the above information and any idiosyncratic requirements with your local carrier. This will also give you an opportunity to get a feel for how helpful or vague they will be, perhaps even to establish a good working relationship with that one person who may just help you through the application process.

Finally, it is now possible to enroll entirely online at the Provider Enrollment, Chain and Ownership System. This method is highly recommended.

What to Expect

If you are a clinical psychologist by Medicare's definition and have no prior adverse events related to health-care services billing, your application will be approved usually in less than 60 days after they have all the information they need (45 days through online enrollment). You will receive a written confirmation from Medicare that your application has been approved and the effective date.

You may see Medicare patients between the time you apply and when your application is approved. Once approved, you may bill for services previously provided. Billing before then will cause denials, and of course be aware that, if for some unforeseen reason your application is not approved, you will not subsequently be able to bill patients directly for those services.

MEDICARE 2015

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Novitas Solutions, Inc., is the interface between Medicare and providers. Specifically, Novitas is the Medicare Administrative Contract (MAC) for Jurisdiction L (JL) serving Pennsylvania, New Jersey, Delaware, and Washington, DC. On the Novitas website, you can find information about enrolling as a Medicare provider. You can also access a current fee schedule and locate the address to submit paper claims (Novitas Solutions, n.d.).

I strive to balance the business of psychology with the satisfaction I derive from practicing psychology. To strike this balance, I recently withdrew as a provider from an insurance company because of low reimbursement and poor customer service. Consequently, I increased my income by replacing those hours with more favorable reimbursement, like Medicare.

Though processing Medicare claims is more time consuming, I will continue to be a Medicare provider because I enjoy working with older adults like Thomas. I will also continue to advocate for changes to Medicare reimbursement, and I invite you to join me, because Medicare affects us all.

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Medicare's Approach to Quality Assurance: PQRS

Samuel Knapp, EdD, ABPP

Dr. Samuel Knapp

While commercial managed care companies are experimenting with or debating pay for performance measures, Medicare has taken a unique approach through its Physician Quality Reporting System (PQRS). The PQRS program is one of several initiatives by the Centers for Medicare and Medicaid Services (CMS) to improve efficiency and effectiveness of Medicare. The data it generates will be used in two new programs from Medicare: Physician Compare and value-based payments.

The PQRS program was originally developed in 2006 when President Bush signed the Tax Relief and Health Care Act of 2006. It has since been amended four times. According to the PQRS, physicians and other health-care professionals report activities that they did, or did not, perform while delivering a health-care service. For example, when conducting an initial evaluation with an older adult, psychologists may report whether they did, or did not, screen for elder abuse. There is no presumption that psychologists have to screen for elder abuse as there may be good reasons why, for a particular patient, such a screening would not be needed or could even be clinically contraindicated.

Originally a bonus program, PQRS has transitioned into a penalty program. In 2014, psychologists (and other professionals) who met certain participation requirements received an incentive payment equal to .5% of allowed charges, while participants who met lower participation standards avoided a 2% penalty that will be applied to payments for services in 2016. Starting in 2015, PQRS shifted to a penalty-only program and professionals who do not participate will have payments for all services reduced by 2% in 2017. The PQRS program is limited to fee-for-service Medicare and does not apply to those services provided to patients in the Medicare Advantage programs.

Psychologists who are interested in the details of how to use the PQRS program are directed to the PPA website, which includes information on how to actually use the PQRS program and submit data. Psychologists can also take a 1 hour CE program on the PQRS through the PPA website. In addition, the website article includes information on how psychologists can enroll in a registry that can do the PQRS reporting for them.

Currently PQRS information can be reported through hand-completed claims forms, the use of a registry, or through electronic health-care records. CMS has stated that its eventual goal is to phase out hand-completed claims submitted forms, although it gave no timeline for that change to occur. From the perspective of CMS, it spends less per unit of billing when dealing with large groups. Currently about 18% of physicians and 13% of nonphysicians submit claims to Medicare as solo practitioners.

The PQRS data will be part of two new initiatives by Medicare: Physician Compare and value-based payments. Medicare is in the process of establishing a website that includes information on physician performance under PQRS. Its goal is "to help consumers make informed health care choices" (CMS, 2014, p. 67769). Currently, Physician Compare includes basic information about physicians who participate in Medicare, including name, primary and secondary specialties, practice locations, group affiliations, languages spoken, and board affiliation. Eventually it may include data on participation with PQRS. The goal of CMS is to include quality data on the Physician Compare website, such as data on PQRS reporting, patient outcomes, and patient satisfaction.

In addition, Medicare is moving toward value-based payments. Starting in 2015, groups with 100 or more professional employees will be evaluated according to the extent to which they participate in the PQRS program (physicians will be able to select the PQRS measures used in the evaluation). The program will apply to physicians in groups of 10 or more in 2016 and to all physicians in 2017. The secretary of Health and Human Services has the discretion to apply it to nonphysicians in 2017. As a result we do not know when, if ever, value-based payments will apply to psychologists.

The value-based program involves complicated formulas, and I am only giving a rough sketch below. A bonus will be given to practitioners or groups that maximize high quality and low cost. Those who provide high quality at a low cost will receive a bonus of 2% in payments; those who provide average quality for a low cost or high quality for an average cost will receive a bonus of 1%. As seen in the table below, some physicians will receive penalties depending on the cost-quality relationship.

Table 1. Bonus and Cost Quality
(Percentage Increase or Decrease in Medicare Payments)

Cost	Low Quality	Average Quality	High Quality
Low	0	+1.0%	+ 2%
Average	-.05%	0	+1%
High	-1.0%	-.05%	0

In 2015, 106 large physician groups self-nominated themselves to be evaluated for value-based payments and 14 received a bonus, 11 received reductions in payments, and 81 saw no change in their reimbursements (CMS, 2015). The program must be cost neutral, so that the increased expenditures through the bonuses are offset by the reductions in expenditures through the penalties.

Physicians who are participating in Medicare's experimental programs with accountable care organizations or

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How to Opt Out and Stay Out of Medicare: An Update and Resources

Christine Molnar, PhD

Dr. Christine Molnar

This article is intended to provide guidance for psychologists in Pennsylvania who want to opt out of the Medicare network of providers (MNP) and is not meant to replace existing laws or regulations. It is an update to Baturin (2013).

Why would a psychologist want to opt out? Many opt out of Medicare's network for the same reasons they are not in network with insurance companies—because they do not want to be required to submit claims on behalf of Medicare beneficiaries (MBs).

If you are already an out-of-network psychologist for non-Medicare clients, then it is likely you are inclined to opt out of the MNP for similar reasons. Unfortunately, you are not opted out of Medicare by default, even if you have never been in the network. To opt out you must file an affidavit and enter into a private contract (PC) with each MB you serve. The affidavit and PC must meet several criteria that are outlined in chapter 15, section 40, of the Medicare Benefit Policy Manual.

Despite the availability of this manual, much confusion is encountered by providers. This article was written to reduce confusion by providing specific guidelines and resources and by answering common questions.

Two Steps

If this is your first time opting out of the MNP, you must submit an affidavit and your PC by mail to the Medicare Administrative Contractor (MAC) that has jurisdiction over the area(s) in which you practice. See "Resources" toward the end of this article to find your MAC(s). You cannot opt out until a MB wants to receive services from you that would otherwise be covered by Medicare.

The two steps required to opt out are (1) mail an affidavit, and (2) mail your first completed PC to your MAC. Both must follow criteria set forth by the Centers for Medicare and Medicaid Services (CMS). The first PC you enter into must be signed by you and a MB client and submitted to the MAC, along with the affidavit, within 10 days of providing services to the Medicare beneficiary.

After you have opted out, you must renew your opt out status every 2 years by submitting a new affidavit by mail to cover the next 2-year period. You must enter into a PC with each new MB you serve, but you do not have to provide PCs, after the first opt out, to the MAC unless asked for it.

The MAC may ask for a copy of the PC for several reasons. Most commonly a MAC will request a copy of a PC because a MB client submits a claim for reimbursement despite having entered into a PC with you that clearly stated the MB should not and will not receive reimbursement for services with opted out providers.

What are the consequences of not properly opting out and staying out? You may have to reimburse client fees above an allowable amount, and you will have to complete lots of unwanted paperwork in this process. You can refer to chapter 15 of the CMS Medicare Benefit Policy Manual for the specific consequences. You will be given a chance to make a good-faith effort to comply, but it will be a hassle.

How Can I Get a Sample of the Affidavit to Properly Get Out?

You can obtain a sample of the affidavit for Pennsylvania at the Novitas Solutions, Inc., website. Once at the site, you should click on the icon of the state of Pennsylvania entitled MAC Jurisdiction L. You will then find it under Self-Service Resources by clicking on Opt Out Listing and then the example Affidavit. You may

What are the consequences of not properly opting out and staying out? You may have to reimburse client fees above an allowable amount, and you will have to complete lots of unwanted paperwork in this process.

be prompted to select Part B: Physicians & Other Health Care Professionals.

Novitas serves as the administrator (or MAC) for Medicare in Pennsylvania. You can reach the Pennsylvania MAC by phone at 877-235-8073 from 8:00 a.m. to 4:00 p.m. Eastern time. Once you hear the automated recording, select Medicare Part B and then Pennsylvania. If you do not want to be on hold for long they suggest calling between 8:00 a.m. and 9:00 a.m.

When asked for your Provider Transaction Access Number (PTAN) on the phone or when completing the affidavit, note that you do not have one, if you have never been in the MNP. You will also be asked for your personal (not your business) National Provider Identification (NPI) number. When you complete the affidavit you can write "none" under PTAN and because only an individual and not a business can opt out, use your personal NPI.

How to Stay Out

If you are among the psychologists who have successfully opted out and want to stay out, then you should resubmit just an affidavit within 30 days of the expiration date of the current opt out. Optimally, submit the new affidavit 60 days before

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HOW TO OPT OUT AND STAY OUT OF MEDICARE

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the end of the opt-out period. Note that the renewal affidavit cannot be submitted any earlier than 60 days prior to the expiration date of the current affidavit. Also note that you may get very different answers from the very different enrollment specialists and customer service representatives that you talk with at the MAC. I was actually advised by one that psychologists opting out for the first time need not submit their first PC and from what I can tell this is blatantly incorrect.

The Private Contract

In addition to chapter 15 of the Medicare Benefit Policy Manual, you can also refer to resources on the MAC website. Once there, under Opt-Out Listings and then under More Information, you can select A/B Reference Manual Chapter 4–Assignment, Program Participation, and Opt Out Process to find criteria for the PC that you should ask Medicare beneficiaries to complete if you opt out.

Remember, you only have to send in the first PC. There is no need to send subsequent PCs after the very first, even when renewing to maintain your opt-out status, unless a MAC requests a PC from you.

Chapter 4 also contains information about the consequences of not opting out. I was fortunate to receive a sample of the PC years ago from an enrollment specialist at Novitas. Apparently this is no longer possible but who knows what can happen if you call many reps! You can also confirm you are on the opt-out list at the Novitas Solutions website by navigating to the Opt-Out Listings section.

Online Resources

- Find your Medicare Administrative Contractor
- Affidavit from Medicare Learning Network Matters

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Common Questions

Q: Can Medicare clients be reimbursed for services with me if offered for a business that accepts Medicare even if I personally have opted out in a separate private practice?

A: No.

Q: What is Part B?

A: According to Social Security Medicare, "Medical insurance (Part B) helps pay for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment and some preventive services."

Q: What if I treat people who receive Medicaid?

A: Medicaid and Medicare are two different programs. Medicaid is a state-run program that provides hospital and medical coverage for people with low income and varies by state in terms of eligibility and coverage. Some people qualify for both Medicare and Medicaid. For more information about the Medicaid program, contact your local medical assistance agency, social services, or welfare office.

Q: What is the double "S" in the Medicare reference manual?

A: This symbol refers to a section of the manual.

Q: Can I opt out in some states and not others or with some clients and not others?

A: No. Several MACs cover the United States. You should submit an affidavit and your first PC to each MAC that administrates benefits for your clients.

Q: Can I submit an affidavit online?

A: Not currently.

Q: Must I file a separate affidavit in every state?

A: Yes

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comprehensive primary care initiatives are exempted from this program. No doubt this program will be modified over time as CMS gains experience in implementing it. However, it does represent a large shift away from payment based on volume to payment based, at least in part, upon the quality of services.

As a result of the Medicare Access and CHIP Reauthorization Act of 2015 (2015), CMS will be required to develop quality enhancement measures to be used in determining bonus payments. These measures must include patient outcome, patient experiences, coordination of care, and appropriate use of services (lack of over utilization). CMS must develop its plan for this quality project by January 1, 2016, and a status report by May 1, 2017.

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Getting Along With Medicare

Brett Schur, PhD

Dr. Brett Schur

Many psychologists in clinical practice face the decision of participating in Medicare. It is likely that more psychologists participate in Medicare than in any commercial insurance panel. There are drawbacks to Medicare. While the compensation is comparable to many of the largest commercial panels in Pennsylvania, reimbursement rates under Medicare have declined over the last several years from a high achieved about a decade ago. Medicare rules can seem cumbersome and the penalties for not following them Draconian. We often see complaints about Medicare posted on the PPA listserv.

On the other hand, I have found that I get along well with Medicare, for the most part. I've learned the basics of what I need to know. Claims are generally paid, and usually I get the amount I expect. When a claim is rejected, it is usually my error and the correction is usually straightforward. Here are a few thoughts and suggestions based on my knowledge and experiences with Medicare.

It Helps to Have a Friend

Medicare rules and regulations are often written in archaic language with lots of conditions and clauses. They are hard to read and hard to understand. Once you understand them, getting paid for services to Medicare patients is pretty easy and reliable. When I started, I didn't have the good sense to ask another psychologist for help with my initial billing. Ask for help, lots of help, repeatedly. A psychologist, or someone who understands Medicare for psychologists, would be a good resource because a few nuances exist in the rules that differ across disciplines (e.g., rules regarding what a psychologist can and cannot bill for).

Your Status With Medicare

With most commercial insurers, either you are in the network or you are not. With Medicare, there are three possible statuses. You can be a participating provider, a nonparticipating provider, or opt out (Novitas Solutions, 2014). The default status (your status if you do nothing) is nonparticipating provider. If you are not already a participating provider, learn about the three options, so you can decide which category is right for you. Talk to at least one colleague in each category before you decide.

When you enroll as a Medicare provider, you agree to accept Medicare's "allowed amount" (including any deductible and coinsurance) as full payment for your services. You also must agree to abide by Medicare regulations, to bill Medicare for services (rather than collecting payment and asking the patient to seek reimbursement), and to accept payment directly from Medicare (accept assignment).

It is likely that more psychologists participate in Medicare than in any commercial insurance panel.

If you do not enroll as a Medicare provider, you are a nonparticipating provider. Because Medicare is a federal program, the government has the leverage to compel you to follow many of the Medicare requirements even if you are a nonparticipating provider. Nonparticipating providers may not charge more than Medicare permits (the Medicare Limiting Charge). They must accept assignment. They must provide advance notice to the patient when billing for services not covered by Medicare.

The third status is to "opt out" from Medicare. This status exempts the provider from Medicare-limiting charges and certain other Medicare regulations. It requires completion of very specific forms with Medicare every 2 years. It also requires that the provider sign a contract with each patient that says the patient agrees not to bill Medicare for any services from that provider. The contract must have specific language. So . . . if you provide any services to Medicare subscribers, you are subject to some form of regulation by Medicare.

Enrolling as a Medicare Provider

Enrolling as a Medicare provider seems laborious, but it is much more straightforward than enrolling with many commercial insurers. Medicare accepts all qualified professionals, and you will not face some of the issues you might with many commercial companies, such as a provider panel being full.

Novitas is the company that has a contract to process all Medicare enrollment and billing for the mid-Atlantic states. The form for enrolling is called the CMS-855I and it is available online from Novitas. Though this form is 28 pages, it is actually not so bad to complete. This is the kind of form you can fill out on your computer and print. Use this form if you are:

- Practicing independently and doing your own billing
- Practicing independently and paying someone else to do your billing
- New to Medicare and joining an existing group practice
- Already a Medicare provider but you are now joining a group practice
- Already a Medicare provider but you are changing your practice address
- Planning to work (as employee or independent contractor) for a healthcare corporation (hospital, residential treatment center, etc.)

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When completing the CMS-855I, be very careful. For example, in Section D, skip D-1, since you are not a physician. In Section D-2, be sure to indicate that you are a "Psychologist, Clinical" and not "Psychologist Billing Independently." Psychologist Billing Independently is a very limited status that allows testing only.[1] It does not matter whether your degree is in clinical or counseling or elsewhere. (You will be asked to specify your degree later.) For definitions of these categories, click here.

Likewise, complete Section H, "Clinical Psychologists," and leave Section I, "Psychologists Billing Independently," blank. Section 4 has options for setting up an independent practice (single or multiple locations), joining a group, working for a hospital, and so forth. If you are doing a combination of those, it is all on this form. Just read carefully so you cover all options. If you are going to be working for someone else, your employer will complete some items on billing.

Medicare now requires direct deposit of payments. You must complete form CMS-588 to set up direct deposit. There may be a few providers who still receive paper checks. They will be required to convert to electronic deposit the next time they make any change or revalidate their enrollment. If you are going to be working for someone else (group practice or hospital, for example, regardless whether you are an employee or independent contractor), there is an additional form called Reassignment of Medicare Benefits (CMS-855R). You will complete part of the form and the employer will complete part.

You will be notified, usually within a couple of months of your application, that you are now a Medicare provider. You can then begin providing services and submitting claims to Medicare. There is a provision for providing services and billing later while you wait on application approval; however, I am not sure of the details.

Billing Medicare for Services

Billing instructions are contained in chapter 9 of the Medicare Part B Manual, available online (Novitas Solutions, n.d.). There are three ways to bill Medicare. You can submit paper claims, bill online, or submit claims electronically through a clearinghouse. All three have drawbacks. I submit paper claims.

I usually bill once a month, regardless of the number of sessions in a month. I wrote a series of Microsoft Word templates to help me with the task. With the system I developed, I can enter demographic and treatment information for a new patient and store the information. The next month, I only have to fill in the new dates of service. Billing programs are available that fill in the forms and help you keep track of payments received.

One of the drawbacks of paper claims is slower payment. By law, Medicare must not pay an electronic claim sooner than 15 days after receiving it and must not pay a paper claim sooner than 29 days after receiving it. I usually receive payments on paper claims about five weeks after I drop them in the mail. I get the Explanation of Benefits two or three days after payment is electronically deposited in my bank account.

One of the advantages of Medicare is having up to a year to file claims. As with any other electronic service, precision is key. Errors can be immediately obvious or may be difficult to track down and understand. I usually find customer service people to be friendly, knowledgeable, and willing to help.

There are various types of errors. Some errors are considered so basic that the claim is never processed. Examples include having the patient's Medicare number wrong or a date that doesn't make sense (e.g. 12/10/15 instead of 12/10/14). The form is returned with an explanatory note. Correct the error and resubmit. Some errors are noted on an Explanation of Medicare Benefits, such as when another insurance is primary to Medicare. Again, fix the problem and resubmit.

There may be some errors that you detect. Examples include billing $10 for a session instead of $100 or billing for a wrong date of service. These errors are more difficult to correct. You have to appeal the determination, return the money to Medicare and then resubmit the claim. If you detect a payment error, it is your legal and ethical responsibility to notify Medicare and correct the error. It is also your responsibility to have a system for detecting errors. An example would be a system for reviewing every Explanation of Medicare Benefits form for accuracy.

One of the advantages of Medicare is having up to a year to file claims. As with any other electronic service, precision is key.

The most difficult claims problem I seem to encounter is when a Medicare subscriber's status is changing. One example involved a patient who had commercial insurance primary and Medicare secondary. After she divorced, she dropped the commercial insurance and Medicare became primary. It took a while for Medicare to record the change and for me to get the correct date on which the change took effect, so I had billing errors. However, I was eventually paid for all the back claims. Part of the difficulty was that I was not making effective use of Medicare's automated telephone system. Once I called into the system and determined the date that Medicare became primary, I was able to correct the errors.

I find it helpful to read Novitas bulletins which apply to psychologists and to watch the PPA listserv for announcements of important changes in Medicare billing (such as last year when the forms for paper claims were revised). APA also sends announcements of changes in Medicare rules to members who sign

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[1] A clinical psychologist can do anything an independently billing psychologist can do. However, enrolling as a clinical psychologist requires a doctoral degree. A psychologist in Pennsylvania who is licensed at the master's level may enroll as an independently billing psychologist and receive reimbursement for testing services.

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up for e-mail announcements. It is possible to sign up for daily announcements of new policies from Novitas. Most are irrelevant, but it only takes me a minute to scan the e-mail for issues related to psychology.

For more information, visit the Novitas website. In the column on the left, hover over Education & Training, then click on More. . . . The last item in the left-hand column is "Join our email lists." Select Jurisdiction L—Part B—General Information.

Medicare Protects Itself and Its Subscribers, Sometimes at the Expense of Providers

One drawback of participating with Medicare is that some Medicare rules can limit our ability to charge for services. For example, Medicare seeks to protect its subscribers by prohibiting charges for missed appointments. This provision seems to protect patients at the expense of providers. Yet it may also have unintended consequences for patients. What options does the provider have when the patient misses sessions? Certainly there is the option of forgiving the instance or of addressing it in session. But missed sessions without some compensation may lead the provider to terminate treatment prematurely.

Another example of a Medicare rule to protect itself and patients is the Medical Necessity requirement. All services must be medically necessary under Medicare rules. This sometimes prevents a patient from paying the provider for services that are not considered medically necessary. How does this affect the practice of psychology? The psychologist must make predictions about what level of services will meet criteria for medical necessity. If the patient wishes to continue see the therapist three times a week for psychotherapy sessions, for example, would that pass a medical necessity audit? If not, the psychologist cannot bill Medicare and may not be able to charge the patient, either.

The same might also apply to the patient who wishes to continue therapy longer than medical necessity criteria would support. Under some circumstances, the psychologist can follow procedures to provide "Advance Beneficiary Notice," but those rules are problematic, too. So the patient loses options due to Medicare rules.

Hidden Gems of Medicare

Medicare is complex, making it a challenge for professionals to be aware of all of the rules and provisions. We tend to think of many of the rules as burdensome or even as tricks to trip us up. However, there are some little-known benefits, too. For example, did you know that you can bill Medicare for reimbursement of HMO co-pays when the patient has an HMO as primary insurance and Medicare as secondary? There is a form available for download at Novitas. As far as I know, the form can only be used with a paper claim.

Documentation of Services

Documentation of services is not substantially different for Medicare, except that record retention requirements are longer. In part, this is because Medicare has largely set the standards for documentation that other payors, as well as regulatory agencies, generally follow. The caveat is that Medicare has the reputation of being much less forgiving than other insurers in an audit. Medicare rules allow auditing of charts and the consequence of proportional repayment if deficiencies are found. If Medicare audits 10 charts and disallows two of them, it will demand repayment of 20% of all your Medicare claims for all patients.

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) began in 2007 as a small incentive program to get physicians to carefully document several indicators that were believed to improve quality of care. It was gradually expanded to include more items and more providers, including psychologists. In the beginning, the program paid a lump sum bonus to providers who successfully documented a subset of the indicators. As of 2013, the program began to penalize providers who did not participate or who did not meet the set standards, with a deduction of 1.5% of all Medicare payments in 2015. There is a 2-year lag time between reporting and penalty.

There are a number of resources to help you understand PQRS. One of them is a paper written by Knapp, et al., (n.d.), which is revised annually to cover changes to the program. The American Psychological Association (n.d.) publishes a summary of changes. I found it helpful to use these guides side-by-side when I was learning PQRS, and I continue to use both of them.

Closing Thoughts

Many psychologists in clinical practice find Medicare worthwhile, despite its quirks. It allows us to work with specific groups of clients who clearly benefit from treatment and often have difficulty accessing services, including older adults and individuals with disabilities. Medicare can be a reliable part of the income stream for groups and independently practicing clinicians. With a modest effort, it is not difficult to keep up with the most essential rule changes. In my practice, I will likely remain a Medicare provider, even if I needed to cut back on other insurance panels.

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Matched in Match Phase I. What Now?

Adrienne B. Gallo, MS

Adrienne B. Gallo, MS

You have matched! Congratulations! After you have finished celebrating, calling all of your friends and family members, and posting on various social media sites, you may wonder: What now?

Graduate school has been a series of hoops for us to jump through. Everything you have done during graduate school, and especially during the past six to eight months, culminated with the content of a single e-mail received on a Friday morning toward the end of February. It is now safe to take a deep breath and congratulate yourself on your huge accomplishment. The next step is to create your preinternship to-do list. Some of the important items to include on this list might be:

1 Self-Care. Take some time to do the things you enjoy the most. Engage in the activities that you may not have had time for during your course work.

2 Course work. Confirm that you are on track with your course work for school. Double check that you are enrolled in all the classes you need to graduate. Though it may be tempting, try not to fall behind on your current classwork. You have come this far. Finish strong!

3 Dissertation. Now is a great time to work on your dissertation if you have not already completed it. Internship will be a full-time commitment and possibly located far from your school. As a result, meetings with your chair and participants could become difficult and costly. Meet with your chair to discuss a feasible timeline for the completion of the chapters of your dissertation. Discuss the potential challenges that writing a dissertation on internship can pose and brainstorm solutions. The more you have completed, the less stressed you will be during internship.

4 Moving? The next consideration is whether relocation is necessary. If not, you can go back to self-care and working on your dissertation and course work. If relocation is necessary, start planning your move as soon as you feel ready. Many internships are very helpful with the moving process and are knowledgeable about their areas. Reach out to your internship training director for help and ideas. Also, find out from your current director of clinical training whether someone in your program has matched there before to see if they can be of any help. It is important to start this process early to make the transition as smooth as possible.

5 Licensure. It is also important to consider licensure requirements for each state. Have you decided where you want to practice in the future? It is okay if you have not, but remember that licensing requirements are not universal. It is important to do your research and plan ahead for licensure.

As you create your to-do list, keep in mind that you have accomplished something huge! You have successfully matched during an internship crisis. All of your years of hard work have paid off, and you now have a paid internship to show for it. At some point this summer, you will be working in the field, doing something you love around competent and talented professionals. Once that "imposter syndrome" wears off, you will realize that you are one of those competent and talented professionals as well. So again, congratulations, ladies and gentlemen: You have successfully matched!

So You Didn't Match in Phase I of the Predoctoral Internship Process . . .

A Bump on the Road to Graduation

Sneha McClincey, Doctoral Candidate, Chestnut Hill College

Sneha McClincey

So you didn't match. Maybe this wasn't outside of the realm of possibility, or maybe it took you by complete surprise. Either way . . . what do you do now? First and foremost: breathe! You need a game plan, but before you start down that road, you need to contact those who can support you through this process and let them know what you need. This might include your training director, cohort, and/or advisor, among others. These are the people who can help guide you to be more successful in Phase II of the match. For general mental health, your family and friends are vital to keeping the balance and may offer needed moments of respite to the preparations for this stage of the match process.

With your supports in place, take a look at what's different in this stage of the match process. All of the same rules from Phase I apply for Phase II, with a few exceptions. The biggest difference is that there are no supplemental materials required beyond the online application. Another difference is that sites typically conduct phone or Skype interviews. However, in the event that you live within driving distance of the site, there is a possibility that you may be invited to interview in person. A third difference is that sites are not obligated to inform you if your application is not being considered. A final exception (and a pleasant upside) is that there is no cost to apply to sites in this round. Please note there may be other exceptions from year to year, so be sure to check the Association of Psychology Postdoctoral and Internship Centers (APPIC) website.

If you're not sure where to begin, the first place to look would be the APPIC website. Helpful links include "Phase II Getting Started Guide" as well as "Instructions" and "Frequently Asked Questions." There is also a section of the website devoted to "Late Breaking News," an important page to check periodically, in order to ensure that you're not missing any newly added internship sites. Though changes typically get reflected in the general APPIC site list, one can never fully account for technology, so do your due diligence and check the "Late Breaking News" link often. When you begin reviewing sites, keep in mind the site requirements of applicants (e.g., required assessment and intervention hours). Also keep in mind your institution's own requirements of sites.

Before you decide on sites to apply to, consider the sites you chose in the first round and where you were invited for an interview. If you had few interviews, it may have been that the other places you applied to could not see how your past experience and internship goals aligned with the training experience they were offering. A good fit between your previous experienceand training goals and the site is crucial to matching!

On the other hand, if you had a number of interviews and did not match in Phase I, you may want to consider your interviewing skills. Ask a fellow classmate to role-play an interview and practice answering questions with him or her. Practice helps you prepare to shine! Also take some time to review your materials (e.g., essays and cover letters) and, if possible, have someone review or edit those materials.

Finally, with cover letters and references completed, submit your materials to each site at least a day or two before the deadline to avoid any hiccups due to technological issues. Once submitted: relax. You've done everything you can to make that phone ring. *Bonne chance!*

Phenylketonuria: Cognitive, Socio-Emotional, and Behavioral Implications

Erin Esposito, BS, Immaculata University, and Marie C. McGrath, PhD, Immaculata University

Phenylketonuria: Etiology, History, and Prevalence

Phenylalanine hydroxylase deficiency, traditionally referred to as phenylketonuria, or PKU, is an autosomal recessive disorder caused by a mutation on chromosome 12 that results in problems coding the enzyme phenylalanine hydroxylase (PAH) (Moyle, Fox, Bynevlt, Authur, & Burnett, 2007). PAH helps to convert the amino acid phenylalanine (PHE), which is found in foods with protein, to the amino acid tyrosine. When PHE cannot be metabolized effectively, it may build up in the brain, interfering with neural myelination and impacting neuronal transmission (Huijbregts, de Sonneville, Licht, Sergeant, & van Spronsen, 2002). The disorder varies in severity along a spectrum of PAH deficiency, with "classical PKU" representing a more severe presentation and hyperphenylalaninemia (or "hyperphe") a milder presentation (NIH National Human Genome Research Institute, 2014). Given this heterogeneity, recently issued diagnostic guidelines suggest that the term "phenylalanine hydroxylase deficiency" is a more inclusive, and thus more appropriate, name for the disorder (Vockley et al., 2014); however, this article will refer to the disorder using the more familiar term phenylketonuria, which is still commonly used in both research and clinical applications.

Phenylketonuria was first discovered in 1934 by Norwegian physician and biochemist Ivar Asbjørn Følling as a result of his work with two siblings who demonstrated progressive cognitive deficits and who had high levels of phenylpyruvic acid, a phenylalanine metabolite, in their urine (Vockley et al., 2014). Wide-scale newborn screening via blood test was implemented approximately three decades later, making the disorder the first metabolic abnormality identified via population-level screening (Anton, Tocan, Iliescu, & Diaconu, 2011; Vockley et al., 2014). Neonatal screening helps to prevent death and alleviate severity of disabilities in affected individuals by enabling early intervention (Anton et al., 2011). Currently, it is estimated that phenylketonuria impacts 1 out of every 10,000–15,000 individuals (NICHHD, 2013).

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Symptoms of Phenylketonuria

Symptoms of untreated phenylketonuria usually first appear around the age of 3–4 months and may include intellectual disability, behavioral disturbances, psychological issues, neurological deficits, and malfunctioning of major organs (Anton et al., 2011). The white matter abnormalities seen in phenylketonuria have shown some level of reversibility with dietary interventions (Anderson et al., 2007). However, MRI studies have nonetheless demonstrated white matter abnormalities in children and adults with phenylketonuria who were treated early, as well as in those treated later in life (Anderson et al., 2007), indicating that treatment does not provide total protection from the neurological consequences of the disorder.

There is evidence to support that individual variations in the blood-brain barrier play a role in determining PHE levels in the brain, which in turn affects neurological outcomes for individuals with this disorder (Grosse, 2010). Additionally, since the amino acid tyrosine is a precursor to several monoamine neurotransmitters, failure to synthesize tyrosine in adequate quantities can potentially result in altered dopaminergic, norepinephrinergic, and serotonergic activity in the central nervous system, leading in turn to altered cognitive and affective functioning; however, the impact of altered phenylalanine and tyrosine levels on neurotransmitter synthesis and function is not yet fully understood (Anderson et al., 2007; Anton-Paduraru, Grigore, & Diaconu, 2013).

PHE levels have been shown to be negatively correlated with mental health functioning, social skills, and behavioral stability in both children and adults (Jahja et al., 2013). Successfully treated children and adolescents generally have levels of mental health symptoms and social skills that are similar to those of controls without phenylketonuria, while untreated children and adolescents show more impairments in these areas of functioning. Specifically, children and adolescents with higher PHE levels tend to be more depressed, anxious, and avoidant, and to demonstrate more behavioral issues, than those with lower PHE levels (Jahja et al., 2013). Physical complaints, thinking problems, and somatic concerns are also positively correlated with childhood PHE levels (Jahja et al., 2013). Some have noted that, as with many other disorders, the behavioral presentation of phenylketonuria can be easily mistaken for ADHD (Stevenson & McNaughton, 2013).

Wide-scale newborn screening via blood test was implemented approximately three decades later, making the disorder the first metabolic abnormality identified via population-level screening.

A number of studies suggest that individuals with phenylketonuria experience

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deficits in executive functioning whether or not their PHE levels are well controlled. Although some studies have suggested that executive functioning deficits are related to current and lifelong dietary practices and PHE levels, when children with early and consistently treated phenylketonuria were studied, they had significantly more difficulty than neurotypical controls on tasks that involved planning, problem solving, and attention, suggesting that executive deficits may persist despite diet management (Azadi, Seddigh, Tehrani-Doost, Alaghband-Rad, & Ashrafi, 2009).

Children with well-controlled PHE levels generally have average IQ scores, but Azadi et al. (2009) found that their scores were lower than would be predicted by the scores of their unaffected parents and siblings (Azadi et al., 2009). When Channon, German, Cassina, and Lee (2004) looked at early-treated and untreated adults with phenylketonuria, they found that both groups demonstrated performance deficits on measures of selective and sustained attention and working memory, though the deficits seen in the early treated group were less significant than those seen in participants with untreated phenylketonuria. On timed tasks, individuals with phenylketonuria also demonstrated difficulties, supporting the hypothesis that white matter integrity and functional connectivity between frontal and nonfrontal regions that control executive functioning is also impacted by the disorder (Channon et al., 2004).

Online Resources for Practitioners and Families

- Children's PKU Network
- "How Much Phe?" Diet Management Tool
- The Mid-Atlantic Connection for PKU and Allied Disorders (MACPAD), Inc.
- NIH National Human Genome Research Institute's "Learning About Phenylketonuria" webpage
- NIH National Institute of Child Health and Human Development (NICHHD)'s "Phenylketonuria" webpage
- National PKU Alliance
- National PKU News
- The New England Consortium of Metabolic Programs PKU Toolkit

Medical Treatment for Phenylketonuria

Following diagnosis, a person's blood must be frequently drawn and dietary intake must be monitored to ensure that PHE levels are within a therapeutic range, since current PHE levels and mean lifetime PHE levels are both thought to predict prognosis for those diagnosed with the disorder (ten Hoedt et al., 2011). Initially, it was thought that less strict adherence to low-PHE diets in adulthood was acceptable; however, more recent findings regarding long-term neurocognitive and neuropsychiatric implications of the disorder, including increased symptoms in non-dietary-compliant adults, suggest that dietary interventions should be extended throughout the lifespan (Vockley et al., 2014). It is especially important for women who are pregnant to keep their PHE levels within recommended ranges, since PHE crosses the placenta at increased concentrations, which can cause facial and heart abnormalities, small head circumference, slowed intrauterine growth, and increased risk for intellectual disabilities in the developing fetus (Bouchlariotou, Tsikouras, & Maroulis, 2009).

A lifelong medical diet is currently considered the therapeutic procedure of choice in the United States (Vegni, Fiori, Riva, Giovannini, & Moja, 2010). Impacted individuals are encouraged to limit their intake of phenylalanine through foods. Dietary restriction of foods containing natural protein; provision of supplemental nutrition via medical foods (e.g., formula that contains phenylalanine-free synthetic protein or pills containing large neutral amino acids); and supplementation with vitamins and minerals is considered to be the best and safest intervention for the disorder (ten Hoedt et al., 2011). Some individuals are also treated with Kuvan (sapropterin dihydrochloride), a medication that can boost phenylalanine hydrolase activity in individuals that retain residual PAH function, but this is used only as an adjunct to dietary intervention, rather than as a primary treatment.

When children with early and consistently treated phenylketonuria were studied, they had significantly more difficulty than neurotypical controls on tasks that involved planning, problem solving, and attention, suggesting that executive deficits may persist despite diet management.

Although people with phenylketonuria may show impairments in certain areas of functioning regardless of diet adherence, the severity of many cognitive deficits tend to decrease with dietary compliance (Vegni et al., 2010). VanZutphen et al. (2007) found that diet noncompliance happened more frequently in adolescence than in childhood, and that their PHE levels increase as diet compliance decreases among adolescents. Additional support may therefore be needed during adolescence to ensure dietary compliance is maintained.

Suggestions for School-Based Practitioners

Given the significant and global impact that phenylketonuria can have on neurological functioning, continued monitoring of symptom progression and the effectiveness of treatment, especially in childhood and adolescence, is critical to better outcomes (VanZutphen et al., 2007). Ensuring dietary compliance

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is necessary, especially for adolescents, who are more likely than younger children to make independent food choices, as well as more likely to resist or deny interventions that differentiate them from peers. Involving the person with phenylketonuria and their support system, such as family and teachers, in treatment planning can help with dietary compliance and symptom management (ten Hoedt et al., 2011). However, regardless of compliance, individuals with phenylketonuria may demonstrate needs that will need to be addressed via special education, accommodations, or other interventions in school settings. The following strategies and considerations may be useful to school psychologists or others who work with students with phenylketonuria:

Given the range of symptom severity associated with phenylalanine hydroxylase deficiency, it is necessary to consider the needs of each child individually in educational planning. While some individuals' needs may be met through provision of accommodations via a Section 504 plan, other individuals may experience cognitive and/or behavioral symptoms that will cause them to require specially designed instruction via an IEP. Depending on the severity of the condition and the specific impairments noted, eligibility under a variety of categories, including Other Health Impairment and Emotional Disturbance, among others, should be considered.

Because the cognitive, academic, executive, behavioral, and socio-emotional difficulties that individuals with phenylketonuria may experience present very similarly to other disorders, including ADHD, learning disabilities, and idiopathic intellectual disability, it is necessary for practitioners to obtain comprehensive histories on these students, and to thoroughly evaluate for potential deficits in areas of possible difficulty. However, empirically-supported interventions and accommodations that address attention, memory, executive functioning, processing speed, and academic needs in children with other disabilities may also benefit individuals with phenylketonuria.

A variety of dietary accommodations will be necessary for individuals with phenylketonuria. Provision of accessible and safe storage options (including refrigeration) for formula and other supplies is necessary. The use of alarms, cueing systems, and/or consistent routines, and the ability for students to leave classes to access medical foods, may be useful strategies to improve dietary compliance.

Ensuring that low-PHE options are available during events that involve food, taking precautions to minimize students' access to unauthorized foods, and helping students to monitor their PHE intake at school may all be helpful. The school nurse should be involved in planning for these needs, and all relevant school staff should be informed of dietary needs and restrictions.

Open communication and information-sharing with other specialists who treat the child (e.g., physicians and/or psychologists at PKU clinics) and with students' parents or guardians is recommended in order to identify intervention strategies that work across settings, and/or changes in functioning that may need to be addressed by treatment providers.

Access to a school psychologist, school counselor, or other appropriate staff member who can provide therapeutic/counseling support addressing social, attentional, and other skills impacted by this disorder, and/or stressors related to the disorder (e.g., feelings of isolation from/fear of rejection by peers), may be helpful.

Supporting students in accessing social supports, educating teachers and peers about the disorder, and advocating for their own needs may improve both treatment compliance and socio-emotional functioning.

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What Can PPA Do for Academics?

David J. Palmiter Jr., PhD, ABPP

Dr. David J. Palmiter Jr.

The Pennsylvania Psychological Association (PPA) is widely regarded as not only one of the largest state psychological associations in the country (usually ranked second or third) but also as one of the finest and best organized. However, I've sometimes heard it said that PPA is an organization that caters to the needs of clinicians, offering little value to academic psychologists. The purpose of this article is to challenge that statement. I've been both a full-time academic and a member of PPA since 1998; in my experience PPA provides numerous benefits for academic psychologists.

We academics typically have to account for our work in three categories: scholarship, service, and teaching. Let me address what PPA can do for academic members in each of these areas.

Scholarship

Members can use PPA to advance their scholarship in at least five ways:

1. This bulletin provides an outlet for publishing articles. As a committee selects topics and authors, and articles are edited, it is a peer-reviewed publication.
2. The annual convention in June provides an opportunity to offer poster sessions; again, these are peer reviewed. Posters may have been presented elsewhere first or simultaneously.
3. PPA offers three opportunities for academics to offer peer-reviewed professional presentations: at the annual convention, the spring conference, and the fall conference.
4. The member listserv provides at least three opportunities for academics. Members may:
   - Solicit participation for research subjects (twice per study)
   - Announce publications (e.g., books, tests)
   - Solicit feedback for an assortment of issues that arise in academic life (e.g., receive help in developing a new course, receive help in solving training conundrums)
5. PPA has a history of various collaborations with research projects (e.g., the Practice Research Network and the Pennsylvania Pediatric Mental Health Task Force).

Service

There are more ways to provide professional and public service through PPA than I can review in this brief article. However, I will focus on four kinds of service activities:

1. PPA has 27 committees. If you have a passion within psychology, the odds are high that there is a PPA committee that is working on that passion and would both enjoy and benefit from your engagement.
2. Advocacy Day offers an annual opportunity to come to Harrisburg and lobby state legislators on a wide assortment of issues relevant to psychology (this year it is on May 4). Such efforts have facilitated it being illegal to deliver corporal punishment in schools, ensured that psychologists can submit for Medicare and Medicaid reimbursement, and contributed to the expansion of the mental health services that psychologists may offer.
3. There are numerous opportunities to take on leadership roles. Personally, this has been my favorite thing about being a PPA member. For example, I used to leave a weekend of Board of Directors activities feeling as if I had gotten much more energy than I had given. Moreover, if you are going up for rank or tenure, having been elected to a leadership position in one of the top state psychological associations in the country can only be a good thing.
4. PPA emphasizes public education. It does this through the work of multiple committees (e.g., the Public Education Committee and the E-Newsletter Committee) and presentations to the public (e.g., at the annual convention, to staff at the Pennsylvania General Assembly). If you care about making your academic work products available to the public, PPA is for you.

Teaching

In my travels, I've learned that most of us academic psychologists are on a passionate mission to serve students with excellence. Of the three areas for which we are accountable, this is the one that may afford the most benefit through PPA.

First of all, just about every activity I've listed above is available to students as well. I've had my students join committees, accompany me to Advocacy Day, copresent both professional and lay presentations, conduct research, publish within the bulletin, and offer poster sessions. I've also had students, and former students, take on leadership roles within PPA.

Next, PPA offers multiple ways for students to be recognized for their work both directly (e.g., awards for posters) and through its sister organization, the Pennsylvania Psychological Foundation (e.g., student monetary awards). Academic members have also won multiple annual awards offered by PPA.

PPA activities offer students numerous networking opportunities as well. For example, the PPA network has facilitated my students landing both internships and jobs.

Finally, work done through and with PPA portends to offer a plethora of content for lectures. Active academic members are in a position to give firsthand

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WHAT CAN PPA DO FOR ACADEMICS?

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illustrations of cutting-edge issues and activities within psychology. I don't know about you, but I've always found my talk feels much stronger when it has followed my walk.

There are other opportunities for academics outside of these three traditional areas. For example, PPA holds annual events exclusively for those who teach doctoral students (i.e., the Doctoral Summit) and ethics (i.e., the ethics educator program). PPA also has an entire board devoted to the subdiscipline of school psychology. Moreover, if I have a professional conundrum I can call a PPA colleague—and usually one who has at least a state reputation for excellence in the area in question—and get an answer that same day.

Finally, there are so, so many friendship opportunities that members enjoy. I'm not sure which is my stronger motivation for attending the annual convention: to grow professionally or to cut up and catch up with friends. Indeed, some of the finest people and psychologists that I know are PPA volunteer leaders. It is for these and other reasons that I've found my PPA dues to be the professional expense that offers me the very best cost-benefit ratio. If you're an academic, and are not a member, I strongly encourage you to consider what's in it for you to join our ranks. We would love to have you and all that you have to offer!

Getting Started in Teletherapy

Ed Zuckerman, PhD

Dr. Ed Zuckerman

Many X-rays taken in the United States are read on the other side of the world, the military has moved from arranging telemedical specialist consultations to real-time treatments, and psychotherapy will not be far behind in this electronically interconnected world. Doing therapy with video will become more common, accepted, and productive despite legal and payment obstacles. This might be a good time to consider learning more, getting trained in its differences from face-to-face therapy, and trying out some technologies.

Why Now?

A big door has finally opened. Medicare is now paying for psychotherapy via telehealth, albeit with some significant limitations. The beneficiary must live in a rural census tract, but the definition has been expanded and some are included in Metropolitan Statistical Areas. The client must come to a facility, but the facility is paid for this. Rates are the same as office visits and the currently eligible CPT codes now include 90846 (multifamily group therapy) and 90847 (family therapy with patient present). Annual wellness visits are included with HCPCS codes G0438 and G0439 (initial and subsequent). As has been true in the past, other payers are likely to follow Medicare's model, especially when they can save money.

Why Do Teletherapy?

Our current clients can benefit. A sick child or personal illness would not mean a lost session and delayed recovery. Those who go on vacation or are business travelers but still want therapy with us or who move and have not yet connected with a new therapist can continue the therapeutic relationship. We could provide more frequent or just necessary treatment to clients who cannot travel to our offices for a variety of reasons. Teletherapy could support family therapy meetings among members at a distance from one another. Clinical case consultations can benefit professionals. Home visits are often very revealing and, if performed electronically and paid for, could become common. Agoraphobics could benefit without having to come to an office.

Teletherapy would be advantageous for all types of situations. The Internet can nullify barriers such as distance, skirt delays and procedures imposed by current payment and service delivery systems, and minimize irrelevant considerations such as race, age, and gender or, alternatively, maximize these to advantage. In one way or another, all areas are underserved, and telehealth can better distribute highly specialized services for unusual problems. The painfully shy, the socially inappropriate, those with disfiguring or mobility-limiting injuries, and the anergic depressed could receive therapy. Adding teletherapy to wearable sensors and cameras would open additional doors.

What Tools and Training Do I Need?

Almost any computer with a camera and microphone and a moderately fast and reliable Internet connection is sufficient because the work is done by "teleconferencing programs." Better speakers, microphones, multiple and higher resolution cameras, and faster Internet connections can be added later. A method of recording sessions is desirable.

Teletherapy presents unique and novel concerns, such as impersonation, health insurance fraud, and assuring privacy when the camera cannot see the client's location. Training is therefore essential. Marlene Maheu, PhD, has been a tireless advocate for teletherapy, and her organization, the TeleMental Health Institute, offers training and other support. The Resources section of this paper contains many additional materials I think efficient and helpful. While there are hundreds of communication programs ranging from easy-to-use and encrypted FaceTime to Google Hangouts and Skype, telehealth requires both assured privacy and security.

Teleconferencing Programs: Privacy and Security Issues

HIPAA's privacy and security rules are complex, as are the technology and risks of teletherapy, and so I will mention only a few here. HIPAA does not specify technology but only the goals and outcomes, allowing many programs to flourish.

The best-known, easiest, and most-popular teleconferencing program is Skype, but it is unsuitable for teletherapy for reasons worth exploring. The business providing the electronic linkages has access to your PHI (the conversations and video) and is not your employee. They are your business associate. They must protect the privacy of this information as you do and this is assured by their methods and their promise to comply with HIPAA through a business associate contract with you, the covered entity. Skype does not provide the security and privacy and will not sign such a contract. Be aware that this contract will provide you with a technical and legal defense for a HIPAA complaint. You will still, however, experience the costs of amelioration, reputational loss, and perhaps a board inquiry.

In addition, Skype includes neither the audit controls (which real person accessed the PHI, when, and what changes were made to the PHI) nor the tools to alert you that there has been a breach (unauthorized access or disclosure), which will require investigation and notifications. Click here for information on the liabilities of Skype or visit the Online Therapy Institute.

A widely praised but not perfect alternative is VSee. It uses less bandwidth than others and so will send high-definition video even on a 3G cellular network (e.g., your smartphone). Others include GoToMeeting and VIA3. For more

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programs, see the Resources section toward the end of this article.

Legal and Ethical Issues

Because telehealth services make practical sense and are cost efficient, 21 states have "telemedicine parity" legislation requiring that insurers reimburse licensed health-care providers for services delivered remotely, just as they would for in-person visits. Even Mississippi has taken a lead on this.

Changes to ethics and laws always lag technological changes. It appears that only nine states have addressed telepsychology issues (Drude, 2013), and Pennsylvania is not one of them. The APA released Guidelines for the Practice of Telepsychology in 2013. The American Mental Health Counselors addressed these issues in 2000 in Principle 14 of their Code of Ethics, and the American Counseling Association added it to their code in 2006.

For this novel medium, clients must give informed consent. Two basic forms—consent for treatment and release of information—are required.

Across State Lines

The primary function of a licensing board is to protect its state's citizens and to ensure that it can prosecute any professional who treats its citizens, regardless of where the professional is located or licensed. For a psychologist intending to continue to treat a client who has moved, seeking permission to practice in the client's new state of residence is the best course. Most boards will allow such work limited by time, clients, or number of sessions. If the client's residency has not changed, the therapist can legally and ethically continue therapy with the client as long as the mental health issues are such that they can be effectively treated and managed via the phone, videoconferencing, or other digital technologies.

Becoming licensed in other states has gotten easier with reciprocity agreements among a few boards (not in Pennsylvania) and the acceptance of the Certificate of Professional Qualification in Psychology (CPQ) in 44 states. The CPQ attests to the psychologist's educational preparation, supervised experience, and examination performance, which are typically needed in applying for additional licenses. In addition, the Association of State and Provincial Psychology Boards offers an online "credentials bank" called the Psychology Licensure Universal System (PLUS) to support license applications. The National Register of Health Service Psychologists has a similar data bank for license mobility.

Not Across State Lines

While a licensing board is unlikely to extradite an out-of-state professional, a decision by the client's state board against a professional may be seen by the professional's state board as worthy of investigation or action. Note that the Pennsylvania Board of Psychology has prosecuted a psychologist licensed in Israel who advertised a practice located in Pennsylvania. HIPAA applies only to covered entities and not to professionals of any other country so while psychotherapy from Mumbai is feasible now and may become acceptable if costs are low enough, boards will have future challenges.

Risks have dissuaded the thoughtful practitioner from treating those in another state, including the licensing issue and the need for handling emergencies. Harris and Younggren (2011) provide a thoughtful overview of the risks.

Resources

- The American Telemedicine Association has published many guidelines including Practice Guidelines for Video-Based Online Mental Health Services (2013).
- National Telehealth Resource Centers (NTRCs) offer information and resources without bias. There are policy statements, technology guidance, and links to local and regional resources.
- There are 12 Regional Telehealth Resource Centers (RTRCs) covering all states. Related to these are the National Telehealth Technology Assessment Resource Center and the National Telehealth Policy Resource Center.
- Telemental Health Therapy Comparisons compares perhaps a hundred teleconferencing software programs on dozens of criteria organized for users ranging from consumers, private practitioners, and provider networks to enterprises. Free simple registration is required but this is a gigantic resource, beautifully and functionally organized. A lot of work went into the data and the design.
- Although from Vsee, this table offers links to many other applications for telehealth and some critiques (which I cannot evaluate). Comparisons between just about every program have been written by Vsee.
- Marlene Maheu, PhD, of the Telemental Health Institute has been a pioneer, expert, and advocate for telehealth services for many years. This site offers training, webinars, and consultations on topics such as reimbursement and legal and ethical issues. A table lists about 40 video teleconferencing companies (with links), their costs, and their HIPAA compatibility.
- The Zur Institute is probably the best resource for all aspects of teletherapy, offering an online course entitled Ethical, Legal, Clinical, Technological, & Practice Considerations.
- The American Psychological Association publishes *Telehealth 50-State Review*, a set of tables for all 50 states on the legal and regulatory status of telehealth legislation, board opinions and regulations for psychologists, guest privileges, and penalties for unauthorized practice. It is current as of October 2013.
- For current legislation in each state see the American Telemedicine Association.
- Roy Huggins, LPC, NCC, at Person-Centered Tech provides smart, legally informed, and technologically sophisticated consultation, training, and advice. See also his courses at the Zur Institute.

References

Drude, K. P. (2013). State psychology board telepsychology laws, regulations, policies, opinions. Retrieved from http://telehealth.org/psychology/

Harris, E. & Younggren, J. N. (2011). Risk management in the digital world. *Professional Psychology: Research and Practice, 42*(6), 412–418. http://dx.doi.org/10.1037/a0025139

CE Questions for This Issue

The articles selected for 1 CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($35 for nonmembers) and mail to:

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Allow three to six weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before June 30, 2017.

Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Fox

1. Medicare reimbursement has been cut over the years due to sequestration, which is:
   a. A term that refers to the state of being alone or kept apart from others.
   b. A process that allows providers to submit CMS-1500 insurance claims electronically.
   c. A process that automatically cuts the federal budget across most departments and agencies.
   d. A process that prevents physicians from receiving incentives for instituting electronic medical records in their practices.

2. Cuts to the Medicare Sustainable Growth Rate (SGR) are:
   a. A result of overspending on entitlement programs by the U.S. government
   b. An elegant solution to steep increases in compensation to insurance company CEOs
   c. A process of incremental payments intended to encourage people 65 and older to delay signing up for Medicare.
   d. A result of the Balanced Budget Act of 1997 and designed to control the cost of Medicare payments.

King

3. Children who are eligible for receiving Medicaid because of a severe intellectual or physical disability can be restricted from receiving it if their parents' income is too high.
   T
   F

4. Parents who believe their child may qualify for the Medicaid "Loophole" benefit can apply by going to:
   a. Their local county assistance office
   b. The COMPASS website
   c. a and b
   d. Their local school district's office

Sweeney

5. Geropsychology competency can only be achieved through a formal internship or postdoctoral training program.
   True
   False

Knapp

6. Which of the following is true about PQRS?
   a. Most submissions under PQRS come from solo practitioners.
   b. CMS has a long-term commitment to ensure that practitioners may submit PQRS data through claims forms.
   c. Starting in 2015, PQRS shifted to a penalty only program.
   d. All of the above

Molnar

7. Which of the following statements is accurate about psychologists who see Medicare beneficiaries without an affidavit and a private contract?
   a. They will have to pay back any fees-for-services that were collected if the fees exceed what is allowable by Medicare.
   b. They will be fined thousands of dollars.
   c. They will lose their license to practice.
   d. They will have to memorize the Medicare Policy Manual as evidenced by a multiple choice assessment.

Schur

8. If you are a nonparticipating provider for Medicare, you are free to charge your usual fee.
   True
   False

9. Which of the following is not true about Medicare "opt-out" status:
   a. You must file an opt-out form with Medicare every 2 years.
   b. You must complete a contract with each patient explaining your opt-out status.
   c. You may charge your usual fee.
   d. The patient is free to submit a claim to Medicare for your services.

10. Which of the following is true for a provider who participates in Medicare:
    a. The patient may be billed for missed sessions.
    b. When a patient has an HMO as primary insurance and Medicare as secondary insurance, Medicare will pay the HMO copayment.
    c. Medicare will preauthorize services so the provider knows in advance that the service is considered medically necessary.
    d. Medicare pays claims in one to two weeks.

Esposito & McGrath

11. Research has shown that individuals whose phenylketonuria is treated with dietary intervention and individuals without the disorder differ in terms of _____.
    a. Sustained attention
    b. Working memory
    c. Processing speed
    d. a and b
    e. a, b, and c

Palmiter

12. Which of the following activities was listed as a type of service academics might perform through PPA:
    a. Advocacy Day
    b. Scholarship Committee
    c. Re-unification Day
    d. Maintenance Committee

Zuckerman

13. The Skype program is not suitable for teletherapy because of all of the following except:
    a. It does not encrypt calls.
    b. It allows law enforcement to listen to calls.
    c. It will not sign a business associate contract with covered entities.
    d. It lacks audit controls.
    e. It lacks breach notification alert tools.

Continuing Education Answer Sheet

The Pennsylvania Psychologist, June 2015

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d		**8.**	T	F		
2.	a	b	c	d		**9.**	a	b	c	d
3.	T	F				**10.**	a	b	c	d
4.	a	b	c	d		**11.**	a	b	c	d	e
5.	T	F				**12.**	a	b	c	d	
6.	a	b	c	d		**13.**	a	b	c	d	e
7.	a	b	c	d							

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist:*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

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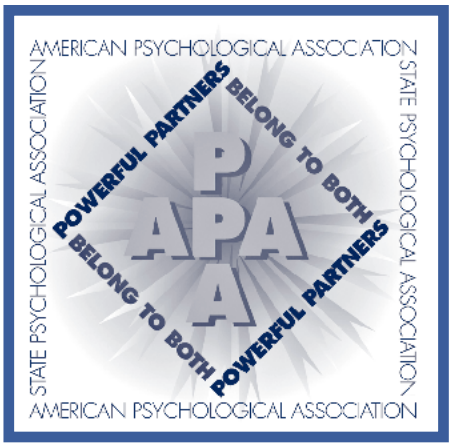
A check or money order for $20 for PPA members ($35 for nonmembers) must accompany this form.
Mail to: Continuing Education Programs, PPA, 416 Forster St., Harrisburg, PA 17102-1748.

Now available online, too! Purchase the quiz by visiting our online store at www.papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between February 11 and May 4, 2015!



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Leann Alysse Foster, MS
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Continued on page 29

WELCOME NEW MEMBERS!

Continued from page 28

Julia Gomes, MS
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***This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

NEW Home Study CE Courses, developed by Dr. Sam Knapp and Rachael Baturin, coming soon. More information will be available soon.

For all Home Study CE Courses above contact: Judy Smith, 717-232-3817, judy@papsy.org.

CE Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

June 17–20
PPA2015
Hilton Harrisburg
Harrisburg, PA

October 29–30
Fall Continuing Education and Ethics Conference
Sheraton Great Valley
Frazer, PA

Contact: judy@papsy.org

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.papsy.org.

Registration materials and further conference information are available at www.papsy.org.

If you have additional questions, please contact judy@papsy.org.

Podcasts 1 CE Credit each

New podcasts for CE credit by Dr. John Gavazzi are now available on www.papsy.org.

- Critical Incidents and Psychologist Safety
- Existential Angst, Ethics, and Your Professional Will
- Ethics and Telepsychology (Parts 1 & 2)
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- Why Marketing is Our Ethical Duty
- Psychologist as Collaborative Coach
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