

# Psychotherapy Finances

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### MEDICARE: Psychologists and CSWs trying to reverse rate cuts

The 9% Medicare rate cut that socked psychologists and clinical social workers in January would be partially reversed under a children's health care bill passed by the House on August 1. An increase of 5%--to take effect on January 1, 2008--made it into the final bill (HR 3162) after a joint lobbying effort by the Clinical Social Work Association (CSWA), the National Association of Social Workers (NASW), and the American Psychological Association.

"We've been working together over the last couple of months," notes Laura Groshong, director of government relations for the CSWA.

The House bill, called the Children's Health and Medicare Protection Act (CHAMP), also contains a provision that would create Medicare parity for outpatient behavioral health. Currently, the effective Medicare co-pay for these services is 50%, but that would drop to 20%.

A companion bill was passed by the Senate on August 2 (SB 1893), but it addresses only the Children's Health Insurance Program--not Medicare issues. A conference committee will be charged with working out a compromise between the two versions. Groshong says she's hopeful. "From what we hear, there's support for keeping [the Medicare revisions] in the Senate version."

However, the final bill has to survive a veto threat by President Bush. The administration and some congressional Republicans oppose the bills, arguing that expansion of the children's program would encourage parents who have private health insurance to drop their coverage. There is also opposition to a 61-cent increase in cigarette taxes aimed at funding the measure.

But supporters feel they have reason for optimism. The bill has garnered some Republican congressional support: Sixty-eight senators voted for it, enough for a veto override. Says Groshong, "I think the president backed himself into a corner, because he didn't realize what kind of support there was for this bill."

And Jim Finley, senior associate at the NASW, thinks the 5% increase may be under the radar for budget hawks this fall. "It's just a flyspeck," he

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says. "It's smaller than budget dust to them." The reduction in co-pays, however, may be too much to hope for. "That will get more scrutiny."

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#### NICHE MARKETING: A look at ways to tap the eating disorders specialty

At least 10 million American girls and women have an eating disorder, plus another million boys and men, according to the National Eating Disorders Association (NEDA). Millions of others are binge eaters. And with a media culture that promotes thinness even as real people get fatter and fatter, clinicians who specialize in this niche have an abundance of work.

Below, we talk with three practitioners who focus their practices on eating disorders--each in a slightly different way. Note that while this is often a cash niche, patients can generally access insurance benefits as well.

- At least that's the case for Brock Hansen, a Washington, DC, clinician who devotes at least half of his practice to eating disorders. Most of his clients see him for binge eating problems, and most use insurance benefits. Hansen has been working in this specialty area for 25 years. His clients stay in therapy for at least six months, "but I've had some severe cases where people work with me on and off for 20 years."

Hansen's typical client has been dieting since high school or college, sometimes bingeing and purging. "They're beginning to lose hope that they can control this behavior...First I work on motivation, then we establish a program they can follow to change. We also have to sort out whether there is some trauma that needs to be worked through, because a high percentage of people with eating disorders have experienced sexual abuse or emotional abuse --something that sets them up for high anxiety, depression, or shame-related issues."

Hansen has established a small network of other professionals who refer to him, including physicians and dieticians. "I have two or three physicians, and other clinicians who keep me very busy."

He pays \$75 per year to be listed on the eating disorder Web site [www.edreferrals.com](http://www.edreferrals.com). He also pays \$30 per month for a PsychologyToday.com listing--those clients come to him more often for depression and anxiety than for eating disorders. He also mentions that a new book he's published, *Shame and Anger: The Criticism Connection*, is drawing clients.

Hansen charges \$110 an hour, with managed care reimbursement knocking that down to about \$70. He's also launched a coaching practice, and offers four 30-minute phone calls per month, for \$200 per month, under a three-month contract.

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● Robin Landau says her Beverly Hills, CA, practice is perfectly situated for this specialty. About 75% of her clients are with her to deal with eating disorders--more of them for bulimia than for anorexia. She adds that in her experience, eating disorders tend to be more prevalent in big cities: "There's more of a focus here on fashion and quick living...There's also a lot of money here. And the more money, the more focus there is on appearance"

In addition to individual work, Landau has two groups going most of the time. Two new groups will be launched in October: one for adolescents and one for adults. Her groups meet weekly, usually with six members.

"I try not to make them too big. I want everyone to have their time." Participants pay \$40-\$60 per session, and she requires a six-month commitment. Individual therapy runs \$150 per session, and Landau doesn't take insurance.

Like most therapists we speak to about this specialty, Landau emphasizes the necessity of coordinating with family physicians. Therapy often goes on for a year, and sometimes up to seven years, she says.

"I'm very much of the opinion that you need to discuss the underlying issues," she says. "It's not about the purging and binging--that's all metaphor. A lot of it has to do with feeling isolated, and lack of nurturing early in life. Food makes them feel better. They binge, but after that they worry about their weight and they want to get rid of it."

Once she identifies the triggers and makes clients aware of them, "the eating disorder slowly loses its power."

● Valery Rockwell, who practices in Cambridge, MA, devotes about a third of her time to eating disorders, with the rest split between couples work and PTSD clients. "There's an overlap with eating disorders in that population."

Anorexia, she tells us, "seems to be the most difficult in terms of moving treatment along. If the person has been anorexic for years, that's tough to treat. The best thing is to get them into treatment as early as possible.

"Bulimia often starts when someone has experienced some kind of loss--a breakup with a boyfriend, or parents getting divorced. The younger girls have a lot of pressure with body image and weight and grades."

When it comes to treatment, "The first thing I'll get young women to do is keep an eating and emotion log. That means paying attention to everything they put in their mouths, including gum and water. We want them to keep track of what was going on right before that--anxiety, fear, sadness, or anger. Eating is a way of numbing the feeling rather than working it through... There's also a lot of work we do about their relationships with their partners, and their friends and family."

This is a medical niche, Rockwell emphasizes. She insists on making physicians aware of the work. Clients who say they don't have a physician

### Resources

The National Eating Disorders Association lists conferences and seminars on its Web site: [www.edap.org](http://www.edap.org). Its national conference will be held in San Diego, October 4-6.

Also see the the International Association of Eating Disorders Professionals at [www.iaedp.com](http://www.iaedp.com). It's a membership organization with local chapters, and it offers training opportunities. The home page has a therapist directory.

The National Association to Advance Fat Acceptance (NAAFA) has news and information about eating disorders at [www.naafa.org](http://www.naafa.org).

have to get one. "I also work with nutritionists who are sensitive to eating disorders," Rockwell adds.

(For articles about establishing and maintaining better relationships with physicians, see *PsyFin*, July and October, 2006. Subscribers can receive free email copies. Send your request to: editors@psyfin.com.)

Rockwell set up her Web site ([www.valeryrockwell.com](http://www.valeryrockwell.com)) five months ago, and has started to get some clients from it. Her listing over the past seven months on PsychologyToday.com has been disappointing, "but we just revamped it--there's a professional photo on it now and I think that's going to make a huge difference."

She charges \$140 per hour and says the average client stays with her for two years. "Often people want a quick fix, but that's not how it works. I'm honest with people and say this isn't going to happen as quickly as you want it to." Also note: Rockwell takes no insurance.

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PRACTICE BUILDING: Developing workshops that people are willing to pay for

Group therapy programs can be effective practice builders. On the other hand, when clients use their insurance benefits, reimbursement is low and the paperwork is time consuming.

In Austin, TX, Jane Cobb is working around that problem. By giving her groups a bit of an educational spin, she's repackaged them as self-pay workshops. "With third party payors, if you say you're running a group, you get a pittance. With a workshop, you can charge a more appropriate fee."

A workshop should be consumer and wellness oriented, Cobb says. Her previous workshops focused strictly on eating disorders. Now, she charges \$300 for a 10-week workshop called "Women, Mood and Food." Five members meet every Wednesday for 90 minutes. Some clients are paying upfront, while others pay in two installments.

Although Cobb treats serious eating disorders in her practice, the workshop is "not targeted at bulimics...It's for any woman who feels she can relate to issues of eating when she's not hungry, and feels like her eating is related to moods she's suffering."

Cobb's goal is a no-managed care practice--right now she figures just under half her caseload is managed care. Her income stream is broken down this way: 70% individual therapy; 20% couples; 10% workshops. Her standard fee for an individual therapy session is \$100.

She's preparing a new workshop called "Group Process Workshop." The focus there will be on developing better communication skills. Participants will be charged the same rate as the food workshop. She has a two-pronged effort at bringing people out for this.

First, she's distributing fliers through coffee houses and pharmacies in Austin. Second, she has sent letters and fliers to about 100 physicians, some of whom are already referring eating disorder patients. (Naturally, she has fliers in her waiting room, and promotes her workshops on the home page of her Web site, [www.janecobbtherapist.com](http://www.janecobbtherapist.com).)

Clients for the "Food and Mood" workshop "fell into my lap because there were enough women in my caseload who said they had an interest. I've always been told to strike while the iron is hot--and a number of women thought this was relevant."

It should be noted that Cobb didn't start from scratch in developing her workshops. She's done community presentations from time to time over the years to get her name out there. Some of these talks have been income producers, and others strictly "soft sell." But her fliers and business cards were always at hand.

Some of her past presentation topics: "From Flirting to Forever"; "Facing the Grinch: Coping With Holiday Stress"; "How to Have an Emotionally Intelligent Relationship"; and "Your Best Relationship Ever--How to Have it."

Her Web site, by the way, is attracting an increasing number of clients. About six people in the past year have found her directly through the Web--and these are all cash clients. "I see that going up over time."

She also pays \$30 a month for a listing on PsychologyToday.com, which includes a link to her home page. "I think a lot of people shop for therapists that way."

You can contact Jane Cobb at 3724 Jefferson St., Ste. 212, Austin, TX 78731, (512)323-0021, [www.janecobbtherapist.com](http://www.janecobbtherapist.com).

### ***Beyond parenting workshops: Clinician puts focus on fatherhood***

Parenting workshops are a proven draw. Jeremy Schneider, a clinician who practices in Manhattan and Long Island, NY, has refined his market strategy further by offering workshops specifically about fatherhood.

Schneider's practice breaks down into three income streams—traditional clinical work, workshops, and writing/publishing.

He sees about 10 clients for individual therapy, and conducts his workshops roughly once a month. He attract up to 30 participants who pay about \$20 each for a one- or two-hour educational seminar.

But instead of arranging and marketing the workshops himself, he solicits sponsorship from larger organizations which take care of promotion. His most recent workshop, for example, was held at a synagogue.

"With some places, I put together the flier they use for their mailing...But I don't have to worry about mailing it out to anybody."

The demand for programs on fatherhood is stronger than he'd realized, Schneider tells us. "I originally intended it to be for fathers of infants and toddlers.

"But I've been surprised at the wide range of fathers showing up. I'm getting fathers with adolescents, and

even fathers with adult children who have a hard time making the transition."

He develops his list of would-be sponsors through Internet searches, then mails them an extensive press kit—available on his Web site: [www.jgs.net](http://www.jgs.net).

Schneider's rates are low for New York at \$75 per session. But these are all cash clients. He leases a small office in Manhattan "very cheaply" and does some off-site therapy as well.

"I've also developed a small niche with actors," he adds. "Most of them are part-time while they're auditioning—I just enjoy it."

Schneider's marketing efforts are high tech. His Web site has links to a monthly column he writes called "A Father's Voice."

It appears on other Web sites including [fatherville.com](http://fatherville.com), [cleverparents.com](http://cleverparents.com), and [fathersforum.com](http://fathersforum.com).

He also does "A Father's Voice" podcasts, which are available on his Web site and at [www.itunes.com](http://www.itunes.com).

"I have people who listen to my podcasts and shoot me an email," he says. "It's really cool."

***You can contact Jeremy Schneider*** at (917)687-9202, email: [Jeremy@jgs.net](mailto:Jeremy@jgs.net).

PRACTICE ALTERNATIVES: No shortage of work for pain management specialists

We've frequently recommended pursuing medical niches. The reason is simple--that's where the overwhelming majority of the health care dollar is spent. The article beginning on page 2 focuses on one medically-oriented niche: eating disorders. Other clinicians focus on health regime compliance for diabetes or heart disease patients.

Below, we look a bit further afield--at a pair of therapists who've left conventional practice behind to focus a large part of their time on another medical niche: pain management. Of course, most clinicians won't want to follow their lead--but their example illustrates that motivated therapists can find interesting and rewarding avenues despite the predations of managed care.

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- In Davis, CA, Lee Ockenden works as a contractor with a wellness center called the Institute for Restorative Health (IRH). He serves as IRH's assistant director of behavioral medicine services--and uses his office to see about 25 private clients per week.

One big advantage to working in a clinic setting: "I work with a lot of physicians, and they'll point to me and say, 'You need to go to this guy.' There's a lot of credibility in that."

Ockenden's pain management clients include patients suffering from Parkinson's disease, back problems, and neurological problems. And he's currently working with four brain trauma patients.

His fee is \$110 an hour--and most of his clients pay cash. "I see fewer people but I make more money. I charge a premium rate, but people don't seem to mind. I'm near a military base and people don't want to use their insurance--they'd rather pay out-of-pocket."

However, Ockenden has a contract with one HMO in the San Francisco area. Under that arrangement, he works with chronic pain clients by phone for a flat fee of \$460 per case. He considers it training, not therapy. The method, developed by one of his colleagues, is called neurobehavioral mind/body pain management. It involves four sessions ranging from 30 to 90 minutes each.

The method, Ockenden says, is based on the mind's ability to create a physiological change. "It allows us to create a link between the conscious self and the unconscious self in order to get the pain gates to close." (For more on that, see [www.neurobehavioralprograms.com](http://www.neurobehavioralprograms.com).)

The goal is to reduce the patient's stress, "and once we reduce their stress, their pain invariably begins to go down."

Ockenden gets clients through the IRH Web site ([www.4irh.com](http://www.4irh.com)) as well as his own Web site, [www.leeockenden.com](http://www.leeockenden.com). He also has a listing at Psychology-Today.com. Another key marketing tool is a four-hour anxiety workshop he offers several times a year. Up to 10 attendees pay \$150 each to hear a program featuring Ockenden and other IRH clinicians. Two new clients came in following the most recent workshop.

And they may stay for months, Ockenden adds. "Once we're finished dealing with pain, they often have other issues."

● In Portland, OR, Ron Lechnyr works in private practice with his clinician-daughter, spending 99% of his time with pain management clients. His background in this area is strong, including 10 years as clinical director of the Oregon Pain Institute. Early on, he explains, many of his patients had been classified as "kooks" by orthopedists and others who were unable to deal with chronic pain issues.

Today, he says, there's a greater interest in his specialty among medical professionals, and he has little trouble attracting referrals.

Part of what he does, Lechnyr explains, is help patients deal more effectively with their doctors. He encourages the "Dragnet approach" when talking to a physician--just the facts. "I teach patients to go to their doctors just for information, and then educate themselves on their condition." He keeps current editions of medical manuals in the office for clients to peruse. "Patients need to educate themselves and manage their own care."

Another lesson: Don't leave messages with your doctors, then sit by the phone waiting for them to return the call. "I teach them not to expect the physician to call at all."

Lechnyr sees about five patients per day. Nearly all are covered by health insurance, Medicare, or workers comp. He usually sees patients for 8-to-12 sessions, teaching basic techniques for managing pain so they feel they're more in control.

He starts with relaxation, teaching them that the same site in the brain controls pain and moods. One can affect the other, he says. Often, he'll spend a session or two on EMG or muscle biofeedback.

Lechnyr records the sessions for patients to take home for further work on their own. At the end he deals with relapse prevention and flare-up management. Some clients, he adds, need a "booster session" later on. "It's the same as drug and alcohol treatment. You need to assume relapses will happen."

Lechnyr's standard rate is \$150 per session. How much does managed care pay? It varies widely, not surprisingly--but he says getting sessions approved hasn't been a big problem. The necessity of some level of treatment is widely recognized by managed care, he insists.

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#### ***A pain management sub-niche***

Lately, Ron Lechnyr has expanded into a pain management sideline: pre-surg evaluations for clients about to have spinal cord stimulators or morphine pumps surgically implanted.

With the first, an electrode is placed in the spinal cord, with a battery pack placed below the skin. This can reduce 50% of acute pain.

Patients with diffuse pain use the morphine pump, which metes out a constant, small dose of the medication. This is a focused drip—producing a localized effect, not a systemic one. Intoxication and dependency do not result, and the medication is refilled subcutaneously every few months.

Lechnyr determines if patients will be able to handle these devices, while educating them. Physicians don't have a lot of time with the patients, so he explains how to use the devices, what kind of follow-up will be needed, and other details.

He also does personality testing to see what sort of post-op trouble may arise.

This process is done over several days, and Lechnyr's fees vary, going up to \$500. Many of the insurers require this evaluation before they'll okay a surgical procedure that costs between \$40,000 and \$50,000.

Sometimes he'll follow up when patients feel they need extra help.

FOLLOW-UP: To barter or not to barter--licensing boards don't like it

Last month's "Feedback" item on bartering drew an interesting array of responses. In particular, the opinion expressed by California psychologist Ofer Zur--to the effect that swapping therapy for services like housepainting is acceptable if done carefully--proved controversial. William Doverspike, for one, tells us it's a dangerous practice no matter how careful you are.

"Even though it's not prohibited, I can guarantee you any licensing board can find a problem with it," Doverspike says. Patient complaints rarely originate with bartering, he explains. But if you find yourself before the board on another matter and the bartering comes to light, it may be perceived as an indication that you run a sloppy operation.

"There are loopholes," he adds. "But anybody could look at an arrangement you have and say it's clinically contra-indicated and is an example of something that's exploitative. That's how licensing boards look at it."

An Atlanta-area psychologist and author of the book *Ethical Risk Management: Guidelines for Practice*, Doverspike allows that Ofer Zur "makes a good case for his position...But I say when it comes to me protecting my license or protecting my malpractice policy, I'm not going to do it.

"I don't want to engage in anything with my client that might affect my objectivity or my effectiveness. Like if I notice that little smudge mark that [the painter] left by the light switch, and when he's in session that's all I can think about."

Bartering through a co-op or clearinghouse, as described in the box below, is a lot safer, Doverspike feels.

But that practice hasn't caught on very much with health professionals, according to Tom McDowell, executive director of the National Association of Trade Exchanges. This organization represents bartering exchanges around the country--particularly in California, where they are most popular.

McDowell says bartering has been embraced by some dentists and chiropractors, but efforts to attract physicians, other health providers, and lawyers, have not been successful.

"The reason people get involved is to attract new business," McDowell

### **Trading therapy for charity work**

Clinicians in Hartford, CT, who want to work with cash-strapped clients have an alternative to bartering. They can offer therapy through an organization called Volunteers in Psychotherapy (VIP).

The non-profit organization, launched in 1999, lets people do four hours of volunteer work at any of dozens of charitable organizations in the Hartford area in exchange for one hour of therapy.

Seven practitioners have signed up with VIP, and they receive \$55 per session from the program, which is underwritten by 10 community organizations.

"It's sort of a clinic without walls," says Richard Shulman, a licensed clinician who created the VIP pro-

gram. "[The therapists] make available to us as many hours as they choose. They usually work with one to three clients at a time."

About 300 clients have accessed VIP care over the past eight years. Participating providers include psychologists, CSWs, LPCs, and a psychiatrist.

Shulman says there has been some interest in launching similar groups in other parts of the country. "We've encouraged practitioners to contact us and consider developing some variant of this."

**You can contact Richard Shulman** at Volunteers in Psychotherapy, 7 S. Main St., West Hartford, CT 06107, (860)233-5115, [www.ctvip.org](http://www.ctvip.org).

says. "But in certain professions--physicians for example--customers maintain long-term relationships with the provider. There's not a lot of changing of providers going on.

"We've had tremendous success with dentists," he adds. "Why? Because when people leave a dentist, they may still be in pain. They're not happy campers. They make a change because they want instant relief."

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#### MANAGED CARE: MultiPlan rate cuts sock therapists after merger

With all the mergers and acquisitions in the health care industry, sometimes it's hard to figure out who you're working for. Recently, the purchase of the Massachusetts-based Private Health Care Systems (PHCS) by New York-based MultiPlan has left some practitioners reeling.

As MultiPlan completed the transition, they reduced rates they were paying to many members of both networks--20% or more, *PsyFin* readers tells us.

For clinical social workers in New York, for example, reimbursement dropped from approximately \$76 to \$63. New Jersey psychologists saw their fees cut from \$113 to \$90. California clinicians also experienced a drop--though we've had trouble pinning down exactly how much.

What happened? Depending on the contract and the location, one company was often paying more than the other. When MultiPlan purchased PHCS, they streamlined the fee schedules--dropping the higher of the two in a given market to match the lower. Russ Holstein, a psychologist and managed care gadfly based in Long Branch, NJ, tells us that he had a higher rate with MultiPlan--but it dropped to the lower PHCS rate after the merger.

On the other hand, Susan Frager, who runs a billing service for a national clientele, knows several clinicians who've experienced the opposite--they were drawing a higher rate from PHCS, and now get less from MultiPlan.

An interesting detail: Six months before the PHCS purchase, MultiPlan itself was bought by the Carlyle Group, an internationally-known investment company with high profile backers including former President George H.W. Bush and John Major, the former British prime minister.

Below, we detail two clinicians' specific experiences with MultiPlan's rate cuts. But first, it's important to note that MultiPlan--and PHCS as well--are not truly managed care companies in their own right. They are provider networks used by self-insured companies. They also function as a supplier of out-of-network providers for some managed care companies including United Behavioral Health and CIGNA Behavioral.

- One clinical social worker in New York had contracts with both MultiPlan and PHCS before the merger. She filed a claim with PHCS in June, and when she received the reimbursement, "I thought there was a billing error. It had changed from \$72.92 to \$63.27."

### **MultiPlan or PHCS — ‘It’s both, ma’am’**

Here’s a transcript of the conversation about fees between MultiPlan and the New York provider featured in the accompanying article:

**MultiPlan staffer:** “Because the MultiPlan fee schedule is proprietary and confidential information, I need to request your verbal agreement, number one, not to disclose the fee schedule to any other person; and number two, not to use the fee schedule in any way other than to evaluate your participation in the MultiPlan network. Do you agree to comply with these requirements?”

**Therapist:** “What else would I do with this propri-

etary information?”

**MultiPlan:** “Ma’am, it’s what we have to do or we can’t discuss the claim with you.”

**Therapist:** “I just didn’t understand. Is this MultiPlan or is this PHCS?”

**MultiPlan:** “It’s both ma’am. All PHCS claims are MultiPlan. You can talk to someone in provider relations but I can’t discuss the CPT code or the 90806 unless you’re willing to comply with this.”

The therapist adds: “She said if you don’t like the rates, you can terminate. And she volunteered that without me even asking...But I wouldn’t terminate mid-treatment.”

When she called to ask questions, MultiPlan told her they’d notified her about the rate cut by mail. “But I never received the letter.”

And interestingly, the New York provider says that before the MultiPlan staffer would even discuss the problem, she was asked to agree verbally not to disclose MultiPlan’s rates to anyone else. (See the box, above.)

● Meanwhile, Russ Holstein says these cuts may be negotiable, depending on where you are. In contrast with the New York provider discussed above, he’s in a distant suburb where therapists aren’t quite as thick on the ground. When he called MultiPlan, “First they said, ‘Tough.’ But then someone sent me an email and said, ‘Let’s talk.’”

“I got another call, and when I was on the phone with the person I went through the individuals who are listed on their network. I said, ‘You’re going to lose myself and my wife [who is also a psychologist], so you won’t have anyone in Long Branch, NJ. And you don’t have many people nearby, so you can’t afford to do that.”

“After I talked to them, they did not restore [the higher rate] completely, but they came up more than half way. And I asked for the same rate with PHCS and they said, ‘We can do that.’”

Another important note: Susan Frager says that some of her clinician-clients who work with MultiPlan on an out-of-network basis have acquiesced to lower MultiPlan rates when they didn’t have to.

“United is the key offender, through MultiPlan,” she says. “What they’ll do is hold onto your claim until just shy of the state statute.”

### **MultiPlan addresses merger complaints**

Networks for MultiPlan and PHCS will remain separate, says MultiPlan spokesperson Jackie Ibbitson. What about rate changes? “Some went down and some went up, depending on location and specialty,” she says.

“I know California was one state that saw a significant decrease in rate structure.”

There are three parts to the MultiPlan network, according to Ibbitson. PHCS is the company’s “primary PPO,” while the MultiPlan network is complementary—used by UnitedHealth, CIGNA, Aetna and other companies to en-

hance their provider networks.

“The third is fee negotiation,” she says, acknowledging that out-of-network providers receive discounted fee offers. But she denies that taking a discounted fee offer automatically puts a therapist on the MultiPlan network.

She also insists that clinicians are *not* told they can’t talk about fees with outsiders “I would find that very unusual,” she says.

**You can contact Jackie Ibbitson** at MultiPlan’s Waltham, MA, office, (781)895-3183.

### Managed Care Alert: New Opportunities for Providers \*

**Concern Services**, based in Cincinnati, maintains a national EAP panel to serve its employer-clients. Additionally, a company rep tells us, Concern maintains a smaller managed behavioral health care panel in Ohio and northern Kentucky only—but that panel is full. Clinicians interested in applying to the EAP panel should call (800)642-9794 and ask for the “National Affiliate Team.” An application will be sent based on geographic need, the rep says, adding “and we’ll negotiate rates.” Special qualifications in EAP or chemical dependency are preferred but not required. See the company’s Web site at [www.concernservices.com](http://www.concernservices.com).

**Invest EAP**, based in Burlington, VT, operates in that state and in New Hampshire, plus “a little in Massachusetts.” Some employer-clients have a few covered lives in other states, but the vast majority are in New England. A rep says the company is “constantly filing resumes” for future needs. Reimbursement is \$60 per session, and Invest operates a five-session assessment and referral model. To request an application, mail a CV to Invest EAP, Attn. Evelyn, 108 Cherry Street, Second floor, Burlington, VT 05401. Also see the company online at [www.investeap.org](http://www.investeap.org).

**People Resources, Inc.**, based in St. Louis, is accepting applications from providers of managed behavioral health and EAP services. On the managed care side, a rep tells us, they operate strictly within Missouri. “For EAP, we’re pretty much anywhere.” Standard reimbursement for both products is about \$60. Two years post-licensure experience is required. To request an application, send copies of resume, license, and malpractice face sheet to People Resources, Attn. Kathy Shoop, 9666 Olive Blvd., Ste. 705, St. Louis, MO 63132, fax: 314-222-4026. See the company online at [www.peoplereourceseap.com](http://www.peoplereourceseap.com).

**PsychCare**, a Miami-based managed behavioral health and EAP company operating in Florida, is accepting applications from providers. Download their application from the company’s Web site, [www.psychcare.com](http://www.psychcare.com). Click the “Join Network” tab near the top of the homepage. The company’s phone number is (800)221-5487, but it’s not worth calling unless you want to devote a significant chunk of your day fighting your way through to an actual human voice—which will direct you back to the Web site in any case.

**Update:** Last month’s “Managed Care Alert” column included a listing for KGA, a Massachusetts-based EAP. Subsequently, the company got back in touch with us, asking that *PsyFin* readers please stop calling. “We have rather stringent requirements,” explained Jack Burke, the company’s manager of clinical services. “Most unsolicited applicants do not meet them.” The company typically pays \$65 per session, we’re told by another KGA rep.

\* **Using Managed Care Alert:** We generally specify the department within a company that you’ll need to reach. But sometimes it isn’t possible. If you don’t know who you need to contact, try asking for “provider relations.” Some companies use the terms “network development” or “network manager.” **And please note:** Listings in Managed Care Alert are verified by our editors. At times, however, clinician response overwhelms company employees—and they are less than accommodating to you. Our advice is to stick with it. If you’re discouraged from applying, put the info away for a while—and then try again.

(That’s in states with laws governing how fast MCOs must pay.) “If it’s 30 days, on the 28th day they’ll send you a fax saying, ‘Respond ASAP. We want to pay you promptly, and we want you to accept this discount.’”

“When my providers are out-of-network and they get one of those, I tell them to rip it up. Don’t ever sign it. And guess what? They’re still paid--it has nothing whatsoever to do with prompt payment.”

Holstein says he’s heard the same stories. “My advice is to wait. If you’re going to give me \$200 tomorrow, but \$150 today, then I’ll wait...I’m not that desperate.”

**Contacts:** 1) Susan Frager, Psych Administrative Partners, St. Louis, MO, (800) 841-5565, [www.psychadminpartners.com](http://www.psychadminpartners.com); 2) Russ Holstein, Long Branch, NJ, (732) 571-1200.

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9/07

PROFESSIONAL NOTES:

Aetna says it has achieved medical cost offset with its "Medical/Psychiatric High Risk Case Management Program." In cases of co-occurring problems like diabetes and depression, overall costs (including medical and pharmaceutical) were \$136 lower over a one-year period for members who participated in the Med/Psych program. For more, see [www.aetna.com/news/2007/0816.htm](http://www.aetna.com/news/2007/0816.htm).

This year's APA convention, August 17-20, drew about 16,000 members. That's the preliminary figure from American Psychological Association spokesperson Pam Willenz. It's a big jump from last year's event in New Orleans which drew just 9,800--at least partly because of a Katrina hangover. Next year's convention is in Boston, then Toronto in 2009, San Diego in 2010, and Washington, DC in 2011. Thereafter, every third convention will be in Washington.

Use of pain medication in the U.S. is soaring. The sale of such prescription drugs as oxycodone, codeine, and morphine jumped 90% between 1997 and 2005, according to the DEA. More than 200,000 pounds of these drugs were sold in 2005 alone, enough for everyone in the country to take a 300 mg dose. The increase has been attributed to an aging population and effectiver marketing by pharmaceutical companies. (Source: *Associated Press*, August 20.)

Hawaii's governor says no to prescribing psychologists. A prescribing bill passed the legislature and sat on Governor Linda Lingle's desk for two weeks. There was speculation that it might become law without her signature--but just prior to the July 10 deadline, Lingle vetoed it. In an accompanying statement, Lingle said, "Psychologists with limited didactic and clinical training are not prepared to handle the side effects of psychotropic medications on patients with medical complications." (Source: *Psychiatric News*, August 17.)

A drug used to treat adult schizophrenia and BPD was approved for youths. The medication, Risperdal, was okayed by the FDA for use in adolescents with schizophrenia, aged 13 to 17, and for youths aged 10 to 17 with bipolar disorder. It was approved last fall for treatment of irritability in autistic patients. (Source: *Associated Press*, August 22.)

Psychologists declined an outright ban on assisting military interrogations. But at its convention in San Francisco last month, the American Psychological Association (APA) approved a resolution denouncing a list of specific torture techniques such as water boarding, sexual humiliation, and rape. The resolution did not quiet a crew of protesters who gathered near the convention site. Some of them wore black hoods to simulate prisoner treatment at Guantanamo Bay and other American military prison facilities. "The APA came in line with the minimum of its responsibilities by condemning, in certain circumstances, the most egregious forms of torture being committed in our name," psychologist Steven Reisner told *Salon.com* (August 21). Reisner and others have pressed the APA to take a position similar to that of the American Psychiatric Association--which says essentially that members shouldn't participate, even as consultants, in any sort of military interrogation. See the APA news release on the issue here: [www.apa.org/releases/councilres0807.html](http://www.apa.org/releases/councilres0807.html).

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