CONTRA COSTA PSYCHOLOGICAL ASSOCIATION

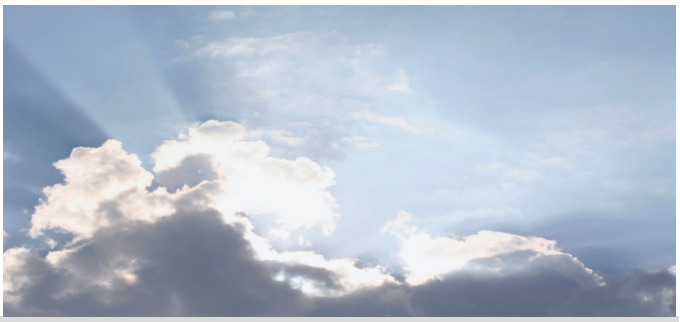
2013 Winter Newsletter

The President's Message

By Howard Friedman, Ph.D., ABPP

Welcome to the first edition of our CCPA newsletter in 2013. I am very pleased to serve as your president (again) from 2013 to 2015. As some of you may recall, I was CCPA president for three consecutive terms in the 1980s, and then served on our local and state boards. Being involved in organized psychology has always been very enjoyable personally and professionally. I truly enjoy the contact and stimulation I experience with diverse colleagues I wouldn't otherwise have a chance to know through my private practice.

This experience also leads me to set an important goal for the coming year: to increase the social and professional connections we develop through CCPA. I had the opportunity to become involved with CCPA as soon as I was licensed, so it was a formative experience in my development as a psychologist. I was brought into the fold right away, and it was immediately enriching to be exposed to established professionals who were enthusiastic about practice and professional development, as well as mentoring a new chapter member. At that time, we expanded the board membership and built CCPA with well-attended meetings and a focus on practical issues such as how to bill, and creating continuing education courses related to delivery of services, rather than the business of psychology. We also initiated dinner meetings that increased connections across chapters and important sharing of ideas. At the same time, CPA was advancing and hiring lobbyists to advocate for issues of key influence on psychology.



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The scope of our practice is developed in Sacramento, and we function as a profession based on what the legislation enacts. We protect our practice domain by having an advocacy presence in Sacramento. We maintain our professional standing (i.e. licensing laws and CE through state law and regulation) through legislation. A number of years ago, we finally passed the CE requirement that increased our professional credibility. The CE requirement also limited legislation impacting us with specialty CE requirements. The change in CE requirements was brought about through the advocacy of our associations. In fact, the first step in this was local. Bill Coby and I met with State Senator Dan Boatwright who carried the bill for us. We were able to achieve this as CPA set up regular face time with Senator Boatwright.

These grassroots advocacy efforts are quite productive for our profession in the long-term. CCPA manages grassroots efforts that percolate up to state-level action. I've had the opportunity to be governmental affairs coordinator recently, as well as a few years ago. This has enabled me to see the effort CPA puts into our grassroots efforts. While passing the baton to Ellin Sadur in this capacity and as representative to the CPA Board, I remain very interested in the importance of advocacy, how our chapter links with CPA, and how all of us need to participate in advocating for our profession.

In the next two years, Ellin and I will engage in advocacy. We hope to facilitate contributions to our political action committee that will enable us to gain access and provide support for lobbyists and others who monitor bills of significance to psychology. It doesn't take much for each psychologist to underwrite these initiatives. Occasionally, you may get requests to send a letter to a legislator or governor; all you have to do is print what we send and sign it.

In that vein, the proportion of psychologists we represent has been static at the local and state level, as many psychologists have yet to join CCPA. Many psychologists don't realize what organized psychology has to offer, and this also raises the question about what we need to do to attract more members. I want to hear from you regarding what we can initiate to draw more members to CCPA. Networking with, and mentoring each other are extremely important. In the last few years, we have added a couple of committees and meetings run by Drs. Candia Smith and Karyn Goldberg-Boltz. Dr. Nicole Shore is joining Dr. Smith in hosting the Networking Committee with a focus on attracting new psychologists. We are open to suggestions about how we can do more to meet new interests and needs of potential members. Let's discuss how we can attract a wider membership. We will also be developing new advocacy goals in line with CPA targets for the next legislative session. At the local level, we will increase grassroots contact, organizing a meet-and-greet or a fundraiser with local legislators. As some of us can attest, it can be fun to hobnob with politicians, while promoting our professional interests.

I look forward to this next two years, and I intend to work with you to accomplish much while having fun together.

I wish each of you a delightful, productive 2013 and look forward to connecting with you in the coming days and week. ◊

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Dialectical Behavior Therapy: A Focus on Acceptance and Change

By Sarah E. Wood, Ph.D.

Treatment strategies in DBT draw on standard behavioral and cognitive therapy procedures and on principles and findings from research on learning, emotions, social influence and persuasion.

Strategies for helping the therapist to convey his or her acceptance of the client draw primarily from client-centered and emotion-focused therapies. Core strategies in DBT are validation (acceptance) and problem solving (change).

The fundamental concept of mindfulness, by which much of DBT is influenced, is drawn primarily from eastern philosophies.

To date, there is extensive research supporting the efficacy of DBT with Borderline Personality Disorder, Substance Use Disorders, Eating Disorders and Depression (in the elderly and in suicidal teenagers.) Protocols are also available for the treatment of Anxiety Disorders and Depression in all age groups.

Clinical formulation in DBT is based on the biosocial model of psychological development wherein the transactional relationship between biological vulnerability and an invalidating early environment gives rise to problems in regulating cognition, affect, sense of self, interpersonal relationships and behavior.

In Stage 1 of DBT treatment, the focus is on behavioral dyscontrol such as self-injury, disordered eating, substance abuse. The goal of Stage 1 is for the individual to develop greater behavioral control and to develop and employ more effective coping skills. The goal of Stage 2 treatment is to increase the appropriate experiencing of trauma-related emotions. The habitual use of escape or avoidance-based coping strategies is extinguished and replaced by an integrated, present-focused experience of emotion.

In the DBT approach, the ordering of skills acquisition before trauma work is based on the belief that the client will be less vulnerable to regression (eg. resuming self-injury) if she has sufficient coping skills.

Stage 3 focuses on developing a pattern of more ordinary fluctuations in mood, improved relationships and enhanced self-esteem. Stage 4 moves away from the amelioration of problems to the promotion of an increased sense of connectedness, joy, and freedom.

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When a client enters DBT treatment, the focus is on; (a) decreasing life threatening and other self-injurious behaviors; (b) decreasing treatment-interfering behaviors (eg. behavioral acting out in session, inattention, and lateness); (c) decreasing serious quality-of-life-interfering behaviors (eg. substance abuse, compulsive gambling and remaining in an abusive relationship); (d) increasing knowledge and performance of skilled behaviors; (e) addressing motivational obstacles to skills use and; (g) helping the patient generalize what he or she learns to their daily lives.

These goals are reached through the combination of four treatment components: individual sessions, group skills training, telephone coaching and team consultation. The individual, group and team consultation meetings occur weekly. The client is encouraged to use telephone coaching as needed between group and individual meetings to generalize the use of skills to day-to-day life.

The groups teach clients mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness skills. The format is didactic though group members have weekly homework that is shared and discussed in each group.

A key aspect of DBT is the instruction in mindfulness practices. The purpose of such instruction is to promote an increased sense of calm and groundedness, to establish a more stable, objective experience of self and others, and to decrease the experience of being driven and controlled by intense emotion.

Other concepts taught in skills groups include the understanding and slowing of automatic emotional reactions, self-soothing, examination of core beliefs, learning to notice and challenge extreme ways of thinking, and practicing acceptance.

The work is informed by an ever-present understanding of the dialectical nature of reality that every truth is made up of an array of ever-changing opposites. Clients are taught that, while their behavior makes sense given their skill and background, so does the behavior of others make sense to them given the same variables. They are taught that, while they may not have caused their problems, they must nonetheless solve them and that, while their feelings of overwhelm and despair are valid, they must still work to solve the problems facing them. Marcia Linehan identifies several dialectical dilemmas that characterize borderline clients and illuminate how they so often vacillate between opposite, extreme orientations to their own behavior. One is emotional vulnerability versus self-invalidation wherein borderline individuals move between poles where the experience of intense emotional reactivity/sensitivity is contrasted, at times, with the denial of emotional needs/feelings and intense shame and self-hate.

Essentially, the practice of DBT recognizes that there are characteristic dilemmas faced by many clients. For the borderline client, there is the desire for health and freedom with contrasting, intense fears of abandonment and being alone without needed help.

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For any client, intense emotionality triggers strong (often ineffective) expressions of needs and feelings yet the success of a mutual relationship rides on modulation and balance.

For all of the clinical populations that Dialectical Behavior Therapy is being used to treat, the work is guided by continual and flexible shifts between such dialectical poles as acceptance/validation and the push for change and problem-solving. It is informed by the understanding that, to recognize and work effectively with the patient, one must simultaneously acknowledge and address two opposing views. With this view, the therapist strives to find "the kernel of truth" in their client's experience and still push for a greater perspective.

Contact Sarah E. Wood, Ph.D. for a list of references at sarahewoodphd@yahoo.com. ◊

Letter from the Editor

The CCPA newsletter is a forum for sharing information. I invite submissions about 1) groups that you offer, 2) reviews of workshops you have attended or book that you have found useful or 3) a variety of other topics relevant to the community. Occasionally, I include an interview with a CCPA member,, so if you would like to respond to a list of questions about yourself and your practice, please contact me. It is a great way to be better known within the organization.

Please consider contributing to future newsletters. The following dates are deadlines by which I must have your submission. Thank you in advance!

April 15, 2013- Spring edition
July 15, 2013- Summer edition
October 15, 2013- Fall edition

The following prices are in effect for advertisements:
¼ Page Ad $30 ½ Page Ad $60 ¾ Page Ad $100
Note: Advertisements for office space are free to CCPA members.

All professional advertisements are free on the listserv for CCPA members.

Email submissions by the deadline to sarahewoodphd@yahoo.com ◊

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2013 Psychotherapy CPT® Codes for Psychologists

Practice Update October 11, 2012

Diagnostic interview procedures	
90791	Psychiatric diagnostic evaluation
Psychotherapy	
90832	Psychotherapy, 30 minutes with patient and/or family member
90834	Psychotherapy, 45 minutes with patient and/or family member
90837	Psychotherapy, 60 minutes with patient and/or family member
90845*	Psychoanalysis
90846*	Family psychotherapy without the patient present
90847*	Family psychotherapy, conjoint psychotherapy with the patient present
90849*	Multiple-family group psychotherapy
90853*	Group psychotherapy (other than of a multiple-family group)
Interactive complexity add-on code	
90785	Add-on code to be used in conjunction with codes for primary service: psychiatric diagnostic evaluation (90791); psychotherapy (90832, 90834, 90837); and group psychotherapy (90853)
Psychotherapy for crisis	
90839	Psychotherapy for crisis, first 60 minutes
90840	Add-on for each additional 30 minutes of psychotherapy for crisis, used in conjunction with code 90839
Pharmacologic management add-on code	
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services; used only as add-on to primary psychotherapy code (90832, 90834, 90837)

*Same code numbers as for 2012

Note: The 2013 CPT manual contains additional new codes for use by other qualified health care professionals, such as those eligible to use evaluation and management (E/M) codes. Examples: 90792, 90833, 90836, 90838. This code list for psychologists is also available as a PDF (PDF, 280KB) in the billing and coding section of our website. Visit regularly to get information and updates about the 2013 psychotherapy codes, including a forthcoming crosswalk that compares the current psychotherapy codes to the codes for 2013.

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Updates on Evidence for Trauma vs. Fantasy Models of Dissociation and on DSM-V Changes to Disorders Involving Dissociation

By © Adrianne B. Casadaban, PhD,
BrainMindSelf.com, Lafayette, CA, January 15, 2013

The issue of adult traumatic memories has embroiled American health and science professionals, as well as society at large, for over the past twenty years. Are traumatic memories real, or fantasies? If the client is dissociative, does that make him or her more prone to fantasy? These questions were rigorously reviewed and the results were recently published in psychology's prestigious *Psychological Bulletin* journal. The results clearly indicate that real trauma incidents are behind dissociation. The fantasy prone argument did not hold up. DSM-V changes are taking account of this scientific advance.

"Abstract The relationship between a reported history of trauma and dissociative symptoms has been explained in 2 conflicting ways. Pathological dissociation has been conceptualized as a response to antecedent traumatic stress and/or severe psychological adversity. Others have proposed that dissociation makes individuals prone to fantasy, thereby engendering confabulated memories of trauma. We examine data related to a series of 8 contrasting predictions based on the trauma model and the fantasy model of dissociation. In keeping with the trauma model, the relationship between trauma and dissociation was consistent and moderate in strength, and remained significant when objective measures of trauma were used. Dissociation was temporally related to trauma and trauma treatment, and was predictive of trauma history when fantasy proneness was controlled. Dissociation was not reliably associated with suggestibility, nor was there evidence for the fantasy model prediction of greater inaccuracy of recovered memory. Instead, dissociation was positively related to a history of trauma memory recovery and negatively related to the more general measures of narrative cohesion. Research also supports the trauma theory of dissociation as a regulatory response to fear or other extreme emotion with measurable biological correlates. We conclude, on the basis of evidence related to these 8 predictions, that there is strong empirical support for the hypothesis that trauma causes dissociation, and that dissociation remains related to trauma history when fantasy proneness is controlled. We find little support for the hypothesis that the dissociation–trauma relationship is due to fantasy proneness or confabulated memories of trauma. (PsycINFO Database Record (c) 2012 APA, all rights reserved).

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Prior to publishing, the article went through rigorous scientific scrutiny. Research design and statistics specialists, including major experts in the field of False Memory Syndrome, meticulously reviewed the results, requested further statistical calculations, and otherwise exercised scientific 'due diligence' to answer these important questions. The result was the acceptance of the scientific validity of the review articles findings.

Bethany Brand, Ph.D and colleagues presented and discussed this research at the October 2012 Annual International Society for the Study of Trauma and Dissociation (ISST-D, http://www.isst-d.org/). They reported that the field of psychology is now squarely on the side of the trauma model of causation of memories of childhood trauma as compared to the model of fantasy causation, when dissociative symptoms are involved. According to several of the presenters, this new consensus was cemented by the above publication.

Dissociation is a regulatory response to trauma, i.e., "fear or other extreme emotion with measurable biological correlates" (from abstract). Dissociation can include past or present forgetting and a fantasy place/state to which an adult or child goes for mental survival. Dissociation Disorders are DSM diagnostic categories that include symptoms of memory, consciousness, or perception disruption.

The DSM-V changes (very close to final) to definitions of Dissociative Disorders were also presented and discussed at the conference by David Spiegel, MD, a member of DSM-V work groups. Such changes include the following: A diagnosing professional will no longer have to observe a client actually switch between alternate identity states to give the diagnosis of Dissociative Identity Disorder (DID). Aiming for more articulation of cultural diversity and inclusion of indigenous culture's experiences, DSM-V will include pathological possession language in dissociative disorder symptom criteria. Depersonalization and Derealization Disorders will become one combined disorder. Dissociative Fugue will be a subtype of Dissociative Amnesia.

Post Traumatic Stress Disorder (PTSD) will now have a dissociative subtype. In my experience, this will help clinicians with accurate diagnosis and timely treatment of PTSD. Dissociative reactions can be a normal stage of the grieving process and a sign that the brain needs a temporary cushion or respite - at minimum - in order to mentally handle the blow. The stages of mourning are sometimes described as follows: denial/shock/dissociation/numbness, crying/sadness, anger, bargaining, acceptance/able-to-move-on/experience-joy-peace again.

Temporary dissociative experiences can occur in individuals with 'only' recent trauma experiences to process, such as those who work in emergency response or military professions and those who have experienced the death, suicide, or accident of someone close. Some adolescents and adults, who had experienced 'too much' exposure to death and destruction, reported later in recovery: "I just went away" or "I mentally go away."

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Dissociative responses to recent trauma are observed in behaviors and other acted-out states (sensory-motor performances).

Reactions that the brain initially automatically activates can get stuck and lead to more serious mental problems. Dissociative responses can fairly quickly form grow, over time, into enduring discrepant self-states or more than one self-identity. Self-states (otherwise termed parts of self or partial-identities) are co-conscious if the person is able to notice them internally. Co-conscious self-states, subjectively experienced or enacted in behavior, may be felt as self-identified conflicting urges or preferences, or as "not-me" (ego-dystonic). When the individual is not consciously aware of the other(s), the person has a dissociative identity disorder (not-co-conscious).

It is important to note that the *'new unconscious'* science research is documenting that automatic, enduring, distinct self-states are normal and universal in humans. Emotional, behavioral, and motivational reactions of any kind may activate in a self-adaptation sequence, in which the person consciously experiences only the current trigger and the last internal self-activation. Accessing and processing unhealed trauma is a key component of psychotherapy. My presentation at the ISST-D conference described such self-adaptation sequences and their psychotherapy components. Dissociative responses may be part of these sequences.

Sadly, too many children who experience traumas are not treated in a timely and effective manner. They may have none or too little of: others noticing and acknowledging distress; others noticing and stopping their abuse; reinstitution of protecting and healing; and the presence of supportive adults and circumstances. Unfortunately, as individuals of a highly adaptive species, our brain automatically and unconsciously associates or 'tags' living memories of experiences with conclusions about self, other, and the world. We hold them as living memories or neural self-renditions.

A basic psychological truism must also be processed: Once something traumatic happens to someone, they can never go back to not having experienced it. The brain will need to make sense of it, sooner or later, one way or another, for better or worse. Adaptations to unhealed childhood trauma can contribute to many diagnoses.

Changes in the DSM-V are also addressing the impact of the 'double whammy' of trauma and caregiving adult failures for such children. (Note: This statement is separate from an assessment of blame and does not factor in the circumstances of the caregiving adults. It is an assessment from the point of view of the child experiencing unmet biopsychosocial needs at/in a particular developmental age and context.)

A developmental trauma disorder diagnosis is one way the distress of these now adult individuals is being researched. At the ISST-D conference, the on-going developmental trauma disorder research of Bessel van der

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Kolk, MD and Judith Herman PhD (http://www.traumacenter.org/research/DTD_Field_Trial.php) was discussed. While that diagnosis is not in the DSM-V, changes and additions were included from DSM-IV to address their emerging findings. Examples are the inclusion of pathologically negative self-beliefs and somatic symptoms as qualifying criteria for certain anxiety and dissociative disorders.

My clinical experience includes treating adolescent and adult clients presenting with physical diagnoses co-morbid with delayed-onset (or missed-diagnosis of) PTSD and dissociative disorders. The physical symptoms may or may not be manifestations of the mental disorders. Psychotherapy treatment progress sometimes helps clarify diagnoses. Eating, substance, and other addictive disorders may additionally co-occur. Further co-morbidity with personality disorders is common. My experience is also that mild, or more severe, dissociative reactions might underly the difficulties experienced by a number of my clients diagnosed with Attention Deficit Disorder (ADD.)

In conclusion, psychological science has now definitively shown that actual trauma causes dissociative disruptions in memory, perception, or consciousness. DSM-V diagnoses are accommodating the results. This empirically validated conclusion is now available for scientists, diagnostic experts, practitioners, educators, and policy makers alike. I, and many I know, am grateful for it. ◊

CALL TO THE MEMBERSHIP!

Your board would like to hear from you with suggestions about topics for CEU presentations. For example, is anyone interested in disaster-related issues?

Let us know at ccpaboard@yahoogroups.com. Your ideas are welcomed!

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Calendar of Events

Mark Your Calendars!

Working with Gender Creative/Transgender Children, Adolescents and Their Families

Presenter: Shawn Giammatti, Ph.D.
Date: March 14, 2013
Location: Lafayette Park Hotel
Time: 6-9pm
RSVP to: **Dr. Alissa Scanlin** 3468 Mt Diablo Blvd, Ste. B203, Lafayette, CA 94549
PHONE: (925) 283-3902
EMAIL: drscanlin@pacbell.net Include your Name, Address, License#, Phone and Email (All event locations are wheelchair accessible. Please let me know if you need any special accommodations.)

Professional Networking Group

Date: 3rd Friday of every month
(see listserv for specific dates)
Time: Noon
Place: The office of Dr. Goldberg-Boltz, 2930 Camino Diablo, #305, Walnut Creek
Contact: Dr. Goldberg-Boltz (925) 788-7888

Early Career Group

Date: 2nd Friday of every month
Time: 5 - 6 or 6:30 pm
Place: ATC, 61 Moraga Way, #6 in Orinda
Contact: Dr. Candia Smith (925) 254-7823

Any suggestions for topics and speakers can be sent to:
ccpaboard@yahoogroups.com
Alissa Scanlin or Marc Kamori-Stager

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List of Groups

A Healthy Divorce/Separation Group

Meeting Day: Monday's
Meeting Time: 7:00 – 8:30 pm
Group Leader: Shendl Tuchman, Psy.D.
Contact Number: 510-201-3435
Email: dr.tuchman@earthlink.net

Breakthrough Weight Loss and Maintenance Group

Meeting Day: Thursday's
Meeting Time: 6:00 - 7:30 pm
Group Leader: Candia Smith, DMH
Contact Number: (925) 254-7823
Email: candia.smith@comcast.net

Introduction to Meditation for Stress Relief Group

Meeting Day: 1st and 3rd Tuesday of each month
Meeting Time: 6:00 -7:00 pm
Cost: Free.Small donation asked for rent.
Group Leader: Candia Smith, DMH
Contact Number: (925) 254-7823
Email: candia.smith@comcast.net

Men's Group

Meeting Day: Monday's
Meeting Time: 7:30 -9:00pm
Group Leader: Bruce H. Feingold, Ph.D.
Contact Number: (925) 945-1315

Men's Group

Meeting Day: Wednesday's
Meeting Time: 6:00-7:30 pm
Group Leader: Bruce H. Feingold, Ph.D.
Contact Number: (925) 945-1315

Mindfulness-Based Stress Reduction Class

Group Leader: Susan O'Grady, Ph.D.
Contact Number: 925-938-6786
Website: www.ogradywellbeing.com

Dialectical Behavior Therapy Groups (ages 19+)

Meeting Day: Tuesday's
Meeting Time: 5:30-7 PM
And
Meeting Day: Wednesday's
Meeting Time: 9:30 – 11 AM
Group Leaders: Elizabeth Rauch Leftik, Psy.D.
Sarah E. Wood, Ph.D.
Contact Numbers: Dr. Rauch (925) 314-6354
Dr. Wood (925) 680-1844
Website: mtdiablopsychologicalservices.com

Interpersonal Psychotherapy Group: Co-ed

Meeting Day: Wednesday's
Meeting Time: 5:00-6:30
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060

Chronic Medical Illness Group

Meeting Day: Wednesday's
Meeting Time: 12:30 - 2:00
Group Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060

Psychotherapy Group for Psychotherapists

Meeting Day: Thursday's
Meeting Time: 12:30 - 2:00
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060

Psychotherapy Group for Pre-Licensed and Early Career Therapists

Meeting Day: Thursdays
Meeting Time: 9:00 - 10:30 am
Leader: Ann Steiner, Ph.D., MFT, CGP
Contact Number: 925-962-0060
Website: www.DrSteiner.com

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Disaster Response

Following the tragedy in Connecticut, the following links were posted on the Disaster Response Network listserv by CCPA's Disaster Response Chair, Elizabeth Rauch Leftik, Psy.D., They are excellent!

Helping your children manage distress in the aftermath of a shooting
http://www.apa. org/helpcenter/ aftermath. aspx

Managing your distress in the aftermath of a shooting
http://www.apa. org/helpcenter/ mass-shooting. aspx

Five Questions on the Tucson, Ariz., Shootings for Psychologist Joel Dvoskin, PhD **please see # 3 question and response
http://www.apa. org/news/ press/releases/ 2011/01/tucson- shootings. aspx

Tips for Talking With and Helping Children and Youth Cope After a Disaster or Traumatic Event
A GUIDE FOR PARENTS, CAREGIVERS, AND TEACHERS
http://store. samhsa.gov/ shin/content/ SMA12-4732/ SMA12-4732. pdf

Helpful Hints for School Emergency Management:
Psychological First Aid (PFA) for Students and Teachers: Listen, Protect, Connect – Model & Teach
http://rems. ed.gov/docs/ HH_Vol3Issue3. pdf

Listen, Protect, Connect – Model and Teach Psychological First Aid for Teacher and Students
http://www.ready. gov/sites/ default/files/ documents/ files/PFA_ SchoolCrisis. pdf

After a Loved One Dies – how children grieve and how parents and other adults can support them
http://www.newyorkl ife.com/newyorkl ife.com/General/ FileLink/ Static%20Files/ New%20York% 20Life%20Foundation%20Bereavemen t%20Guide% 20-%20After% 20a%20Loved% 20One%20Dies% 20.pdf

School Crisis Guide: Help and Healing in a Time of Crisis
http://www.neahin. org/educator- resources/ school-crisis- guide.html

Disaster Helpline from the Substance Abuse Mental Health Services Administration Disaster Distress Helpline
http://www.disaster distress. samhsa.gov

CPA Progress Notes- November 2012

Required Steps Before Providing Services To Medicare Beneficiaries Using A Private Fee Arrangement

In order to protect vulnerable, older adults from exploitation, federal law requires certain steps to be taken before psychologists can establish a private, contractual fee arrangement with a patient who is a Medicare beneficiary.

The psychologist must first file an application to Opt Out of Medicare and have the application approved before treating the Medicare patient. While a psychologist can establish a private fee arrangement with other patients who choose to not use the insurance benefits provided by a private indemnity carrier, federal law regulates the relationship of health practitioners and their patients who are covered by Medicare and Medi-Cal.

Below is information from the California Medicare Intermediary that describes the Opt Out process that psychologists must do before establishing a private fee arrangement with a patient who is a Medicare beneficiary. The Opt Out procedure is necessary when an existing patient becomes a Medicare beneficiary during the course of treatment.

It is highly recommended that California psychologists in practice who want information about Medicare to directly consult the website of the designated Medicare intermediary for California. Although some psychologists are well-informed when they comment on a topic, fully relying upon advice and unsupported opinions about Medicare volunteered by colleagues is not recommended. Answers to nearly all Medicare questions psychologists may have can be found on the Medicare intermediary's website. The Medicare Intermediary for California is Palmetto GBA, Jurisdiction 1, Part B. The link to the intermediary's website for California psychologists is:

http://www.palmettogba.com/palmetto/providers.nsf/docsCatHome/providers~Jurisdiction%201%20Part%20B

Jurisdiction 1 Part B
Opt Out of Medicare Provider Enrollment: Instructions and Affidavit
Private Contract
As provided in § 4507 of the Balanced Budget Act of 1997, a private contract is a contract between a Medicare beneficiary and a physician or other practitioner who has 'opted out' of Medicare for two years for all covered items and services he or she furnishes to Medicare beneficiaries.
In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

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To opt out of Medicare:
Participating physicians must first terminate their Medicare Part B participation agreement. Participating providers are only permitted to opt out at the beginning of each calendar quarter. Therefore, a provider must submit a completed Opt Out form attached below at least 30 days before the first day of any quarter (January, April, July or October).

Non-participating physicians and practitioners, however, may opt out at any time. Certain health care provider categories, however, cannot opt out of Medicare. These include chiropractors and physical therapists in independent practices and occupational therapists in independent practices.

The opt out contract is for a two-year period from the date the physician or practitioner files and signs an affidavit notifying Medicare that he or she has opted out of Medicare. After the two-year period is over, the physician or practitioner could elect to return to Medicare or to 'opt out' again.

Please send your opt out request to:
J1 MAC - Palmetto GBA
Provider Enrollment
P.O. Box 1508
Augusta, GA 30903-1508
http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Medicare_Opt-Out_Affidavit-J1B.pdf/$File/Medicare_Opt-Out_Affidavit-J1B.pdf

Medicare Will Now Cover Services Even if Patient Not Likely to Get Better
Editor's Note: It is not yet clear if this recent court decision will affect the criteria for approving psychological services for Medicare patients.

By RON LIEBER, From New York Times

Should the federal government cover the costs of many kinds of treatments for patients who aren't going to get any better?

It didn't, for many years. But after the settlement of a landmark class-action lawsuit this week, Medicare will soon begin paying more often for physical, occupational and other therapies for large numbers of people with certain disabilities and chronic conditions like Alzheimer's disease, multiple sclerosis and Parkinson's disease.
The two questions patient advocates were left with this week were just how many people may benefit from the clarification of the regulations and how quickly.

The settlement, if approved by a federal judge, would end a lawsuit that accused Medicare of allowing the contractors that process its claims to use a so-called improvement standard over the last few decades. To the Center for Medicare Advocacy and the many other organizations that joined the suit, that standard seemed to call for cutting off physical, occupational and speech therapy and some inpatient skilled nursing for many people who had reached a plateau in their treatment.

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Medicare is supposed to pay for reasonable treatment of an illness or injury as long as a doctor has prescribed it. For the sort of in-home care that this week's settlement may affect the most, a doctor must have certified that you are, in fact, homebound and have prescribed treatment that only a skilled practitioner can provide. (The "skilled practitioner" rule keeps Medicare from paying for assistance with everyday activities like bathing and dressing.)

But for people who advocate for patients with particular diseases, having treatment cut off for lack of improvement was intensely frustrating.

"The idea that you would have to show improvement when you have a degenerative disease is blatantly absurd," said Amy Comstock Rick, chief executive of the Parkinson's Action Network. In her world, holding steady or degenerating more slowly than you might otherwise is often the definition of success.

Over the years, however, the Medicare contractors that process claims started to see things differently than patients and many health care professionals. And for family members of the sick, the denial could be quite abrupt.

"It was like falling off a cliff in that there was no longer any access to Medicare to help with even small, maintenance types of things, like range of motion," said Maureen Conte, a Falmouth, Mass., scientist, recalling the six years her father lived after having a stroke. "Multiple times he was back in the hospital for things that I thought were preventable."

Many other patients, however, may not have even received certain kinds of treatment because their doctors figured that prescribing it would be pointless. "Once it becomes clear what Medicare will and will not pay for, you end up changing your practice pattern based on what it covers," said Peter Thomas, a lawyer in private practice who is the outside counsel for the American Academy of Physical Medicine and Rehabilitation.

The settlement agreement takes pains not to describe itself as an expansion of Medicare coverage. But it does promise that the Centers for Medicare and Medicaid Services will revise the manuals their contractors use to make clear that coverage "does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy but rather on the beneficiary's need for skilled care."

Moreover, the settlement specifies that skilled care can qualify for Medicare coverage even if it merely maintains someone's current condition or prevents or slows further deterioration. Certain patients who have had claims rejected will be able to resubmit them.

Representatives of several patient advocacy groups expressed hope this week that Medicare would soon pay for many forms of therapy that it did not always cover before. For people with cerebral palsy, physical therapy to maintain muscle mass is one possibility. For multiple sclerosis patients, there may be more approval for treatments for spasticity and gait training to prevent falls.

The biggest question mark may be for the large numbers of people who suffer from dementia. According to Robert Egge, vice president for public policy at the Alzheimer's Association, there are many benefits that come from delaying the long-term progression of dementia. Leslie Fried, director of policy and programs at the National Council on Aging,

said there had been a particular Medicare claims bias over the years in applying the improvement standard to people with dementia and other forms of cognitive impairment.

"I think the settlement opens coverage up to pretty much any condition that creates functional impairment," Mr. Thomas said. In this way, he added, it is similar to the Americans with Disabilities Act, which did not confine itself to particular diagnoses. "In that respect, it's probably a more expansive settlement than some people might think." It could be a couple of months before the judge approves the settlement, which everyone I interviewed this week expected her to do. Then it could be a year or more until the Medicare billing contractors get the newly clarified manuals.

Even so, some patient advocates see no reason for people not to demand coverage that maintains their condition or slows deterioration right now, given that Medicare was supposed to be paying for it all along.

"We will be urging beneficiaries and advocates to bring the agreement to the attention of contractors," said Gill Deford, the director of litigation for the Center for Medicare Advocacy. "There is no reason why they can't be urging contractors to make the right decisions now."

Ms. Rick of the Parkinson's Action Network questions how that will go over. "I do encourage people to advocate for themselves as hard as they can," she said, acknowledging that time is of the essence for so many people with degenerative diseases. "But I would be uncomfortable as a contractor reading a settlement agreement and trying to figure out what that means."

Erin Shields Britt, a spokeswoman for the Department of Health and Human Services, did not want to comment, given that the settlement was not yet final, on how patients could best use the settlement to their advantage when trying to get Medicare to pay their claims.

But it cannot hurt to try. The worst that will happen is that you will get a denial, at which point you will need to decide whether you want to appeal and whether you can pay for the treatment yourself.

For all of the improved access to care that may result from this settlement, crucial money questions linger. People who wondered whether any improved Medicare coverage might reduce the need for long-term care insurance will be disappointed to find that the planning challenge remains. While the settlement might improve coverage for certain kinds of inpatient skilled nursing care, you may still have to pay for years in a nursing home when you can no longer handle basic tasks of daily living and staying in your home is no longer practical.

On a more macro level, there are costs to Medicare for all of these treatments, though Medicare does have individual annual limits in certain areas. How much more money might the program spend?

"Under this proposed settlement, Medicare policy would be clarified so that claims from providers will be reimbursed consistently and appropriately, which is always our aim," Ms. Shields Britt said via e-mail. "Because this proposed settlement would clarify existing policy, we do not expect changes in cost relative to what has been projected."
That assumes that there is no exploitation of the newly clarified rules — or outright fraud.

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Nevertheless, there is potential for savings here, too.

"The upside is really important," said Carol Levine, the director of the families and health care project for the United Hospital Fund. "Because if it's done well, physical or occupational or other kinds of therapy prevents the kinds of hospital readmissions that are costly. And not only are they costly, they really contribute to the deterioration of someone with a chronic condition."

Nicholas LaRocca, vice president for health care delivery and policy research at the National Multiple Sclerosis Society, echoed this emphasis on remembering the real live humans whose care hangs in the balance.

"There is always the fear that now you're going to open the floodgates and that this will cost the taxpayers a lot of money," he said. "But this is what Congress had in mind. This is the way that an enlightened society should be treating its most vulnerable."

Frequently asked questions about the 2013 psychotherapy codes

By APA Practice Organization Staff

PROGRESS NOTES Editor's Note: Before using the revised 2013 CPT codes for billing, it is advised to check with the insurance company to verify the carrier will be using the new codes to process claims.

Review this question-and-answer guide to help you prepare for psychotherapy coding in 2013

This article was updated on Oct. 18, 2012. Beginning Jan. 1, 2013, all mental health providers must use new CPT® code numbers for psychotherapy when billing third-party payers. This article provides answers to questions from APA Practice Organization members about the new codes.

When do I use the new psychotherapy codes?

You will use the 2013 psychotherapy codes for billing clients and filing health insurance claims with all third-party payers, including Medicare and all private health insurance carriers, for psychotherapy services provided on or after Jan. 1, 2013. Psychologists will use the new codes for Medicaid reimbursement in states where the Medicaid program includes psychotherapy as a covered service and Medicaid reimburses psychologists as independent providers of psychological services.

Aside from psychotherapy, do other codes used by psychologists change in 2013?

No. The changes in store for 2013 involve only the psychotherapy family of codes — the codes found in the Psychiatry section of the 2013 CPT® manual. There are no changes to other codes that psychologists use, such as testing or health and behavior codes.

What are the new psychotherapy code numbers?

The codes most critical to psychologists who provide mental health services involve diagnostic and psychotherapeutic procedures. For individual psychotherapy, there will no longer be separate codes for outpatient and inpatient settings.

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All individual psychotherapy will be captured through one of three new codes. Unlike the existing codes, the new code descriptions in the 2013 CPT manual will list specific times (for example, 45 minutes) rather than a time range (45-50 minutes). The three new codes for 2013 are:

90832 Psychotherapy, 30 minutes with patient and/or family member
90834 Psychotherapy, 45 minutes with patient and/or family member
90837 Psychotherapy, 60 minutes with patient and/or family member
The code now used for a psychiatric diagnostic interview, 90801, will be replaced by two separate codes. Code 90791 will be used for a diagnostic evaluation, while 90792 will be used for a diagnostic evaluation with medical services such as a physical examination.

What if a session is shorter or longer than the time specified in the code?

According to the 2013 CPT manual, psychotherapy times are for face-to-face services with the patient and/or family member, with the patient present for some or all of the service. Although the time for each code is specific, the manual allows for some flexibility. When reporting a psychotherapy service, the provider may choose the code closest to the actual time of the session. The examples provided in the manual are 16-37 minutes for code 90832, 38-52 minutes for 90834 and 53 minutes or more for 90837.

Since there is no new code associated with psychotherapy sessions that may last longer than 60 minutes, such as exposure therapy, how do I bill for these longer services?

The new codes are not intended to limit the length of time you schedule for psychotherapy. Psychologists who conduct sessions that require more than 60 minutes may continue to do so and will bill using the new 90837 code effective Jan. 1. Regardless of how long the session lasts, the psychologist's reimbursement will be based on the payment amount ultimately associated with 90837. Generally speaking, psychologists should check their insurance carrier's website throughout the fall of 2012 and early in 2013 for new policies on coverage and billing for services related to the 2013 psychotherapy codes.

When will the 2013 Medicare payment rates for the psychotherapy codes be available?

The Centers for Medicare and Medicaid Services is expected to announce the 2013 payment rates in November as part of the final Medicare fee schedule. The APA Practice Organization will share the information with members as soon as possible thereafter.

How will I know if private insurance carriers change psychotherapy payment rates for 2013?

Private insurance carriers likely will publish information on their website and/or send notices to providers during the fall of 2012 about 2013 payment rates. Timing will vary from one company to another, though we generally anticipate seeing private insurance schedules after the Centers for Medicare and Medicaid Services releases Medicare payment rates for 2013 in November. Check the carrier website periodically for payment information and updates.

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Will I need new or updated contracts with managed care and other private insurance companies in light of payment changes for 2013?

Most provider contracts by managed care and other insurance companies discuss specific CPT codes only in the fee schedule — an appendix to the provider contract that is designed to be adjustable as rates change without necessitating a revision to the main body of the contract. Therefore, there would be no particular need to update the main provider contract due to new CPT codes. As noted earlier, we expect these companies to issue new fee schedules late in 2012.

What happens if I bill using the old psychotherapy codes for services provided on Jan. 1, 2013 or later?

Effective Jan. 1, psychologists should assume that their Medicare carrier will reject any claims containing codes that have been deleted from CPT and that these claims will require re-filing. We expect that private managed care and other insurance companies are also likely to reject claims filed using the 2012 psychotherapy codes. Whom do I contact if I have problems with Medicare billing and reimbursement?

Start by getting in touch with the relevant Medicare Administrative Contractor (MAC) for your area (PDF, 149KB). Keep in mind that some of the MACs are changing by the end of 2012.
If you are unable to get what you need from your MAC, you may contact the regional office of the Centers for Medicare and Medicaid Services. Information about CMS regional offices is available online.

Where do a find a list of all 2013 CPT codes that psychologists use?

The CPT manual for 2013, published by the American Medical Association (AMA), contains all codes used by psychologists and other health care professionals, along with details about the use of individual codes. This includes testing and health and behavior (H & B) assessment and intervention codes, which do not change for 2013. Copies of the 2013 manual can be ordered online from the AMA or by calling toll-free, (800) 621-8335.

What was psychology's role in the psychotherapy codes review process?

Revisions to the family of psychotherapy codes for 2013 resulted from the Five Year Review, the process by which the Centers for Medicare and Medicaid Services (CMS) periodically review all codes. Throughout 2011, psychology, along with psychiatry, child and adolescent psychiatry, social work and nursing, participated in a CPT coding workgroup to review the current psychotherapy codes and recommend changes.

Psychology's representatives fought continuously to protect the profession's interests throughout the year-long code review process. Psychology was represented in the coding process both by its advisors to the CPT coding workgroup and its representation on the CPT Health Care Professionals Advisory Committee.

The multi-specialty workgroup was involved in evaluating the definitions of services under the existing psychotherapy family of codes and recommending work relative value units (RVUs) for the new codes. The APA Practice Organization

conducted a member survey early in 2012 as part of the process of determining recommended RVUs for the new psychotherapy codes. Other associations involved in the workgroup also surveyed their members.

The workgroup then brought its suggested work values to the Relative Value Update Committee (RUC), which in turn made recommendations for new code work values to CMS. The work values that CMS adopts for the new codes will be applied to a formula used by the agency to determine Medicare reimbursement rates for psychotherapy services beginning in 2013.

APA was actively involved in the RUC process both through the multi-specialty workgroup and its representation on the RUC's Health Care Professionals Advisory Committee.

All participants in the CPT and RUC processes must sign strict confidentiality agreements required by the AMA to guard against premature release of information about coding and payment changes. Payment information will be made public when CMS announces how Medicare will value the new psychotherapy codes in its final rule on the 2013 Medicare fee schedule, expected in November.

Please note: This question-and-answer set was prepared based on information available early in October 2012 and is subject to change as we learn more about the 2013 psychotherapy codes and their implementation. The APA Practice Organization will continue to keep members apprised of related developments. Visit the billing and coding section and check our biweekly Practice Update e-newsletter.