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SPECIAL EDITION—BECOMING A MORE SELF-AWARE PSYCHOLOGIST

# How Self-Aware Are We? And What Difference Does It Make?

*Samuel Knapp, Ed.D., ABPP*
*Director of Professional Affairs*

Dr. Jane Doe is a senior psychologist who tends to get good patient outcomes. However, her two o'clock appointment is not doing well. Will Dr. Doe identify her patient's distress and move her in the right direction?

The patient is influenced by social desirability and wishes to please her psychotherapist or at least not appear ungrateful or uncooperative. These factors may cause the patient to under report the extent of her distress to her psychologist. Will Dr. Doe pick up on this tendency of her patient? Is Dr. Doe aware of evidence that suggests that she might not? Walfish et al. (2012) found that therapists estimated that about 3.6 percent of their patients deteriorated from therapy, yet the actual deterioration rate is somewhere around 8 percent (Castonguay et al., 2010). This suggests that psychotherapists on the average will fail to detect deterioration in 1 out of every 25 of their patients.

Dr. Doe likes her patient who is an attractive young woman. Physical attractiveness is usually seen as a social asset. However, is Dr. Doe aware that her conceptualization of the case may be overly influenced by the patient's attractiveness? Bias in favor of attractive people could lead professionals to underestimate the amount of dysphoria or physical pain they are experiencing (La Chappelle et al., 2014).

*The patient is influenced by social desirability and wishes to please her psychotherapist or at least not appear ungrateful or uncooperative.*

Dr. Doe originally diagnosed this patient with major depression. However, the patient is not responding well to the treatment. Will Dr. Doe be open to reconsidering her diagnosis, or is she overly influenced by confirmation bias? Among misdiagnoses in a large urban hospital, Sanders (2009) found that the most common reason was confirmation bias[1] on the part of the treating physician. Health care professionals are also vulnerable to other thinking errors including the fundamental attribution error[2] (Rogerson et al., 2011).

The patient is a member of an historically marginalized ethnic group. Dr. Doe believes that she works well with ethnic minorities and considers herself culturally sensitive. But is she? Self-reported multicultural competence has a low relationship to actual multicultural competence (Constantine & Ladany, 2000).

Nothing in this vignette suggests that Dr. Doe is doing anything clearly unethical. After all, she is trained in the relevant area of practice and with the population being served and she follows all the mandated

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[1] "a tendency to search for information that confirms one's preconceptions" (Myers, 1989, G-4)

[2] "The tendency for observers, when analyzing another's behavior, to underestimate the impact of the situation and to overestimate the impact of personal disposition" (Myers, 1989, G-4).

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# How to Become a Reflective Psychologist

*Samuel Knapp, Ed. D., ABPP*
*Director of Professional Affairs*

In the last article, I wrote about Dr. Jane Doe who was skilled and conscientious enough to identify a patient at risk of treatment failure. She accepted feedback from the patient and altered treatment enough to change a potential treatment failure into a treatment success.

Like all of us, Dr. Doe wants to do a good job, help her patients, and follow the enforceable and aspirational standards of the APA Ethics Code. We not only want to talk the talk, but also walk the walk. Peterson (2009) calls this implementation of our values into our daily lives as *lived ethics*, which is the study of "the ways that individuals and group make decisions, set and pursue goals, in short live their lives" (p. 24).

Dr. Doe can do a better job at living her ethics because she can reflect productively upon herself. I suspect that one of the barriers to productive self-reflection is shame. After all, who would want to look at themselves or solicit feedback from others if it results in shame, embarrassment, or humiliation. Self-reflection can be unnecessarily hard or doomed to failure, unless it conducted with self-compassion or treating oneself with "kindness, warmth, and a nonjudgmental attitude" (Hope et al, 2014).

In common parlance, guilt and shame are often seen as interchangeable and both

*We not only want to talk the talk, but also walk the walk.*

involve some transgression of a social norm. Nonetheless, recent writers distinguish between guilt and shame. According to Tangney, guilt involves remorse over a behavior and a prosocial desire to repairing a relationship or make restitution. A person feeling guilt is likely to problem-solve ways to rectify the problem. On the other hand, "feeling ashamed induces the sentiment of worthlessness, inferiority, and incompetence, and often leads to a want to escape and withdraw socially" (Bastian et al, 2016, p. 456). A person feeling shame is likely to engage in unproductive self-recrimination. Guilt encourages problem solving; shame encourages rumination. Guilt can motivate us to do better; shame discourages us because it assumes that we will always be defective.

Dr. Doe did not slip into shame because her self-compassion allowed her to feel guilty without having to feel shame. When she looked back upon her client she might have thought, "this patient is not getting better. Am I missing something here? Do I need to do something differently?" It would have been less productive for Dr. Doe to think, "this patient is not getting better. I will never be a good psychotherapist." Equally worse, a Dr. Doe without self-compassion might have just avoided thinking about her patient to avoid the feelings of shame that reflection might have produced.

Self-compassion also allows us to have *authentic pride* in what we do. Authentic pride involves a justified good feeling at a job well done (in contrast to hubristic pride which is concerned with obtaining superiority over others; Tracy, 2016). With self-compassion, we can feel less fear of looking at ourselves honestly, become more motivated to correct mistakes that we see, and more likely to feel authentic pride in our accomplishments.

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## HOW SELF-AWARE ARE WE? AND WHAT DIFFERENCE DOES IT MAKE?

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standards in the APA Ethics Code. But the word *ethics* has at least two meanings. First, it applies to the enforceable standards of a profession, such as the standards in the APA Code of Conduct. These are standards which, if violated, could result in a disciplinary action against a psychologist. They also establish norms of practice for all psychologists to follow. Second, the word *ethics* applies to the overarching principles or value statements that underlie the profession. These can be found in the General (aspirational) Principles of the APA Ethics Code.

Self-awareness appears to be an integral part of ethical practice at both these levels. Psychologists who lack self-awareness risk delivering less-than-optimal, or even inadequate service. For example, Standard 2.01 of the APA Ethics Code requires psychologists to practice only in areas where they are competent.[3] However, how could psychologists practice competently if they cannot objectively judge their own competence?

Disciplinary actions against psychologists for violating the APA Ethics Code are rare. These actions typically occur when the unethical behavior of the psychologists is egregious or easily apparent. Of course, Dr. Doe, like other conscientious psychologists, wants to do more than just avoid being disciplined by a licensing board. She wants to live out the spirit of the Ethics Code as well. She is not satisfied with only avoiding a licensing board complaint. She would like to uplift the lives of others, feel a sense of authentic pride, and adhere to the overarching principles found in the APA Ethics Code.

Not only do the aspirational principles establish the values for psychologists, they also explicitly recognize the need for self-awareness in reaching those values. For example, Principle A (Beneficence and Nonmaleficence) requires psychologists to "strive to benefit those with whom they work and take care to do no harm." They are "alert to and guard against personal, financial, social, organization or political factors that might lead to misuse of their influence." Principle D (Justice) states that psychologists treat all persons fairly and that they "take precautions to ensure that their potential biases. . . do not led to or condone unjust practices." Principle E (Respect for People's Rights and Dignity) exhorts psychologists to respect the "dignity and worth of all people" and to be "aware of and respect cultural, individual, and role differences."

Fortunately, Dr. Doe is a conscientious and well-meaning psychologist who cares about her patient and strives to deliver a high quality of service. Consequently, she is likely aware of her need to be vigilant about her patient's progress and will seek out and be receptive to information as to whether her patient is improving. She is likely to be aware of the problem of confirmation bias and, like a good scientist, keep her mind open to differing ways to conceptualize the case as new information comes to light.

How did Dr. Doe become so reflective and competent as a psychologist? Read the next article.

[3] The APA Ethics Code allows for limited exceptions such as emergencies (Standard 2.02) or when treating patients in underserved areas (Standard 2.01d). Even in emergencies, psychologists should discontinue services as soon as "the emergency has ended or appropriate services are available" (Standard 2.02) Even when treating patients in underserved areas, psychologists should "make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study" (2.01d).

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# To Cross, or Not to Cross?: Special Considerations for Boundary Crossings with Racially and Ethnically Diverse Populations

*Keisha April, JD*

The aspects of clients that make them diverse add rich and complex layers to the therapy relationship. Understanding the role diversity plays in how a client experiences the world is sometimes vital to conceptualizing a case or determining what interventions to use to best address that client's symptoms. Many non-Western cultures are less familiar with the practice of consulting mental health professionals for assistance with treating their psychological distress, and these individuals may be resistant to the therapeutic process, associating mental health practitioners with sickness or patients confined in mental institutions or hospitals (Savin & Martinez, 2006). Therapists who are unable to adapt when clients' needs differ from Western-based models may be viewed by clients as less credible, and this may lead to client mistrust and/or termination of therapy (Herlihy & Corey, 2014). Boundary crossings are one area where therapists may face ethical dilemmas and should be prepared to appropriately respond to these situations when they arise.

## Crossing Boundaries in the Multicultural Context

A common boundary crossing faced by therapists is gift-giving. Giving a gift to respected figures may be an important cultural practice to a client, and refusing that gift may be interpreted as an insult. However, the client's motivation for gift-giving should be considered by the therapist, even in multicultural contexts. Gifts may be given to curry favor with the therapist, or manipulate the relationship, and in these cases, it would be unwise to accept a gift from a client (Brown & Trangsrud, 2008). Appropriate gift-giving, in contrast, can be healthy for the therapeutic relationship and may increase

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therapeutic effectiveness (Herlihy & Corey, 2014). Thus, therapists should inquire with the client—even for small gifts—about the meaning of the gift. While acceptance of small gifts can likely help strengthen the therapeutic relationship, therapists should also have a plan in place to determine the ethicality of accepting a gift and set limits with clients early in the relationship. This transparency may help to avoid damages to the therapeutic relationship and avoid the risk of insulting a client who may not understand a therapist's ethical duties.

Touch is another common area of boundary crossing. Importantly, any kind of touch that would be interpreted as unwelcome by the client or gratuitous on the part of the therapist is likely to expose a client to exploitation or harm and should not be engaged in (Herlihy & Corey, 2014). Engaging in touch in the therapeutic context should be approached carefully, as a client's receptiveness to touch may vary widely among cultures. Research shows that the majority of therapists who do engage in touch do not discuss this boundary crossing with clients beforehand (Stenzel & Rupert, 2004). Thus, it is extremely important for therapists who choose to engage in touch to consider cultural, gender, religious, and social contexts before engaging in what may be seen as benign touches. It is also important to be aware that some gestures, like kissing on the cheek, may be commonplace in certain cultures, and reacting outwardly negatively to these attempts at touch could serve as potential, albeit unintentional, harms to the therapeutic relationship. Engaging in frank discussions with clients, to gauge comfort level, is important to the collaborative experience of the therapy. Diverse populations may be especially vulnerable to these types of crossings and violations, if they regard the therapist as an authority figure (Speight, 2012).

Therapists should also pay special attention to expectations of self-disclosure when working with diverse clients. In many cultures, unwillingness on the part of the therapist to disclose aspects of one's personal life may be interpreted as disingenuous and untrustworthy, and may communicate a lack of equality to the client (Barnett, 2011). As with any boundary crossing, it is important to consider whether the crossing is helpful to the goals of therapy and whether it is gratuitously motivated. Therapists can, however, use self-disclosure strategically to build connections with clients from marginalized groups who may be distrustful of the therapy process. For clients who might be more familiar with discussing emotional difficulties with friends, family, or religious leaders, or who may not be accustomed to speaking about these difficulties at all, healthcare professionals may be viewed as difficult to approach (Speight, 2012). Even non-verbal self-disclosures

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## TO CROSS, OR NOT TO CROSS?: SPECIAL CONSIDERATIONS FOR BOUNDARY CROSSINGS WITH RACIALLY AND ETHNICALLY DIVERSE POPULATIONS

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(i.e., pictures in a therapist's office of his or her family, or wearing religious jewelry or clothing) can be important to clients, to help them feel as if the therapist is a "real person" (Speight, 2012, p.140). In this way, self-disclosure on the part of the therapist may help clients view therapists more as allies and this shift in the perception of the power dynamic may foster a more trusting relationship with resistant clients (Savin & Martinez, 2006).

Additionally, therapists who, themselves, hail from diverse backgrounds may face unique hurdles in the therapeutic process if they are rigid about boundary crossings. Unwillingness to engage in any self-disclosure can further alienate diverse clients who may have sought therapy believing the therapist they chose would be especially equipped to understand their unique challenges and experiences (Thompson, Bazile, & Akbar, 2004). It has been suggested that the ability to engage in solidarity—broadly defined as shared experience with an identity group—with diverse clients can be an unparalleled way to strengthen the therapeutic relationship and connect with clients who might otherwise avoid therapy (Speight, 2012). While self-disclosure in therapy can potentially blur lines, it can be argued that therapists should not shy away from using their own personal experiences of diversity in the therapy context, if done so with thoughtfulness and with the client's treatment needs in mind.

### Conclusion

Therapy should never be "one size fits all," and this is especially important when working with diverse clients. Instead of rigidly avoiding boundary crossings, therapists should embrace the potential for boundary crossings to contribute positively to the therapeutic environment, while also remembering the importance of doing a thorough and thoughtful cost-benefit analysis before engaging in a crossing. While boundary crossings are undoubtedly complex, the best approach is likely a flexible, culturally-informed approach individualized to each client's specific background and needs (Speight, 2012). Therapists who make a commitment to becoming competent in this area will provide clients who may otherwise feel excluded from the benefits of psychotherapy a place of solace, acceptance, and care.

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# PPA Addresses Highmark's "Educational" Letters on 90837:

*Brett Schur, Ph.D.*
*Chair, PPA Insurance Committee*

Over the past several months, PPA and Highmark Blue Shield have held a series of meetings to discuss Highmark's "educational program" on the use of the 90837 procedure codes by psychologists. This article reviews these meetings and updates members on the current status of educational letters about the use of the 90837 procedure code.

Almost half of Pennsylvania psychologists have received letters from a Chicago-based company called Change Healthcare on behalf of Highmark Blue Shield regarding their use of the 90832, 90834, and 90837 CPT© codes. Many psychologists who received the letters have perceived them to be threatening in tone.

Based on feedback from our members, PPA contacted Highmark in the spring of 2017 to learn more about the program and to express concern about Highmark's intentions in sending the letters. Since then, PPA, in consultation with the American Psychological Association Practice Organization (APAPO)[1] has had a series of phone conferences and face-to-face meetings with Highmark and Change Healthcare. These contacts culminated in a meeting on November 10, in which Highmark and Change Healthcare agreed to a series of changes to make their program more accurately reflect the work of psychologists and to temper the tone of the letters it sends to providers. At the invitation of PPA, representatives of the Pennsylvania Chapter of the National Association of Social Workers (NASW-PA) have also been involved in the more recent meetings.

[1] PPA would like to offer a special note of appreciation to APAPO staff members Alan Nessman and Connie Galietti who offered safe advice to us throughout the entire process. Mr. Nessman and Ms. Galietti had advised psychologists in other states about how to handle similar initiatives

The first letters from Change Healthcare arrived in provider offices in the spring of 2017, and the complaints began within days. PPA contacted Highmark who offered assurances that the intention of the program is to educate providers about the proper use of psychotherapy billing codes, so they don't bill high-level (90837) codes when a briefer (and lower-cost) code such as 90834 is more appropriate. They stated that the letters were only going to providers who were "outliers" in terms of the percentage of claims billed as 90837. They assured PPA that the letters would not lead to formal provider audits or demands for repayment. PPA representatives held a face-to-face meeting with representatives of Highmark and Change Healthcare in May in which they agreed to emphasize the educational nature of the program in future letters.

Another round of letters was sent to providers identified as outliers in June. Then in September, they received a new letter stating that high utilizers of the 90837 procedure code would have their 90837 claims reviewed and might be required to resubmit those claims. Psychologists protested immediately. PPA and APAPO then sent a letter to Highmark alleging that new letters could violate both mental health parity laws and Pennsylvania's laws regarding prompt payment of claims. Highmark responded within a day that the new requirement for resubmitting claims was an error and that providers would receive a new letter correcting the error. A telephone meeting was scheduled for October 19 to include representatives from Highmark, Change Healthcare and PPA and APAPO.

A representative from NASW-PA was invited to join the call. Highmark again offered assurances that the letters were educational and would not lead to punitive actions such as formal audits. However, PPA stated again that psychologists were perceiving the letters as threatening and that many psychologists were either refusing to offer 60-minute sessions or billing 60-minute sessions incorrectly as 90834, to avert any punishment from Highmark. PPA alleged that letters were as intimidating, that the letters violated both Federal and state law, and that the Highmark/Change program was based on several false assumptions. PPA asserted that the difference between 90834 and 90837 is simply a matter of counting minutes in session time, and that not much education is required for so basic a task. PPA also asserted that Highmark's efforts to reduce costs should be better directed at more complex issues such as better integrating behavioral health with physical health to improve the quality of care and reduce overall health care costs.

*These contacts culminated in a meeting on November 10, in which Highmark and Change Healthcare agreed to a series of changes to make their program more accurately reflect the work of psychologists and to temper the tone of the letters it sends to providers.*

Highmark offered to schedule a face-to-face meeting with PPA to try to establish a collaborative relationship to create a mechanism for provider education and awareness of correct CPT© code usage and to improve the data analytics used by Highmark and Change Healthcare to identify providers who are "outliers." This November 10th meeting was attended by Highmark's Director of Fraud, Waste

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**PPA ADDRESSES HIGHMARK'S "EDUCATIONAL" LETTERS ON 90837:**
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and Abuse who manages the program that generated the letters from Change Healthcare, a representative from Highmark's Provider Relations Department, two Medical Directors from Highmark, representatives from Change Healthcare, PPA Staff (Rachael Baturin, who is PPA's Director Of Legal & Regulatory Affairs, Justin Fleming, Director of Government Affairs, and Samuel Knapp, Director of Professional Affairs), two PPA Volunteer Leaders (Vince Bellwoar, PPA Board Member and former Chair of the PPA Insurance Committee and Brett Schur, current Chair of the Insurance Committee), and representatives from NASW-PA.

At a November 10th meeting, Highmark emphasized again that they conceived the program of educational letters as softer than formal audits, which they hoped would be better received by providers. They provided information about CPT© Codes on the medical side which they also target for review. Highmark said that they were surprised to get so much negative feedback about the letters from behavioral health providers, since they weren't encountering similar resistance from medical providers about the other CPT© codes in the program. PPA representatives said that the relationship between PPA and Highmark has historically been positive and that many providers have good experiences serving Highmark subscribers. Highmark's handling of these letters has been changing those perceptions and threatening working relationships.

## The role of psychotherapy in lowering overall medical costs

With two Highmark Medical Directors participating in the meeting, representatives of PPA and the PA Chapter of NASW pressed for Highmark to do more to integrate behavioral health services into overall health care, to increase access to services, reduce stigma of behavioral health services, and ultimately reduce overall medical utilization for Highmark's subscribers. PPA and Highmark agreed to discuss better integration of behavioral health and medical services in 2018.

## Letters from Change Healthcare

In this meeting, Change Healthcare provided PPA with more information about their program of provider education on correct coding than was previously available. Their program of data analysis includes 10 "modules," or groups of related CPT codes. One of these modules involves the psychotherapy codes 90832, 90834, and 90837, which differ from one another only in the number of minutes represented by the code. Most of the other modules involve codes used only by physicians. Change Healthcare stated that their goal is to ensure that providers are properly using each of the codes in a series.

*In this meeting, Change Healthcare provided PPA with more information about their program of provider education on correct coding than was previously available. Their program of data analysis includes 10 "modules," or groups of related CPT codes.*

Their intention was to identify providers who bill the highest-level codes in each series more frequently than their peers, and to encourage those providers to reconsider whether they are using the high-level codes correctly. They planned to target 10-15% of providers using each series of codes, who they regard as "outliers." They could do this for most of the "Evaluation & Management (E&M)" codes, such as 99211 through 99215, which are codes that are restricted to physicians in most states. However, Change Healthcare found that their cutoffs for the outliers in the use of psychotherapy codes identified 40-60% of providers in all the states in their program, including 49% of Pennsylvania providers. PPA asserted that 49% of providers are normative, by definition, rather than outliers.

PPA provided Change Healthcare with some additional information about the use of the Psychotherapy codes which they had not previously considered. PPA asserts that in an outpatient practice, 90834 and 90837 are both normative codes and 90832 is highly unusual. However, in hospital and residential settings, including nursing homes, 90832 and 90834 are the normative codes. If data from those settings are mixed, it will cause outpatient providers who primarily use 90837 to appear non-normative. Change Healthcare says that there is no way to separate the data by settings, since most providers code place of service as "99," other place of service. They asked that PPA and NASW-PA to educate providers on the correct use of place of service codes (see sidebar). PPA believes that most providers in fact code place of service correctly, since Medicare will reject claims coded with "99." PPA asked if the error occurs in the transfer of data from Highmark to Change Healthcare for analysis. Highmark and Change Healthcare agreed to research this problem and PPA and NASW- PA agreed to educate their respective members about the problem. PPA also asked Highmark and Change Healthcare to add the 90846 and 90847 into their calculations when looking for outliers in use of 90837.

PPA identified other problems with Change Healthcare's approach to data analysis. Currently, Change Healthcare analyzes all providers who bill Highmark for more than 20 sessions per year. PPA asserts that 20 sessions per year does not provide an adequate sample size for analysis. PPA asserts that Change Highmark should only include providers who bill a minimum of 100 sessions, and that they should establish a minimum number of patients before including a provider in the analysis.

Change Healthcare suggested that it would like to add a factor for geographic location. They hypothesize that rural locations may draw for longer session times for reasons related to availability of providers. Change Healthcare also suggested that it could include a factor for severity of diagnosis with the assumption being that those with more severe diagnoses should be more likely to get a 90837 level of service. PPA asserted that the relationship between diagnosis and session length is complex and not likely to yield easily interpreted data. For example, sometimes patients with the most severe diagnoses (e.g. Schizophrenia) require

*The program of sending letters to providers who are outliers in the use of the 90837 code will continue, with providers receiving letters each quarter. Highmark will not require outlier providers to resubmit claims billed with 90837, as they do for certain other medical codes.*

shorter, rather than longer sessions. Change Healthcare agreed that the relationship between diagnosis and session length for psychotherapy codes is too complex to yield meaningful information.

Change Healthcare said that the number of claims billed with 90837 has decreased since this program began. They interpret that data to show that the program of education is working. PPA offered a different interpretation. We alleged that the threatening tone of the letters has probably led providers to down-code claims, using 90834 when the service was actually 53+ minutes, or to stop offering longer sessions, even when they are clinically appropriate. Change Healthcare said that use of 90834 when the service was actually 53+ minutes is incorrect and they want PPA and NASW-PA to educate providers not to do that.

Highmark said that they have received very little feedback from other medical specialties regarding their data analytics and provider education program, and that they would like to better understand why they are getting such a different reaction from behavioral health providers. PPA suggested a couple of factors which may account for the difference. First, Change Healthcare identified 49% of Pennsylvania psychologists as outliers, while only identifying 15-20% of providers in other specialties as outliers. Second, a high percentage of behavioral health providers work alone, without administrative staff. In many instances, a physician may not even see the letters from Change Healthcare, since the letter may be handled by the practice manager. When a physician's office is told that they will have to resubmit certain claims, they have a staff dedicated to do that task. Many behavioral health providers do not have paid administrative staff. The letters come directly to the provider and if claims must be resubmitted, it will be a greater burden for behavioral health providers. Finally, the procedure codes targeted for medical professional represent only one out of dozens (or hundreds) or procedures codes that they use while psychotherapists will use only a handful of codes.

## Current Understanding of Change Healthcare and Highmark's Program

The program of sending letters to providers who are outliers in the use of the 90837 code will continue, with providers receiving letters each quarter. Highmark will not require outlier providers to resubmit claims billed with 90837, as they do for certain other medical codes. They stated that the last letter informing providers of that program was an error.

Highmark has said that they continue to audit providers as they always have, and that providers will never be audited on the basis on Change Healthcare's program of data analytics. Change Healthcare has agreed to review its data analytics program for the psychotherapy codes. They would like to figure out how to identify 15-20% of behavioral health providers as outliers, as they do for other medical specialties, rather than the 40-60% they currently identify. They will consider separating the data by place of service, so that services provided in an outpatient office are analyzed separately from nursing home or other such settings. They will also consider including 90846 and 90847 in the program.

Change Healthcare agreed to work with PPA and NASW-PA to modify the letters so that they are no longer perceived as threatening. Change Healthcare will also notify PPA and NASW-PA the week before each batch of letters goes out. PPA and NASW-PA will let their members know the letters are coming and remind their members that the letters are intended as educational only.

PPA and NASW-PA agreed to educate their members both regarding the correct use of 90834 vs. 90837 and correct use of place of service codes. PPA, NASW-PA, Highmark, and Change Healthcare will meet again early in 2018 to evaluate the response to these changes, and to help Change Healthcare incorporate PPA's recommendations for modifying their data analytics.

Highmark, PPA, and NASW-PA will also meet in January to further work on developing programs to maximize psychology's impact on holding down overall medical costs through appropriate mental health treatment of high users of medical services and through integration of psychology into medical practices. One goal of that meeting will be to propose one or more pilot programs to help make co-location of psychological services in medical practices more financially feasible.

## Take-away messages

1. CPT codes for individual psychotherapy are based on session length. Bill 90832 for a session which is 20-37 minutes in length. Bill 90834 for a session which is 38-52 minutes in length and bill 90837 for a session which is 53 minutes or longer.
2. Do not bill 90834 for a session of 53 minutes or longer simply to avoid audits.
3. Always document session start and stop times in the session, or therapy, notes.
4. Document the reason for the procedure code you have chosen. We were given no details as to how much documentation or rationale was needed for this. But we think that a simple sentence or two in the treatment record would be sufficient.
5. Always code place of service correctly. It matters.
6. Letters from Change Healthcare are intended to be educational only. Highmark has assured PPA that the letters will not lead to audits of providers.
7. There is good research that appropriate use of psychotherapy lowers overall healthcare spending, especially for patients with high levels of medical involvement.

# Nominate a Deserving Colleague for a PPA Award

Do you know of a colleague who has distinguished himself or herself as an outstanding professional psychologist? If so, we invite you to nominate that person for a PPA award! These awards, will be presented at the PPA2018 annual convention at the Doubletree Valley Forge in King of Prussia, PA.

**The Pennsylvania Psychological Association's Early Career Psychologist Committee would like to recognize the contributions of an Early Career Psychologist (ECP)** who, in his or her practice as an early career psychologist, is making a significant contribution to the practice of psychology in Pennsylvania.

**Deadline: January 31**

**The Pennsylvania Psychological Foundation in collaboration with the Pennsylvania Psychological Association's Committee on Multiculturalism established a Student Multiculturalism Award in 2010.** The $300 award will be given to a psychology student who is attending school in Pennsylvania and who produced a distinguished psychology related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice.

**Deadline: Jan. 31**

To nominate a deserving psychologist or for more information, contact Professional Development Specialist Judy Huntley at 717-232-3817 or judy@papsy.org.

# Save the Date for PPA's Spring CE Conference!

**April 20, 2018, Sheraton Station Square, Pittsburgh, PA**

**Are you interested in submitting a proposal for presentation?**

**Proposal deadline - January 22, 2018**

**Additional information can be found here: https://papsy.site-ym.com/page/SpringFall**

# Coding for Place of Service

Some providers who bill insurance companies for services do not accurately include place of service on their claims. In a recent meeting with PPA, a Highmark contractor said that most behavioral health claims are coded "other" as place of service. PPA has raised the possibility that most psychologists code place of service correctly and that their computer algorithm may have led to errors. Nonetheless, correct place of service coding is important.

Incorrect coding of place of service can lead to claim denials and can lead insurance companies to misunderstand or misrepresent the services we provide. In addition, Medicare has different payment rates for inpatient and outpatient services, so incorrectly coding place of service can lead to incorrect payment.

The most common place of service codes used by psychologists are these.

| | |
|---|---|
| 02 | Telehealth (new code for 2017) |
| 03 | School |
| 11 | Office |
| 12 | Home (private residence only; not nursing home) |
| 13 | Assisted living facility |
| 14 | Group Home |
| 21 | Inpatient Hospital |
| 31* | Skilled Nursing Facility |
| 32* | Nursing Facility |
| 34 | Hospice |
| 51 | Inpatient Psychiatric Facility |
| 52 | Psychiatric Facility – Partial Hospitalization |
| 53 | Community Mental Health Center |
| 54 | Intermediate Care Facility – Individuals with Intellectual Disabilities |
| 55 | Residential Substance Abuse Treatment Facility |
| 56 | Psychiatric Residential Treatment Center |
| 57 | Non-residential Substance Abuse Treatment Facility |

*If you work in a Skilled Nursing Facility or a Nursing Facility, it is recommended that you consult with the facility manager to determine whether the correct place of service code for that facility is 31 or 32. In some cases, different floors or sections of a facility may be coded differently. Likewise, if you bill for services in other facilities listed above, it is recommended that you confirm the correct place of service code with a facility manager.

# Clearing Up Confusion About Medicare's PQRS Program

*Brett Schur, PhD*
*PPA Insurance Committee Chair*

Many Pennsylvania Psychologists received letters from Novitas this week regarding Medicare PQRS penalties which will be applied to Medicare payments for services beginning January 1, 2018. There has been some confusion among Pennsylvania providers about the Medicare PQRS program and its replacement program, called MIPS.

The PQRS program operated in calendar years 2009 through 2016. Initially, the program offered rewards in the form of payment bonuses to providers who participated in numerous "quality measures." Those quality measures became more complicated over time and beginning in 2013, the bonuses for successful participation were replaced with penalties for non-participation. The program ended for services delivered in 2017. However, there is a 2-year delay in application of the penalties, so providers who did not participate or did not successfully meet the criteria in 2016 will be penalized in 2018. The letters many psychologists received last week are based on program participation back in 2016.

There is an appeals process for providers who participated in the PQRS program and did not meet criteria. Check the letter carefully for information about the appeals process. The window for appealing is very narrow, and if you miss it you may be out of luck. However, you might also decide that an appeal is more work than is worthwhile.

*There will be no penalties for psychologists in 2019 or 2020 because they were not eligible to participate in 2017 or 2018. The $30,000/100 patient criteria for exemption may be adjusted in future years.*

Beginning in 2017, Medicare is replacing the widely unpopular PQRS system with a new system called MIPS, which will be much more complicated, and will require participation in a commercial registry. MIPS will offer both rewards for successful participation and penalties for failure to meet criteria. For calendar years 2017 and 2018, participation for psychologists is voluntarily and psychologists will not receive either rewards or penalties if they choose to participate. Psychologists are currently slated to become eligible for rewards and penalties beginning in 2019.

For eligible providers (mostly physicians in 2017 and 2018), there is currently an exemption from the penalties for small providers, which is defined as less than $30,000 in Medicare payments or less than 100 Medicare patients total during the year. Rewards and penalties for 2017 will be applied in 2019. Rewards and penalties for 2018 will be applied in 2020. There will be no penalties for psychologists in 2019 or 2020 because they were not eligible to participate in 2017 or 2018. The $30,000/100 patient criteria for exemption may be adjusted in future years.

Medicare has said that it will tie future annual increases in Medicare payment rates to participation in the MIPS program. While psychologists may meet the criteria for exemption, they may lose the opportunity for increases in reimbursement if they choose not to participate.

Personally, I participated in PQRS for four years, trying diligently to meet their standards, but not subscribing to a registry to assist me. I succeeded in avoiding penalties in only one of the four years, before the requirements became more difficult and I will again be facing the penalty in 2018.

# Classifieds

**Office to share West Chester.**
Bright, spacious single office, beautifully furnished, private waiting room. Professional building. Free parking. Handicapped accessible. 2-3 days per week. Please call 610-436-1611.

**A fabulous office space in an upscale location is waiting for a tenant.**
The office is well appointed and located at 1515 West Chester Pike, Suite C-2, West Chester, PA 19382. Perfect for therapy or any healing service that is done on an individual basis. Includes carpet, two book shelves, and art work. Easy access for clients into a complimentary and large parking area. Local amenities include a convenient WAWA, Rite Aid, and bank.

The office is one of three along with a lovely and comfortable waiting room. It is quiet and laid back with good energy. The shelving, rug, and a white club chair are included if desired. Other included amenities are: internet, fax, phone, kitchenette, restrooms, utilities, and janitorial services. Testing equipment is available to rent if you are a psychologist or school or forensic psychologist. Most issues are negotiable. I can do a straight lease of the space, or an Independent Contractor (I.C.) position can be opened up for a therapist looking to have a space to see their clients and still gain additional referrals.

For full time (5 days Mon-Fri) $500.00/month; 24/7 access $550.00/month. Larger office is $800/month.

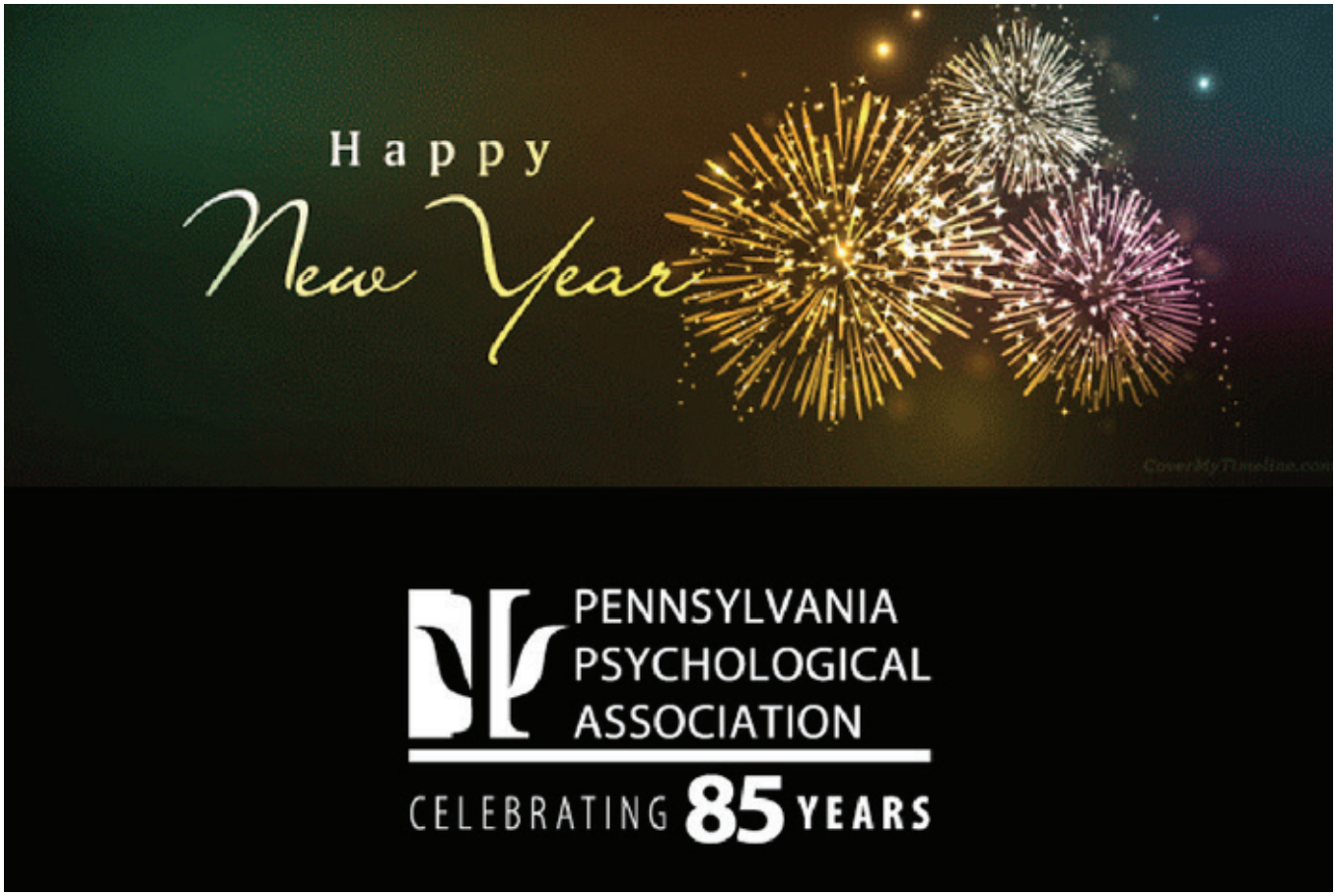
Please call 610-692-2217 and ask for Dr. Montagnolo.

**THERAPY OFFICE TO RENT - Main Line – Haverford.**

Furnished sunny 1st floor office. Shared attractive office suite/waiting room in bldg. with other psychologists, psychiatrists. Hi-speed Wi-Fi. Well –lighted parking lot. $50 per day/evening. Three days or more special pricing.

AVAILABLE IMMEDIATELY carole@mstherapist.com or 610-649-9964

**OFFICE SPACE AVAILABLE: BALA CYNWYD –** Attractive, furnished windowed offices include Wi-Fi, fax/copier, café, free parking, flexible hours weekdays and weekends. Perfect for therapy and evaluations. 610-664-3442.



# 2018 PPA Continuing Education

*PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!*

## Calendar

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

**February 21**
*PPA Webinar Series*
1:00 p.m.–2:00 p.m.

**March 3, 2018**
*ECP Day*
PPA Office
Harrisburg, PA

**April 13, 2018**
*PPA Lunch & Learn*
PPA Office/Virtual Webinar
Harrisburg, PA

**April 20, 2018**
*Spring Continuing Education Conference*
Sheraton Station Square
Pittsburgh, PA

**May 11, 2018**
*PPA Lunch & Learn*
PPA Office/Virtual Webinar
Harrisburg, PA

**June 13–16, 2018**
*PPA2018—PPA's Annual Convention*
Doubletree Valley Forge
King of Prussia, PA

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

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

## Home Study CE Courses

### Act 74 CE Programs

*Assessment, Management, and Treatment of Suicidal Patients*—1 CE

*Older Adults at Risk to Die From Suicide: Assessment Management and Treatment*—1 CE

*Assessment, Management, and Treatment of Suicidal Patients (Extended)*—3 CEs

*Assessment, Management, and Treatment of Suicidal Patients (Podcast)*—1 CE

*Patients at Risk to Die From Suicide: Assessment, Management, and Intervention (Webinar)*—1 CE

### Act 31 CE Programs

*Pennsylvania Child Abuse Recognition and Reporting*—3 CE Version

*Pennsylvania Child Abuse Recognition and Reporting*—2 CE Version

### General

*Record Keeping for Psychologists in Pennsylvania*—1 CE

*Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)*—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Competence, Advertising, Informed Consent, and Other Professional Issues*—3 CEs

*The New Confidentiality 2018*—3 CEs

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

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