Title of Course: Realistic Risk Management  
CE Credit: 6 Hours  
Learning Level: Intermediate  
Authors: Edward L. Zuckerman, PhD

Abstract:

Over the last 10 years there has been a major increase in the number of lawsuits, licensing board actions, and ethics complaints against mental health practitioners. Changes in the economic system, the growth of managed care, increased federal and state regulations, and greater demands for oversight and accountability in clinical practice have made record keeping and communications much more complex, time consuming, and risky. Many clinicians are frustrated by the extra work they must do and the complex and sometimes contradictory demands of regulators and insurance. This course will offer both clarifications and practical methods for covering your assets, associates, and actions.

Learning Objectives:

1. Estimate your own risk of a licensing board complaint and of a malpractice suit  
2. Name the four required elements (“four D’s”) for a malpractice claim  
3. List five differences between a licensing board complaint and a malpractice suit  
4. Develop a plan for responding to a licensing board complaint with at least five steps  
5. Describe the costs, benefits, and appropriate use of HIPAA-protected Psychotherapy Notes  
6. State three risks to confidentiality in managed care practice  
7. Write or expand your practice brochure for informed consent to managed care treatment

About the Author:

Edward Zuckerman, PhD, has worked in community mental health, taught at the University of Pittsburgh and Carnegie Mellon and was in independent practice for almost 20 years. He earned his PhD in clinical psychology from the University of Pittsburgh. Dr. Zuckerman is the author of the best-selling The Paper Office, which contains all the forms and guidance one needs to operate a private practice legally, ethically, and profitably (see www.theclinicianstoolbox.com). Dr. Zuckerman also edits the series of books called The Clinician's Toolbox for Guilford Press.
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XI. About the Author
I. Introduction

A. They say to “begin with a joke” so here is mine.

Question: What is the only thing a lawyer will give you for free?

Answer: A disclaimer

And so here is my Free Disclaimer:

I am not a lawyer. On the net this is abbreviated with its initials - IANAL (!). I am a psychologist and I practice in Pennsylvania - not (necessarily) where you are and so your laws, regulations, and ethics may be a little different. We will address ethical issues, but I am not an ethicist.

B. So why should you listen to me?

I recognize that you have already bought this course, but my ‘credentials’ are relevant. I was in full-time, independent, general practice of clinical psychology for 17 years. I know about licensing board complaints from personal experience: I was complained against 25 years ago for what we would now call boundary crossings (No, I did not touch her or seduce her). It was a complex matter and I have written about it (See section II, A, 5, c).

Resolving the complaint took five years - mainly because of miscommunications, staff changes, ignorance about administrative law, bureaucratic delays, developing of procedures, etc. I had a year of wonderful supervision with readings and discussions. I had to catch up and learn to practice in a world of different rules, expectations and risks than what I had been taught and had been using. I realized others were in the same leaky boat; so I wrote a book on legal and ethical practice for clinicians titled, “The Paper Office” to help others learn what has changed and how to tighten up their procedures and policies to avoid the pitfalls I fell into. I was given an award by the Pennsylvania Psychological Association essentially for writing this book. The Paper Office has now gone through four successful editions.

http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/zuckerman2.htm&dir=pp/CT_series&cart_id

I keep up on these topics and developments with info from CMS and others so that I can post updates to the web and write articles for professionals. Based on this I have also written a book on HIPAA for therapists: http://www.hipaahelp.info/

You can earn CE credits for this course at: https://www.pdresources.org/CourseDetail.aspx?Category=AllCourses&PageNumber=1&Profession=Other&Sort=CourseName&Text=hipaa&courseid=1005

I can’t teach ethics. I am not an ethicist. I have no credentials for it: no supervision, no publications, and no employment. I can preach. In this document I often use words like “should,” “have to,” “ought,” and even occasionally, “must.” However I don’t mean them as commands. I mean them in Albert Ellis’ sense of “it would be in your own long-term best interest, in my opinion.” I can show you the threats and how I and others have and you can cope. I also draw deeply on the literature as it has been peer-reviewed and so is likely to be the Standard of Practice and widely acceptable.

C. Working TOGETHER we can do our good work better - easier, safer, and more productively.

Pay me a little to do the research, organize the issues and facts, apply these to therapists in Managed Care (MC), and offer to you the best practices . . . so that you can do your best clinical work - therapy and evaluation, consultation and teaching, and ... if we work together we can do better than alone in an (often) unappreciative and risky world.
D. How best to use this course.

1. You can print it out, take it around like a book and dip into it, underline or highlight sections. You will lose the hyperlinked resources, but gain portability. You can also print out the CE test from your online account @ www.pdresources.org to mark your answers while reading this course pdf. Then you can login to your account to submit your answers for grading whenever you are ready to receive credit.

2. Because it is an electronic book (ebook) it includes hyperlinks (computerized cross references) to other parts of this book and to valuable resources of the Internet. All the external links worked in June 2009. If clicking on the link gets you a “404 Error - Page not found” the page may be gone or, more likely, has moved [to a new url address on the Internet). You may be able to find it through a Google search.

3. I hate reading big blocks of text, especially on a computer screen, almost as much as I hate dumbing-down, choice-limiting, distractingly cute PowerPoint slides. Some research I recall but cannot find indicated that readers learn as much from an outline as from a narrative. So this document is an effort to combine these two ideas - electronic books and the outline presentation format.

4. The use of color reflects the content:
   K. Basic information is in black.
   i. Important words and phrases are in bold.
   ii. Jargon and terminology are in italic.
   L. Chapter headings are in bold blue.
   M. Bad news and warnings are in bold red.
   N. Advice you should repeat to yourself so you recall it when you need to is in green and may be bolded or italicized as well.

5. If you like the course, tell your friends. If you don’t, tell me: edzuckerman@gmail.com

6. I am always open to suggestions and eager to improve my work. I will sympathize with most rants and tolerate loopy ideas but authors need critics. Let us work together, please.

II. What Are the Risks? Which Are Real and Which are Hype?

As they say, there is good news and there is bad news. Let’s get all of it out and on the table. Let’s hear the worst first. Then we can move on.

A. The BAD news about licensing board complaints and malpractice suits.

1. Emotional costs:
   a. Suffering - A Malpractice Stress Syndrome has been proposed. Sara Charles’ classic paper, “Coping with a medical malpractice suit” is online at: http://www.physicianlitigationstress.org/coping.html
   
   Some information from a lawyer’s perspective and a self-test are available here: http://www.mdmentor.com/MalpracticeStressSelfAssessment.html

b. Your depression and anxiety will greatly stress you, your marriage, your relationships with your kids, friends and peers, for years. And with your patients.

c. My own experience:
   • Wanting to abandon doing therapy which I loved (always had energy for it, always excited to be struggling and working in therapy)
   • Doubting my judgment, honesty, memory, clinical skills, etc.
   • Anxiety, terrors over potential losses (see below for specifics)
   • Withdrawal, guilt and shame, distrust and suspicion, loneliness

2. Personal costs of a complaint or suit:

   a. Possible loss of a hard-earned career. No license. No related careers (see 4a). You will have to start all over.

   b. The enormous time and effort involved in defending yourself, negotiating a resolution, and (likely) completing supervision, readings, training, etc.

3. Financial costs:

   a. The costs of defense in a licensing board complaint.
      • While these costs may be covered by your Professional Liability (“malpractice”) insurance, they can and almost certainly will exceed those limits - usually $5,000 unless you have bought more coverage. When your defense costs reach your coverage limit you will be under great pressure to settle, even by agreeing that you are guilty so as to not have to pay out of your pocket for more defense. You do not want to arrive there any earlier than you have to. That is why most authorities recommend buying as much coverage for defense costs as you can. Besides, it is inexpensive. In a recent example from www.AmericanProfessional.com the cost is about $100 per year to go from $5,000 to $75,000 in coverage.
      • False accusations and groundless complaints still have to be responded to and defended by lawyers.

   b. The cost of defense in a civil suit. Some policies set a limit to these costs and some deduct these costs from the maximum they will pay in any settlement.

   c. The costs of a settlement in a civil suit.
      • There are almost no limits in a malpractice case.
      • The settlement will be paid from your coverage but if the limits are exceeded you will have to pay them from your savings, future income, your spouse’s income, inheritances, the sale of your property, etc.
      • In sexual relations cases, since these are illegal and so not part of therapist’s duties, insurance companies have limited their obligations to $25,000, sometimes for defense as well as settlement costs. This leaves clinicians much more vulnerable.
      • You may not be able to refuse to accept an offer acceptable to your insurer and the plaintiff (this is called a hammer clause).
      • If you do not accept your insurance company’s agreement to settle with the other side and you go on to defend yourself and lose, your insurance company will only contribute the amount they proposed earlier and that you rejected.
4. Legal impacts:

a. There will be a permanent record of any "adverse actions" taken against your license which can involve licensure, clinical privileges, professional society membership, exclusions from Medicare and Medicaid, malpractice payments, and Drug Enforcement Administration actions. Although not open to the public, it can be accessed by any health care organization, licensing body, insurer and plaintiff’s attorneys at the National Practitioner Data Bank/The Healthcare Integrity and Protection Data Bank: www.npdb-hipdb.hrsa.gov/ Accessed May 19, 2009.

b. Loss of license, perhaps permanently, and because of databanks, you cannot get licensed in a different healthcare profession or location. Start all over again in a different career.

c. If you lose a Board complaint the client may pursue a civil (malpractice) suit on bases related to the suit although you cannot be sued for breaking the licensing laws. You can be sued for negligence, dereliction of duty, libel or other torts/tort actions: contract violations, billing fraud, wrongful death, etc.

d. Most states have criminal laws against sex with a therapist which makes consent irrelevant as a defense.

e. HIPAA has large civil penalties for violations of privacy. “Unauthorized disclosures” can result in fines of $100 per offense, with a maximum of $25,000 per year. For more on HIPAA see section V, end of section C.

5. Consequences for relationships:

a. When they find out, and they will despite the rules of confidentiality applied to licensing board complaints, peers will shun you. You will, however, discover your true friends.

b. Peers will know but they may not say anything to you directly. They will talk about you. Remember the old game of “Telephone” in which a message was passed along between people and was completely distorted by the time it reached the last person? This will happen to the complaint.

c. Peers are unlikely to re-contact those they told of your problems to tell them the outcome of a complaint or of your innocence or of how you might have benefitted from the process. The accusation will follow you for life without modification unless you make the effort and raise the issue. I have tried to do that.

Below is the speech I gave to the Pennsylvania Psychological Association, June 2002 upon receiving an Award for Distinguished Contributions to the Science and Profession of Psychology:

I was completely surprised but am quite grateful for being honored with this award recognizing my contributions to PPA and for my writing efforts.

I have only three minutes but I want to tell you how I came to write the book called The Paper Office. I want to tell this story because you may have heard parts of it already and it is of both ethical and personal importance to most clinicians.

Nineteen years ago I treated a married woman for marital and personal unhappiness with some success. Eight months afterwards she filed a serious complaint against me with the state licensing board. No, I did not sleep with her. Essentially, she accused me of two things: confusing the social and therapeutic roles, and of “referring” her to another psychologist to have a sexual relationship. This is not the time, but if you want to know more - please just talk to me later.
The board and I finally agreed that I would have a year of supervision. I must thank Dr. Connie Fischer who could not be here. She rescued me. Her confidence in me and respect for what I could offer clients and the field carried me through those very difficult times when I wanted simply to quit. I came to understand my errors, what the current views of ethical practice involved, and that I could go on.

Okay, what can you learn from my experiences? I think, six things:

1) Just because you intend to do good, and do not sleep with your clients or lie on your bills does not guarantee that you are practicing ethically. Look up the definition of tragedy in Greek drama for a better understanding of this issue.

2) Things change in the psychotherapy business - so keep current. You won’t even know how they have changed unless you make an effort to read what makes you uncomfortable, and attend what you shy away from. Keep up to date on ethical issues, terms and language, and frameworks.

3) Do thorough work. Get old records. Get a good history and make all the diagnoses. If I had done those I would have found the pattern of behavior and the diagnosis that led to the critical incident and handled it much better. Be aware that harms can grow from small errors in decision making, small lapses of judgment, and unexamined assumptions.

4) You can save your own life. However, you may not be able to save your life by yourself. Having peers or friends who care is usually necessary.

5) You too can often make lemonade out of lemons. I had been far too complacent and knew my peers were as well. I had transgressed but with Connie I had grown as well and saw the need to help others learn to play by the newer and better rules to benefit themselves and their clients. My peers didn’t buy and study books on ethics. We attended ethics courses only after they became required. How could I get my friends and peers to do what they must? Finally, I found a way: Build the ethics into the clinicians’ ordinary paperwork. Thus the book, The Paper Office.

6) We all hear about colleagues who violated some rule. We usually hear by rumor, rather sensationalized, and without all the facts and specifics. If you can, call the colleague and ask what has happened. Get the other side. Get the facts. Remember, a complaint is not, in America, proof of guilt. Go back to those who told you and tell them what you learned. If you feel justified, offer to help or offer your help to the other side (the Licensing Board, the lawyer, the client, etc.). At least, do not pass on this gossip. How would you like to be in his or her place? The colleague has no defense against the unacknowledged.

Let me end with sharing the profound gratitude I feel for your recognition and offering to try to do even more for our Association. Thank you.

6. Summary: You can’t win a malpractice suit, but you sure can lose one. Sometimes, with the help of your friends, you can make lemonade out of lemons.

B. Time for a Reality Check

1. First, a little theory. Definitions - meanings matter in the law as well as in therapy.

<table>
<thead>
<tr>
<th>Threat</th>
<th>Vulnerability</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Risk management and the costs of prevention or mitigation**</th>
</tr>
</thead>
<tbody>
<tr>
<td>What could happen? X</td>
<td>Can this happen to me/what I do? X</td>
<td>How often does this happen in circumstances like mine? X</td>
<td>Damage, Cost/loss*</td>
<td>**</td>
</tr>
</tbody>
</table>

* Technically the levels of impact are called Minor, Noticeable, Severe, and Devastating. Just FYI :-(

** That is the legal term. Making repairs, amelioration, getting back up to speed...
2. Weigh the risks:
   a. The threats were listed and described above but they are not all equally or highly likely or all likely to happen to you, of course.
   b. We need real-world, local, accurate, current, and complete information about the rates and frequencies of risky behaviors and their consequences.
   c. With that information we can make good decisions and allocate our time and money resources.

3. The rates or percentages or frequencies we would like to know:
   a. For each unethical or illegal behavior, per thousand full-time therapists, of each discipline, recently, and in your state, how often does it actually occur?
      • Are the rates these behaviors, or of complaints or suits increasing?
      • Which practice areas have much higher risks?
   b. How many complaints are made to licensing boards per thousand full-time therapists, of each discipline, recently, and in your state:
      • What percentage are dismissed?
      • What is the frequency distribution for each kind of consequence the boards can impose (i.e. rehabilitation, supervision, coursework, suspension or termination of license, referral for criminal prosecution, etc.)?
      • What is the average cost of defending against a board complaint?
      • What percentage of this cost was covered by professional liability insurance?
      • How long did the steps and the whole process take?
   c. Concerning malpractice and suits:
      • What percent of clients talk to a lawyer?
      • What percent of those file a case?
      • How many suits are filed per thousand full-time therapists, of each discipline, recently, and in your state?
      • What percent of suits are dropped, tried or settled?
      • In what percent is the clinician vindicated?
      • What is the average cost of defending a malpractice suit?
      • What percentage of this cost was covered by professional liability insurance?
      • How much is the average settlement when the clinician loses?
      • Are the awards increasing in cost or is less of the cost covered by insurance?
      • How long did the steps and the whole process take?
   d. What percent of therapists ...
      • Leave practice after being involved in a complaint or suit?
      • Leave practice after being found innocent in either?
      • Greatly alter their practices?
      • Need or get therapy?
      • Have similar complaints or suits filed against them later or before?
e. Which areas of practice generate the most and least complaints, suits, and losses for clinicians? **Note:** There have been a growing number of complaints about custody evaluations to the point that we had to pass a law that neither party could lodge a complaint during the custody process or until 60 days after the custody decision was made.

4. With data like that we could evaluate - **What are my real risks of a licensing board complaint?**

   a. As a percentage of all therapists of my discipline and in this state, now?
   b. What is the average dollar cost of defending against a complaint?
   c. What kinds of consequences typically follow from being found guilty of a violation by the Board?
   d. How often do complaints result in loss of my ability to practice?
   e. How many typically take more than a year to resolve?

5. And similarly, with data like that we could evaluate - **What are my real risks of a malpractice suit?**

   a. As a percentage of all therapists of my discipline and in this state, now?
   b. What is the average dollar cost of defending against a suit?
   c. What settlement costs typically result from being found guilty of malpractice?
   d. How many might result in losing my ability to practice?
   e. How many take more than a year to resolve?

6. **Answers to these questions are largely unavailable.** Why don’t we know these facts?

   The data is old, incomplete, and not comparable because of...
   - Restrictions on disclosures of settlements
   - Insurance companies’ business practices (‘trades secrets’ and different goals)
   - Different practices between boards and across jurisdictions
   - Differences across disciplines
   - Changes in the laws over time

7. What DO we know?

   Below I will offer all the data I could find, with apologies for its quality and value.

   **C. There actually is GOOD news!**

   1. **Malpractice Suits are rare, not common.**

      I calculate that for psychologists

         out of 100,000 therapy cases

         If 1 in 25 (4%) are disappointed and angry at the clinician = 4,000
         and 1 in 25 (4%) of those consult a lawyer, and = 160.0
         20% of those have evidence to support a suit, and = 32.0 sue
         10% of those go to trial. = 3.2

      Results of the trials

         In 25% of trials the plaintiffs prevail but even so = 0.8
         60-80% of those are resolved without payment. = 0.56

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Summary:

So about one in 200,000 total therapy cases result in a verdict against the clinician in a malpractice case but most of them do not cost the clinician any damages. Pretty unlikely, right?

So what is your risk?

- How many cases will you see in your professional lifetime?
  
  Years in lifetime practice _______ x Cases per year_______ = ______ total cases

- Divide 200,000 by that number = ________________

- Multiply the result by .56 = ________ times 100 yields

- My risk of losing a malpractice case as a percentage = ______%

- Adjust this up or down by your discipline, sex, and any other factors such as they type of cases you see, etc. for your truer risk estimate see Section II, C, 3 below.

For me:

- Years in lifetime practice _18_ x Cases per year_100_ = _1800_ total cases

- Divide 200,000 by that number = _111.11_

- Multiply the result by .56 = _62.2_ times 100 yields my

- Risk of losing a malpractice case = .62 %.

So being a white male my risk of suit is say 30% higher than the average (which is about half males) losing a malpractice suit is a perhaps one percent in my career.

2. **Even complaints are not too common.**

   a. “Over their career about 11% of psychologists will likely have to respond to a licensing board complaint.” (Shoenfeld, Hatch, & Gonzales, 2001).

   In any one year, licensed psychologists may expect to:

   - Be complained against 1/250 = .4%
   - Have the complaint resolved informally 1/300 = .3%
   - Have it reported to the Data Bank 1/400 = .25%

   b. Van Horn (2004) has the most extensive data available on licensing board complaints. She reports that “fewer than 40 in 10,000 licensed psychologists will face any action by a licensing board, while fewer than 13 in 10,000 (.13% licensed psychologists will face a formal discipline reported to the ASPPB Disciplinary Data System.” This is the Association of State and Provincial Psychology Boards.

   c. The notes below are based on her data but do note that it was confined to psychologists, was not based on all states, varied greatly across states and some of it is twenty years old.

   d. In any one year, licensed psychologists may expect to be:

   - Complained against (2% of all licensees) - This is simply that some kind of complaint was made, not that a case was opened or investigation pursued (much lower numbers). This is based on about 1,800 complaints in states with about 80,000 total licensees from 1995 to 2001.

   - Investigated (1.2% of all licensees) - About 70% of Boards screen these complaints and when they do, only 40% go to the next stage, investigation. In the other 30% of Boards all complaints go to investigation. On average, about 59% go on to investigation. Which method does your state use?
FYI: Koocher and Keith-Speigel (2008) offer seven of the most common reasons a Board may decline to pursue formal charges (pages 52-55).

1. No provision in the code.
2. The Ethics Committee is not the appropriate mediator.
3. The respondents are not members of the professional organization.
4. The complaints are against groups, agencies, corporations, or institutions.
5. Anonymous complaints.
6. Improper complaints - frivolous, harassing, speculative, etc.

    Found that there was a violation (.7% of all licensees) - The range was 18% to 38% of findings of no violation after investigation.

Note: Boards can take many kinds of actions after finding a violation. They are divided into those “reportable” to the data bank and those less severe punishments called “non-reportable” or resolved by informal means.

- Have the complaint resolved informally (15% or about .24% of all licensees)
- Have the complaint reported to the ASPPB data bank (25% or about .3 of all licensees)

e. Here is Van Horn’s summary of the risk: The data do indicate that the probability that a complaint will lead to any action by a psychology licensing board is minimal. Realistically, for those psychologists who follow practice standards, recognize their own limits, document their services, and utilize consultation, risk of adverse action against their licenses is negligible. In spite of the low risk, the prudent psychologist has a board defense rider on his or her malpractice insurance. Van Horn, 2004,

f. All of the above numbers are for incidence. Since you will be in practice for 25 years or more - multiply Van Horn’s rates by 20 for lifetime prevalence assuming that complaints are evenly distributed over time and clinicians. (Although I don’t believe this is true).

You might divide by 2 if you are in half-time practice (I believe the rate of complaints is proportional to the number of cases treated but I have no data on this.)

- Based on VanHorn’s data in the career of a licensed psychologist’s he or she may expect to:
  - Be complained against 40% of all licensees
  - Have the complaint result in any discipline 8%
  - Have it reported to the ASPPB data bank 4.1%

- Based on Shoenfeld, Hatch, & Gonzales’s data (2001) multiplying their rates by 25 for lifetime prevalence. In a licensed psychologist’s career he or she may expect to:
  - Be complained against 1/10 = 10.0%
  - Have the complaint resolved informally 1/12 = 8.3%
  - Have it reported to the Federal Data Bank 1/16 = 6.25%

g. A third approach to the question of rates of complaint can be based on data from Pope and Vasquez (2007):

- At the end of 2005 there were about 100,000 psychologists in the US. This number had grown rapidly in later years and so we don’t know the percentages complained against or even the number of complaints with accuracy. I have made a precise guesstimate of an average of 60,000 per year.
- If there were 60,000 psychologists each year, the rate of actual disciplinary actions (of all kinds) taken against them would be 3,471 divided by 60,000 or .0579 or less than 6% over a period about equal to most of a career. A reasonable conclusion is that there is about a 6% risk of a disciplinary action in a career although the rates are likely increasing.
3. **Discipline/tradition, gender and practice area all matter.** Before you panic, note that these rates are very likely (based on incomplete data) to be much less sub-populations.

   a. Social workers have about half the complaints of psychologists and they have half of psychiatrists.
      • Gechtman and Bouhoutsos (1985) found that 3.8 percent of male social workers admitted to sexual contacts with clients (As reported in Pope, 1988).

   b. Social workers engage in lower-risk activities.
      • In the above study, Pope noted that the clients were not all therapy patients.

   c. Female therapists have 1/10 the risk of sexualized relationships.
      • After a review of all empirical studies on the subject, Pope (1988) reported the rate of sexual contacts is 8.3 percent by male therapists and 1.7 percent by female therapists.

   d. Age is likely to matter.
      • The modal (typical, most common) professional complained against is a married, white male in his 40’s and 50’s with a stressed personal life.

   The following characteristics constitute a prototype of the therapist being sued: The therapist is male, middle aged, involved in unsatisfactory relationships in his own life, perhaps in the process of going through a divorce. His patient caseload is primarily female. He becomes involved with more than one patient sexually, those selected being on the average 16 years younger than he is. He confides his personal life to the patient, implying to her that he needs her, and he spends therapy sessions soliciting her help with his personal problems. The therapist is a lonely man, and even if he works in a group practice, he is somewhat isolated professionally, not sharing in close consultation with his peers. He may have a good reputation in the psychological or psychiatric community, having been in practice for many years. He tends to take cases through referral only. He is not necessarily physically attractive, but there is an aura of power or charisma about him. His lovemaking often leaves much to be desired, but he is quite convincing to the patient that he is above all others with whom she needs to be making love. Brodsky, A. (1986) p. 157-158. Cited in Reamer, 2001.

D. **Okay, those are the rates of risk but for what are the complaints filed?**

4. Pope and Vasquez (2007) offer a list or Reasons for Disciplinary Actions from the ASPPB for almost twenty years to the end of 2005. I have shortened and revised this table and added the third column.

<table>
<thead>
<tr>
<th>Reason for Disciplinary Action</th>
<th>Number Disciplined</th>
<th>Estimate percentage of number disciplined for each reason*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual/Dual relationship</td>
<td>866</td>
<td>30.3</td>
</tr>
<tr>
<td>Negligent, unethical, unprofessional practices</td>
<td>845</td>
<td>29.6</td>
</tr>
<tr>
<td>Improper or inadequate record keeping</td>
<td>155</td>
<td>5.4</td>
</tr>
<tr>
<td>Failure to get CE credits</td>
<td>135</td>
<td>4.7</td>
</tr>
<tr>
<td>Breach of confidentiality</td>
<td>129</td>
<td>4.5</td>
</tr>
<tr>
<td>(Working while impaired)</td>
<td>113</td>
<td>4.0</td>
</tr>
<tr>
<td>Fraudulent acts</td>
<td>175</td>
<td>6.1</td>
</tr>
<tr>
<td>Fraud in license application</td>
<td>51</td>
<td>1.8</td>
</tr>
<tr>
<td>Inadequate or improper supervision**</td>
<td>124</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Conviction of a crime | 265 | 9.3
---|---|---
Total | 2,858**

* I have divided each number disciplined by the total for these acts, 2,858 and not the larger total of actions.
** The total above is not the larger total of 3,471 actions reported for all reasons and this is not the number of complaints made or investigated (much larger numbers).
*** Montgomery et al. (1999) reported in a narrow population of therapists that psychologists failed to consider the risks from making incorrect diagnoses and providing negligent clinical supervision. It therefore seems worthwhile, if you supervise to put effort into clarifying the relationship, choosing a model for the supervision process, and formally assessing the supervisee’s competence. For a contract and guidelines see Zuckerman, E. (2008) The Paper Office.

**Exercise:**

1) Which of the acts are under your full or main control? Check them off.
2) Which could you reasonably expect that you could avoid with some planning and thoughtfulness? Check them off.
3) Now add up the percentages and deduct from 100. The result is the share of risks you cannot effectively manage.
4) Does that feel like a large or a small number?

**E. And for what are malpractice suits filed?**

1. For what you might think. (These data are for successful malpractice suits in the 1980s - and a lot has changed but we don’t know in what ways.)

<table>
<thead>
<tr>
<th></th>
<th>Percentage of all successful malpractice suits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual relationships</td>
<td>21.0%</td>
</tr>
<tr>
<td>Suicide &amp; homicide</td>
<td>9.0%</td>
</tr>
<tr>
<td>Confidentiality breach</td>
<td>6.4%</td>
</tr>
<tr>
<td>Custody evaluations</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38.6</strong></td>
</tr>
</tbody>
</table>

2. For what you might not think. (Again, for successful malpractice suits in the 1980s.)

<table>
<thead>
<tr>
<th></th>
<th>Percentage of all successful malpractice suits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect/substandard treatment</td>
<td>19.0%</td>
</tr>
<tr>
<td>Fee collection</td>
<td>6.0%</td>
</tr>
<tr>
<td>Hurt in the office - slips and falls</td>
<td>3.4%</td>
</tr>
<tr>
<td>Failure to protect/warn*</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

* Note the last and recall that the first Tarasoff decision was in 1976.

**F. And what do the suits cost the insurers?**

1. Another way to look at the causes of malpractice actions is to see how much insurance companies have paid in various malpractice claims. Pope and Vasquez (2007, p. 98) offer information from the American Psychological Association’s Insurance Trust. This list is revised and shortened in order to make a point.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective treatment and subsequent failure to consult or refer</td>
<td>29%</td>
</tr>
<tr>
<td>Failure to diagnose properly</td>
<td>16%</td>
</tr>
<tr>
<td>Custody disputes</td>
<td>10%</td>
</tr>
<tr>
<td>Sexual misconduct</td>
<td>9%</td>
</tr>
<tr>
<td>Breach of confidentiality</td>
<td>8%</td>
</tr>
<tr>
<td>Relationship issues with supervision, multiple relationships, conflicts of interest, etc.</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>~ 75%</td>
</tr>
</tbody>
</table>

* These are percentages of all the dollars paid out after a decision/loss in a malpractice suit as covered by American Psychological Association’s Insurance Trust. Note that they are not the percentages of lost cases, or of cases brought, etc. Obviously they are compiled from the perspective of the insurer and so the losses are in dollar terms, not frequency of problematic behavior, its controllability, or it harm to client or clinician.

2. Even when lost, the median award was $36,500 (in 1989) which might be about three times that now or $100K? So therefore you should buy how much insurance coverage?

3. **The Point:** I would classify all of these as largely or fully under the control of the clinician.

G. **Who complains and when?**

1. Koocher and Keith-Speigel (2008) believe that about 60% of all kinds of complaints come from psychotherapy clients or their family members “who were dissatisfied with the conduct, therapy techniques, competence, or payment policies …” and “… perhaps 25%, comes from other psychologists or other closely allied professionals…”

2. Is unhappiness related to a bad outcome? Not necessarily. Consider:
   a. That is why quacks are never sued although they have lots of bad outcomes.
   b. Clients come back for more work on their unresolved problems.
   c. Clients with good outcomes sometimes complain/sue.

3. It is the unexpected bad outcomes that complain.
   a. Disappointed because they were ‘promised a cure’ or unprepared for less than a fantasy of perfection, total and permanent symptom relief, a new personality, hoped for relationships, etc.
   b. Frustration with no change when they have made efforts and investments?
   c. Hurt when the relationship suddenly changed or ended.
   d. Embarrassed and hurt when:
      • they can’t pay your bill
      • what they considered confidential is revealed
      • they are billed for missed appointments

4. Complainants are often just angry about some aspect of therapy and have the resources, persistence, and ability to articulate the problem to pursue a formal complaint. I think it is reasonable to believe that these people are also those who would best be able to resolve a complaint if the therapist learned of and responded to the complaint and would have worked with them.
5. Threats often precede complaints. In a narrow sample, Montgomery et al. (1999) reported that over half of the complaints filed and 71% of malpractice suits were preceded by a threat. About 40% of threats overall resulted in a complaint. These numbers strongly suggest taking any threat seriously and responding to it immediately and energetically. Do not lose your cool, recognize the issues, propose proactively, and document all aspects.

Exercise:

1) Consider a client who was unhappy with treatment. Take a minute. Make a note on some paper.
2) How did you find out? How else might you have learned of their unhappiness?
3) What were the expectations (hopes, fears, fantasies) that were not met?
4) What was the outcome and what might it have been?

Exercise:

1) Do you know a colleague who was the subject of a licensing board complaint? ... of a malpractice suit? In a survey of psychologists in Texas, 72% knew a colleague who had been the subject of a licensing board complaint (Montgomery, Cupit, & Wimberley, 1999).
2) But to know the actual rate of complaints what data should you also collect?
   - Take a minute and think.
   - You need to think of how many colleagues you know; how many are in the group “colleagues”?
   - If a colleague has had a complaint filed against him or her, how many of his or her colleagues are likely to know about it?
3) As well trained clinicians you know that we all make cognitive errors in judging the frequency of events.
   - The Availability Heuristic - Easily recalled events seem more frequent and more likely. E.g. After the 9/11 attacks people chose to drive and not fly although there was no evidence of any further risk of attack and cars had not become safer. As a result an estimated 1500 additional deaths occurred.
   - For those unfamiliar with cognitive biases the entry at http://en.wikipedia.org/wiki/List_of_cognitive_biases lists dozens. For discussion of those issues as related to clinical work, Garb (1998) and Turk and Salovey (1988) will be both educational and challenging.
4) So how would you now interpret the Montgomery et al. report of 72% of psychologists knowing a colleague who was complained against?

6. Ending the affair with a client. Often clients think the affair was loving or good for them until it ends and then the scorn is intense.

7. Disputes over fees and billing, debt collection, and financial disagreements are the second most likely trigger for a complaint. (Note that you may find quite clear justifiable exceptions to these. Just understand the risks and make a good estimate.)

   My Suggested Rules:
   - Never try to collect a debt after 90 days of no payments.
   - Never sue in small claims court although you will almost certainly win.
   - Never engage a collection agency or collection attorney.
   - Never try to “teach the client a lesson” about being responsible.
   - Learn to not extend credit for more than 2 sessions. Accept credit cards?

8. Custody decisions will usually make at least one spouse very unhappy. If you choose to do these, be prepared emotionally, legally, and insurance-wise. As they say, “lawyer up” just as the spouses did.
H. The reality of misbehavior is not captured in any of the above.

a. The true rates of misbehaviors are at least ten and more likely a hundred times the rates of complaints or suits. Very few victims complain despite the intensive “public education” ads of lawyers on television.
b. Very few true victims complain despite the injury. Some of the complainants were not actually hurt or victimized.
c. Malpractice in mental health services remains very hard to prove.
d. There is little evidence that suits or complaints improve practice by reducing misbehaviors.
e. The publicity garnered by egregious examples does little to warn the public about common misbehaviors or teach professionals what is best to do or how to avoid problems.
f. Offensive, tasteless, oafish, “Neanderthal,” piggy, tasteless, behaviors, in themselves, are not illegal or unethical or malpractice.

III. What Does Malpractice Mean for Me?

A. The elements of malpractice

1. The legal definition: Malpractice is a deviation (by commission or omission) from the standards of professional care which results in an injury.

2. The practical lawyer’s definition:
   a. A serious harm (such as an injury or a loss),
   b. Which is easily communicable to and comprehensible by a jury,
   c. Evidence that someone’s behavior caused the injury or loss,
   d. Assets or money (‘deep pockets’) which can be taken as compensation for the injury (and recovery of expenses and time spent),
   e. From a suable person, institution, or insurance company.

3. What must be demonstrated - all four “D’s” - Duty, Dereliction, Direct cause, and Damage.
   a. The clinician/defendant owed a duty to the client/plaintiff because a patient/doctor or clinician/client relationship existed. This is usually pretty easy to demonstrate.
   b. The quality of care provided fell below the standard expected of the average clinician. This dereliction of duty is often very hard to demonstrate. Experts can testify about what is the usual standard of practice.
   c. The client suffered some harm or damage. In psychological injury cases this may be hard to demonstrate or demonstrate convincingly.
   d. The clinician’s dereliction of duty was the direct cause of the harm. It is often hard to rule out other causes or history.

4. Legally speaking, malpractice is a form of negligence and the negligence could be on the patient’s part as well as the treaters’. Some legal arguments on this basis include:
   a. The client was also negligent and caused much of his or her own harm.
   b. The client failed to mitigate his or her own harm or damage, or made the harm or damage worse.
   c. The client gave an informed consent and therefore assumed the risk of any complication or untoward effect.
d. The alleged harm or damage was an unavoidable “known risk” that occurs without any negligence.
e. The client failed to disclose important information to the doctor.
f. The client’s prognosis or condition was not worsened by the alleged negligence.
g. The client engaged in some intervening or superseding conduct following the alleged malpractice that broke the chain of events linking the malpractice to the patient’s damages or harm.

5. As you can see it is not at all easy to demonstrate clear and harmful malpractice. That is why there are so few cases brought, so few won, and so little awarded to them. However licensing board complaints are a different story in many ways. Let us compare them to malpractice suits.

B. A comparison of licensing board complaints and malpractice suits

Below we compare them on five criteria:

(1) The effort involved
(2) Financial issues
(3) The legal processes involved
(4) The standards for guilt
(5) Commonalities

(1) The effort involved:

<table>
<thead>
<tr>
<th>Licensing Board Complaint</th>
<th>Suit for Malpractice</th>
</tr>
</thead>
<tbody>
<tr>
<td>No threshold for the worth of the complaint in many cases. Boards are designed to protect the public and so take all complaints equally seriously.</td>
<td>A lawyer must decide that there is enough to make a case: that it is worth the time/effort/costs, and that the dereliction of duty or negligence rises to threshold of malpractice.</td>
</tr>
<tr>
<td>Free help with making the complaint from experienced professionals.</td>
<td>Difficult to obtain help without expense.</td>
</tr>
<tr>
<td>Complete privacy of the client.</td>
<td>Mental state of the client becomes open to question and examination in court. Both current and past mental state is open.</td>
</tr>
<tr>
<td>No exposure of the client’s past.</td>
<td>Client’s history is made public.</td>
</tr>
<tr>
<td>No publicity.</td>
<td>Media attention.</td>
</tr>
<tr>
<td>No client testifying. Presence not required.</td>
<td>Client must testify and be cross-examined in open court by disbelieving, antagonistic, well-prepared advocates.</td>
</tr>
</tbody>
</table>

(2) Financial issues:

<table>
<thead>
<tr>
<th>Licensing Board Complaint</th>
<th>Suit for Malpractice</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cost to the client - Free!</td>
<td>Client has to find and hire an attorney, find experts and investigators, or get a fraction of an award.</td>
</tr>
<tr>
<td>Licensing Board Complaint</td>
<td>Suit for Malpractice</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| Administrative Law’s rules and procedures apply, not Civil or Criminal laws. | You have **Rights of Due Process**  
- You can challenge the witness and evidence.  
- No hearsay is allowed. |
| No presumption of innocence.¹ | You are presumed to be innocent. |
| In effect by presenting your records you are presenting evidence that can be used against you. | No self-incrimination (5th Amendment²) |
| Minimal investigation by the state’s investigators.  
The investigators typically work for the state’s attorney general and may have no training in mental health issues. | Police/district attorney may do some of the investigation for the plaintiff.  
Your lawyer can hire experienced investigators. |
| Paperwork only, not even attendance at hearings. | Open trial with arguments, evidence, and records. |
| Hearings can be far away in your state. | Local trial |
| An appeal can be based only on an allegation of the Board’s use of improper procedures, not on any new or additional evidence. | Several levels of appeal.  
Your side can introduce new evidence on appeal. |

**Footnotes:**

1. In fact, I have heard a board lawyer express her belief, in a public meeting, that “Where there is smoke, there is fire.”

2. Start of my personal soapbox (which you can disregard): Most Americans do not understand why the 5th Amendment was included in the Bill of Rights. It was not to allow the guilty the convenience of refusing to tell the truth. It was to prevent torture, a subject the Founders were well familiar with and we, thank heavens, were not familiar with, until recently.
(4) The standards for guilt

<table>
<thead>
<tr>
<th>Licensing Board Complaint</th>
<th>Suit for Malpractice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-compliance with rules and regulations is the basis for conviction.</td>
<td>Breaking the law must be shown by at least a preponderance of evidence (51%, more so than not) in civil suits.</td>
</tr>
<tr>
<td>There is no need to demonstrate any harm or benefit occurred.</td>
<td>Harm must be demonstrated.</td>
</tr>
</tbody>
</table>

(5) Commonalities

<table>
<thead>
<tr>
<th>Licensing Board Complaint</th>
<th>Suit for Malpractice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Both end the special relationship of doctor and patient.</td>
<td></td>
</tr>
<tr>
<td>- Fiduciary - client’s needs no longer placed ahead of professionals.</td>
<td></td>
</tr>
<tr>
<td>- Privacy/confidentiality (at least partially broken).</td>
<td></td>
</tr>
<tr>
<td>- Continuity - never a client again.</td>
<td></td>
</tr>
<tr>
<td>- Role of Therapist/healer/teacher/midwife/helper/guide, etc. - gone.</td>
<td></td>
</tr>
<tr>
<td>• Both hurt the clinician</td>
<td></td>
</tr>
<tr>
<td>- professionally</td>
<td></td>
</tr>
<tr>
<td>- financially</td>
<td></td>
</tr>
<tr>
<td>- personally</td>
<td></td>
</tr>
<tr>
<td>Both are clumsy justice/repair of the tear in the relationship</td>
<td></td>
</tr>
</tbody>
</table>

Summary of the Good News

1. There really are only a few areas of risk despite dozens of categories
   - Multiple relationships 22%
   - Improper treatment 20%
   - Confidentiality violations 7%

   These total about 50% of all complaints. The dozens of other categories all contain too few cases to generalize or prepare for.

2. All of the most likely problems are under your control! So you CAN protect yourself.

   This is good news. Do your work carefully and thoughtfully and you can prevent almost all threats from becoming complaints or suits.
IV. Handling Problems

A. What should you do if you recognize that you have made an error, violated a boundary or a licensing board rule, or committed an act that is or might be malpractice?

1. **CONSULT immediately** but be aware that these conversations are not privileged. Use “hypothetical’s” such as “What would you do in a case of ….?”
2. Clarify the facts, create a chronology, recall your perceptions, what the client did, etc.
3. Clarify your responsibilities, your judgments, and what you contributed.
4. Only then can you decide if you will apologize.
5. Document the consultations and conclusions.

B. Consider apologizing

1. If the complaint is valid, accepting responsibility, apologizing, and trying to make things right, in consultation with experts and your lawyer, should be considered.
2. When there is a bad outcome, a rupture of the relationship, or a significant error, the patient and family want to know what lead up to it. They have a right to this information.
3. Professionals have an ethical duty to inform them. Professionals are often afraid that telling the truth will lead to a complaint or malpractice suit against them or others and so remain silent or evasive.
5. What research there is on apologizing in these circumstances reinforces doing it. Remember complaints are not highly correlated with bad outcomes but are with dissatisfaction, strong negative emotions, and poor or ruptured relationships.
6. Consider your and the client’s feelings fully. They are most often an intense mixture of fear, anger, hurt, etc. Consider your peers feeling but do not be bound by their recommendations.

C. How the complaint process works (in most states)

1. Locales differ greatly in their procedures. Go to your state’s Board’s web site and read their operating procedures for a complaint.
2. Here is the usual sequence, based on Pennsylvania.
   a. An unhappy client learns of the licensing board and complaint process.
   b. Client writes up a complaint, often with help from the Board.
   c. Various offices at the state evaluate the complaint, decide on the need for more information, arrange for data collection, investigation, consultations, etc. Some states investigate all complaints and some screen out those obviously irrelevant or otherwise inappropriate and do not pursue them. Also some simple violations are decided at this point and so go to step f.
   d. If more information is wanted the clinician may get a letter asking for more information on paper or get a phone call asking for a meeting or both.
      • The investigator may work for the Board but is often from the state’s attorney general’s office.
      • The investigator need not tell the clinician much, and may ask for copies of records. Note that these can be used against the clinician and additional charges filed for poor record keeping or similar issues not related to the complaint.
      • The investigator will ask for a written response to the complaint in a time frame usually of 30 days.

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1 The Fifth Amendment to the Constitution protects only against compelled testimony and does not extend to any other evidence, such as your records.
• This investigator is not on the clinician’s side or a guide to be trusted. These conversations are risky and definitely not confidential.

3. The board, its attorneys, and perhaps other legal departments, make a determination whether charges should be filed or the case closed. The prosecuting attorney sends a letter to the complainant notifying the clinician of this decision.

4. If formal charges are to be filed the prosecuting attorney sends the clinician an Order to Show Cause which details the allegations and requires a written Answer usually within 30 days.

5. A hearing is scheduled. The clinician may have to or choose to make an appearance before board. The clinician’s attorney may go alone or with the clinician.

6. After the hearing a decision is made in an Adjudication and Order. There can be a series of negotiations concerning decisions, findings, laws, regulations, penalties, supervision, education, etc.

7. A settlement can be made with a Consent Agreement and Order or, if the clinician is unhappy with the decision, appeals to a state court may be possible.

8. The clinician then complies with the settlement and submits any further documentation. Time passes.

9. The case is closed. All decisions are public records. A notice is likely to be posted to the board’s site.

10. Create for yourself a summary of what you did, said, experienced, what happened, choices you made, “notes to self,” etc. Enjoy your survival, make amends and more on.

D. What to do when you receive notice of a complaint against you

1. Don’t panic, there are too many uncertainties to know the outcome. You may have done nothing wrong. You may not even have been involved - it could be an error or a misunderstanding. Just follow the plan you will prepare now for possible use in the future.

2. Don’t ignore it or delay; respond ASAP and respond fully.

3. Do NOT communicate further with the now ex-patient. Do not try to ‘resolve’ the issue therapeutically. It has gone beyond that point with the filing of the complaint.

4. If the client is still in treatment, send the client a certified letter indicating that:
   a. You are ending your therapeutic relationship (“I will no longer be your therapist; we no longer have a patient-doctor relationship,” “there will be no further appointments,” etc).
   b. This ending is due simply to the legal actions the client has taken.
   c. Continuing treatment is in the client’s best interest (if this is so). Although it is customary to provide treatment is in the client’s best interest.
   d. You will furnish a successor therapist with copies of you records if the client desires.
   e. Any monies owed are due immediately. This is an important step for you as it asserts that you do not feel guilty and did no wrong and so deserve to be paid.

5. If you are a member and you feel the need call the professional affairs officer at your state professional organization to discuss the situation but use hypothetical’s and do not reveal details. These conversations are not privileged.

6. If you have a legal defense plan from your professional organization use it for initial guidance.

7. Consider engaging your own lawyer if anything more complex than a simple mistake has occurred.

8. Review the case records.
   a. Collect and make copies of all records in your possession. Decide if you want other records.
   b. Do NOT alter the record; amend it neatly where needed. See section on amending in V, C, 7.
   c. Make up a summary for your lawyer(s) and anyone else concerned.

9. Notify your professional liability insurance program administrator (e. g. American Professional Agency). They will assign a local lawyer to your case. Since your communication with him or her is privileged be open. However, as the case proceeds recognize that this lawyer represents your insurance company, not you and its interests and yours are not identical.

10. Make notes on everything that happens from then on.

11. Confidentiality still applies and so use your judgment when asked to release information. Consult your lawyer before releasing information even to him or her.
a. Just because you are being sued or complained against does not permit you to ignore the confidentiality of everything you have in your records or memory. Be discrete.

b. Do not release anything in the client’s file to anyone without your lawyer’s agreement.

c. Do not, out of anger or spite, release the entire file to anyone (except your lawyer and only with his or her agreement).

12. Keep the originals of everything. Do not let anyone but you or your lawyer make copies of anything. Do not let the originals out of your possession.

13. Expect distressing emotions and get the support you need. See the Malpractice Stress Syndrome section.

Consider entering therapy as a patient with someone knowledgeable in issues of complaints and the laws. Why? Because such conversations are privileged and discussion of these issues with anyone besides your attorney are not and so can be used against you.

You can talk to your legal spouse as most states consider such conversations privileged. Check with your lawyer.

14. Continue to work at the same high standards.

Exercise:

1) Copy the text above to a new document on your computer.
2) Add more specifics and any additional steps.
3) File this as a Plan of Action somewhere you will look for it if the need arises.

V. Self-Protection Is:

✓ Not that difficult.
✓ Not that different because you are very likely doing most of these already.
✓ Part of essential self-care.

A. Some theory and definitions so we can think together

1. There are several approaches for doing risk management for legal/ethical risks.
   • Induction - Analyzing legal cases to discover patterns of errors or misbehaviors and then recommending methods to prevent these practices. We have done some of that above.
   • Deduction - Going from abstract ethical principles (e.g. beneficence) to generate recommended practices.
   • Risk Analysis - This is what we will spend time on here.

2. Let’s go back to the components and definition of risk from earlier:

<table>
<thead>
<tr>
<th>Threat</th>
<th>Vulnerability</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Risk management</th>
</tr>
</thead>
<tbody>
<tr>
<td>What could happen? X</td>
<td>Can this happen to me/what I do? X</td>
<td>How often does this happen in circumstances like mine? X</td>
<td>Damage, Cost/loss*</td>
<td>and the cost of the prevention or mitigation.</td>
</tr>
</tbody>
</table>

<-------------------------------------- Risk Analysis ------------------------------------->
3. **The steps of risk analysis we have taken above:**
   a. Learn/discover the threats - all possible or potential dangers.
   b. Learn/discover your own vulnerabilities.
   c. Weigh the likelihood of each threat.
   d. Understand the consequences of the harm.

4. Now we come to risk management - choosing protective practices recognizing that:
   - All efforts have costs.
   - One cannot insure against or prevent all risks. (That’s why it is called risk *management* not risk *prevention*).

   **Risk management is reducing the potential impacts by reducing the levels of threat, vulnerability, and likelihood at the lowest cost or effort.**

**B. Practical & rational risk management for MH clinicians**

Now we have the theory and know the dangers and their likelihood. Let’s apply this to protecting ourselves.

<table>
<thead>
<tr>
<th>Realistic Risk Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Know</strong> the threats - learn the terms, keep up on changes, consult, take CE courses</td>
</tr>
<tr>
<td>and</td>
</tr>
<tr>
<td>• <strong>Defend</strong> energetically only against the big risks. This is like buying high deductible vs. first dollar home insurance.</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>

**Nine specific ways to protect yourself**

We will spend a good deal of time on some of these, so this is a miniature table of contents.

1) Make and keep protective, high quality, tailored-to-your-practice records  
2) Tighten up your practice’s procedures  
3) Consult with experts  
4) Respond early and fully to any and all complaints  
5) Attend to the client’s expectations and outcomes  
6) Practice at or above the standards of your discipline and community  
7) Keep up and get quality training  
8) Develop an ethics conscience that warns and advises you  
9) Buy the right kinds of professional liability insurance and understand its limitations

**C. Better records**

**Note:** You must make notes. All licensing laws require this and often describe their minimal contents. No realistic argument can be made for not taking notes although you may hear some clinicians say that notes can be used against one. While this might be true in some situations, your notes will have real protective value in every complaint or suit and they are much better protection than your memory.
1. Your Notes can and will be read by everyone, with different intents, from different backgrounds, and in different contexts.
   a. Readers will not know professional jargon - our unique language and alternative meanings. For example, “Client denied smoking marijuana” could mean just that he said, “No” when asked if he smoked it. Or it could mean that he said, “No” but we know that he did (and is lying) or that he did but does not want to face the consequences (denial), or even that he never smoked it but did consume it by a different route, etc.
   b. Readers will not know what our abbreviations mean. For example, does “WNL” mean Within Normal Limits or We Never Looked (medico-legal joke). “SOB” should always mean “short of breath.” And don’t get me started on “vanity” boards’ initialisms, acronyms and abbreviations. Make your meaning clear to every potential reader by avoiding abbreviations. There are lists of abbreviations not to be used in medical records as this one from the Joint Commission: http://www.jointcommission.org/PatientSafety/DoNotUseList/
   c. Even peer readers will not know your personal abbreviations.
      • When the client does not come to your office as scheduled which do you write?: “FTKA,” DNS,” “Failed,” or “Cancelled” “Cancelled + r/s;” or “CAC (cancelled by client), CaCl (cancelled by clinic/clinician) or something else only you understand?
      • Do some of these have meanings for the therapy relationship as you use them? Will others recognize those meanings?
      • As part of your ethical responsibility to care for your records you should keep, with your records, a sheet translating your preferred abbreviations into English (not just jargon). For more on Professional Wills and guidance on other practice operations see my book, The Paper Office.

Advice from a colleague: Don’t let your reluctance to deal with your death/disability prevent you from taking a few small steps right now.

2. Be very discreet when taking notes.
   a. Because older notes were written in a different historical context later readers will attribute different meanings so it is impossible to know what information may be embarrassing or worse. For example, when my mother was politically active in the late 1920's she, like many others interested in social justice, joined the Communist party for a few months. She was proud of this until Senator McCarthy’s House Un-American Activities Committee changed its meaning in the early 1950’s so she kept it a secret until pursuing social justice became acceptable again in the 1960’s.
   b. Don’t record anything irrelevant to treatment. APA Code section 4.03(a) “Psychologists include in written and oral reports and consultations, only information germane to the purpose of which the communication is made.” It is sometimes impossible to know in advance what will be germane so, if you want to record something you think you might forget or some details which might be important, be discreet. A few words may be all that is needed to bring the rest of the situation clearly to mind.
   c. Some exclusions:
      • No juicy details unless your treatment will need them and you or the client are likely to forget them or distort the memories.
      • Omit specifics of embarrassing, illegal, unethical, etc. actions.
      • Avoid pejorative labels like sick, pathological, criminal, degrading, etc.
   d. Consider using only initials for persons’ names.
   e. Maintain a professional writing style and tone of voice. Unless you are using HIPAA-protected Psychotherapy Notes (See section D, below) assume that they will be read by the client and even others hostile to you.

Homework Exercise:

Go back to a closed case and review your notes.
How much did you write that means nothing to you now? How much had no effect on treatment? How much would have been better left unrecorded so you don’t have to re-read it and safeguard it?

You many find that you can keep much shorter but more relevant notes. There are many styles of note taking and you might want to explore some. Sorry for the repetition but I really do describe them in my book, The Paper Office.

3. In courts the rule is often “If it wasn’t written down, it didn’t happen.” This is a difficult standard because it has to be balanced against the time and energy available, the perceived risks of the case when making notes, legal and ethical rules, etc. We will return to this balance several times below to work on it.

This can be stated more positively. Remember the school rule: “Show your work”?

• You can be proud of your work and enjoy documenting its quality.
• Like then, even if you don’t get the exactly right answer, as viewed at a future time, you can get partial credit.

4. If it might make a mess, make a note. If you have any sense of unease due to a learned (well trained) legal-ethical guiding superego/conscience, any vague discomfort about the outcomes of relationships or the consequences of actions or inactions, any tickling small voice, then write it down. What to write? See next.

5. Think out loud for the record. Record your concerns, options, considerations, conclusions, and actions. This is both clinically valuable to a therapist and the main defense you have against a complaint or suit.
   a. Describe the persons, actions, implications and context of events. Go into sufficient detail that you will remember with certainty. Be concise, specific and chronological.
   b. Identify what you don’t know and want to or need to learn. Identify how to get this information.
   c. Succinctly identify all the issues, questions, or conflicts.
      • Do this using the concepts and terms which you understand to apply at the time of writing while fully expecting to understand more and differently later.
      • Pay especial attention to the facts, opinions, and judgments on which you base your clinical decisions and actions.
   d. List all of the options, choices, plans which you might pursue.
   e. Describe all the risks and liability of taking and not taking each action - the cons. For example, harm to the client, others, you, the agency or facility, or to property of inaction as well as of an action.
   f. Identify the benefits/pros of doing or taking each action E.g., benefits to the person, others, you, the agency or facility.
   g. Only after listing them, assign weights or values to the risks and benefits. Note: This approach, the weighting of options (a la Ben Franklin), this hedonic calculus (Jeremy Bentham), this economic analysis (the prudent man) is likely to be minimized after an intuitive, immediate decision has been arrived at and so be doubly careful of your deciding. See V, J, below.
   h. Try to imagine how others would see your information gathering, option creating, weighing of the options, and implementation of the best option(s), and follow-up.

6. Note that your decision making does not have to be perfect - absolutely comprehensive information integrated completely, with all possible options considered thoroughly, and your choice implemented flawlessly, completely consistent with the applicable laws and ethics, etc.
   a. It simply has to be thoughtful, thorough, and well-reasoned and these aspects have to be evident in your records. That is all you would expect of a peer’s professional behavior and it is the legal and ethical standard - not perfection.
   b. Even if the outcome is a failure, sad or just negative, that does not constitute malpractice. It is the lack of good thinking that can be malpractice because that is what professional training confers and licensing for independent practice supposes and requires.
7. If you find that you recorded something in error or is incomplete don’t “change” it. **How to amend a record:**
   a. **NEVER ERASE, ‘white out’ or “black out” anything.**
   b. Why not? If the original cannot be recovered it will be assumed that you had reason to hide it. Drawing a single line through the note is appropriate if it keeps the original readable.
   c. The proper procedure for amending the record: Somewhere near the error on the original page write “See entry of (the current date).” Then, on a page appropriate for the current date, make a note referring back to the previous erroneous entry and enter your corrections, additions, or other changes in full detail. Sign and date your entry.

8. **Keep your notes accessible over time.**
   a. HIPAA sets seven years since last contact as the time for retention but your state laws may have longer periods. Strangely, HIPAA treats longer retention of records as more protective of privacy.
   b. Record retention for self protection suggests keeping all records forever.
   c. Computerized records may not be readable after a few years due to changes in the recording media and formats and word processors.
   d. This issue and its options and decisions are beyond our consideration here. Much guidance is available in my book *The Paper Office*.

**An aside - What is HIPAA? (You can skip this if you know about HIPAA)**

1. What is **HIPAA**? It is the Health Insurance Portability and Accountability Act of 1996. Although its origin was in the lack of “portability” (continued coverage) by health insurance when one changed jobs (with the loss of coverage due to ‘pre-existing conditions’ and similar restrictions), almost all of the law and its regulations address the maintenance of privacy (with the Privacy Rule) and security (with the Security Rule) of medical records and the development of computerization of health insurance billing and payments (with the Transaction Rule).

2. What is **PHI**? *Protected Health Information* is almost all of what we would consider our notes, records, releases, authorizations, other’s records we received, and billing and payment information. If it is on a computer it is called E(lectronic)PHI and the Security Rule as well as the Privacy Rule apply to it.

3. Who is a **CE** (a Covered Entity)? Covered Entities are all those whom HIPAA “covers” or legally applies to such as treaters and insurers. Because some are people and some businesses the term “entity” is used. CEs come in five flavors:

   - Providers, formerly professionals, doctors, clinicians, therapists, counselors.
   - Insurance companies and other payment arrangements collectively called Health Plans.
   - Managed Care Organizations.
   - Billing clearinghouses, and
   - Managers of Medical and Health Savings Accounts.

If you are not a CE or CE-eligible now but consider yourself a mental health professional, clinician, or similar, licensed or not, you can take notes and otherwise comply with HIPAA because your profession might become a CE in the future and you and your practice will be then protected by HIPAA. Complying with HIPAA now will not give you its legal protection but will, in my view, “count” on your side in any legal matters because HIPAA is the default standard in privacy and security.

To find out if you are a CE go to the HIPAA web site: [http://www.cms.hhs.gov/EducationMaterials/02_HiPAAMaterials.asp#TopOfPage](http://www.cms.hhs.gov/EducationMaterials/02_HiPAAMaterials.asp#TopOfPage) and click on “Are you a covered entity?” to download the document.
Notes:

- A billing service, which takes your information about the services you provided, creates claims, and submits them to the health plans is not a CE but is your Business Associate.

- Parenthetically, banks and credit card processors are not CEs because of how much was paid to a CE and when is not officially PHI (Protected Health Information) because it does not indicate what condition was treated or what the treatment was.

4. And who is a “Provider”? Anyone whose profession or discipline is covered by Social Security Law from which CMS, HIPAA and much more spring. Basically, all of the healing arts which were in existence before 1965 and are licensed now. Acupuncturists are excluded but chiropractors are included.

I have argued elsewhere that there are benefits to becoming HIPAA-compliant even if you aren’t legally required to be compliant. If you want to read this go to [http://www.theclinicianstoolbox.com/](http://www.theclinicianstoolbox.com/) and, under the Our Toolbox tab go to the main HIPAA page. You will also find there more information on HIPAA and resources you can use for complying with its rules.

**Another aside - Changes to HIPAA in 2009 - HIPAA as it Should Have Been - February 2009**

Included in the “Stimulus Plan” (the American Recovery and Reinvestment Act, 2009, H. R. 1) are dozens of changes to HIPAA that give it teeth, allow it to be enforced, and close loopholes. Here are the changes most relevant to therapists as far as is known early in 2009.

- Privacy for private pay clients. Essentially private pay clients can now prevent a CE from sending PHI about the services they paid for to an insurer such as when the client applies for life insurance or similar disclosures.

- The contents protected by being included in “psychotherapy notes” will be expanded to include test responses, protocols, test items, manuals and similar materials as decided by the mental health practitioner. Thus test security is back so its benefits can be maintained and clinicians will make the decisions.

- Previously, patients could examine their medical records only from providers. Now all the records of all kinds from other parts of the healthcare system are accessible to patients. Transparency.

- Patients will be able to get electronic copies of their electronic records. Patients can carry around records for emergencies on secured and encrypted flash drives or in their cellphones². They can also keep their records in the data banks of vendors like Google and Microsoft and have them available on the Internet. If they do the latter and a security breach occurs, these firms are now required to notify the patient and others.

- Currently, an accounting of what PHI was disclosed to whom is required only when it is not for “treatment, payment, or healthcare operations” and so the facts of almost all disclosures were not available to patients. Now, clients can receive an accounting of all releases for three years back. However, to reduce the burden, this will only apply to electronic records. More transparency.

- More restrictions on what can be released under the “minimum necessary” rule are to come. In the next eighteen months the Secretary of HHS must clarify what this rule means with the intent of disclosing much less information to insurers and parts of the system. This will still not apply to treaters so it will not interfere with clinical work.

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² These options may not be acceptable for computer security reasons because attaching a new drive to a networked computer in a health care setting would allow malware to be introduced
• Previously companies could avoid the limitations on their use of patient’s PHI by setting up Business Associate agreements with other companies and CEs had only to trust that these companies were protecting the privacy of PHI. Now the punishments - big fines and criminal penalties - apply to these business associates as well.

• The selling of PHI is put under client control in two ways. Releases for “health care operations” will have to use de-identified data as much as possible. These releases were a big loophole for Big Pharma and similar others to collect PHI from pharmacies, drug plans, and others for marketing. Second, no CE or Business Associate can receive payment for disclosing patient’s PHI unless the patient specifically authorizes it.

• Those who let PHI escape can’t hide that any longer. Although most state required some degree of “notification” to patients that their records are no longer confidential after a breach, HR 1 “requires covered entities to notify both individuals and the Secretary of the Department of Health and Human Services (HHS) of ‘unsecured protected health information’ breaches. In the event that the breach affects more than 500 individuals, notification must be made to prominent media outlets serving the state or jurisdiction in which the individuals reside. The Secretary would also post the notification on the HHS website."Yay for transparency!

• There is now a name for the result of a breach of privacy or security: “unsecured protected health information” (oxymoron and bureaucracy appreciators, take note).

• Naming it allowed the law to require the Secretary of HHS to specify the technology to make PHI “unusable, unreadable, or indecipherable to unauthorized individuals.” Here comes encryption which was previously not officially required but is essential for privacy. HHS will name the actual programs acceptable each year. The motivation for getting around to actually using encryption is that it offers an alternative to having to notify almost everyone if a breach of security occurs: Most states that have adopted breach notification legislation so that when a breach occurs the clients have to be notified. However, most of these laws offer a “safe harbor” in which no notification need be sent if the information disclosed was encrypted or generic (“de-identified) so as to be unusable. The feds have adopted this approach.

• As you probably know, enforcement of the HIPAA rules has been embarrassingly absent. Well, clarifications, definitions, and procedures have arrived that make it easier to enforce privacy and security.
  - A strange court decision that held the CE but not its employees subject to penalties has been overturned. Now both are subject to criminal penalties.
  - Wrongful use or disclosure of PHI is now made evident by the simple absence of an authorization.

• Now there are realistic categories of violation with matching penalties.
  1. Despite the increased penalties (below) corrective action without penalty (the “educational approach”) is still the preferred option when the CE did not know and, exercising due diligence, would not have known of the violation.
  2. For ‘unknowing violations’ the penalty is at least $100 per violation up to $25,000 in a year.
  3. ‘Violations due to reasonable cause but not willful neglect - $1000 each and up to $100,000 per year.
  4. Violations due to willful neglect - $10,000 each and up to $250,000 in a year. Here is where the punitive part ‘willful’ comes in: if they knew or should have known of the violation and did not correct it in 30 days the penalty increases to at least $50,000 per violation but not to exceed $1.5 million. These penalties are realistic. Many big CEs have been simply ignoring HIPAA rules due to lack of enforcement.
  5. Money penalties used to disappear into the Treasury; now they will be used to enforce HIPAA.
  6. Some percentage of the penalties can be distributed to those harmed by the violation. (Yay!)

• The HIPAA Monitors have arrived. There never were any “HIPAA Police” but there were HIPAA detectives who could only examine the privacy practices of CEs after a complaint (and the presumed the loss of privacy).
Note: Lawyers have indicated that the inspection would be limited to the one case/complaint and the careful inspection of the clinician’s HIPAA Policy and Procedures Manual so you should put effort into its development.

The Secretary of HHS can now conduct periodic audits of both CEs and Business Associates. Oversight has arrived. Further, State Attorneys General can now bring suit in federal district court against violators on behalf of state residents to stop further violations and obtain damages. And the courts may now award attorney’s fees to the state.

We now return to Note Taking

D. Consider using HIPAA-protected Psychotherapy Notes

1. HIPAA has created two kinds of case or progress notes. If you are a CE you can, but do not have to, create and keep the kind of case or progress notes HIPAA calls Psychotherapy Notes. For clarity I will call these either “HIPAA-protected Psychotherapy Notes” or just “Psychotherapy Notes” for brevity but these are not what we usually have been writing. Those I am going to call Routine Progress Notes.

2. When would you create either or both HIPAA-protected Psychotherapy Notes and Routine Progress notes? Good question. First we will review the differences between them and then the methods of implementation so that you can decide what fits your needs.

3. Criteria for comparing these two types of clinician’s notes as recognized by HIPAA:

   a. Intent and definition

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy notes are “recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.” From Paragraph 164.501 Definitions. Emphases added.</td>
<td>These notes are part of the regular “medical” record.</td>
</tr>
<tr>
<td>“These process notes capture the therapist’s impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. ... process contain sensitive information relevant to no one other than the treating provider.” From Paragraph 164.501 Definitions. Emphases added.</td>
<td>They are used and disclosed for TPO so a managed care plan or insurer may have all of the following information</td>
</tr>
</tbody>
</table>

Footnotes:

1. Notice the influence of professional discipline here.
2. “Used” means how Protected Health Information (PHI) is created and employed by staff and treaters inside the office (or agency or health care system) to make decisions about healthcare.
3. “Disclosed” is any of the typical ways clinicians share client information with others such as releasing records.
4. “TPO” stands for Treatment, Payment and healthcare Operations which just about covers everything in health care including training, billing, monitoring, etc. Research has it own set of rules under HIPAA.
5. This can actually be quite protective of privacy because it is all they can get of PHI. All an insurer can legally seek is the content of the Routine Progress Note. For more on this see below under b. Contents and g. Conditioning.
### Contents of the notes

**Table:**

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
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<tbody>
<tr>
<td>‘These notes might include sensitive information about others in the clients life, fantasies and dreams, process interactions, the therapist’s tentative formulations, hypotheses, or speculations, theme, etc.’ From Paragraph 164.501 Definitions. Emphases added.</td>
<td>Medication prescription and monitoring¹</td>
</tr>
<tr>
<td></td>
<td>Counseling² sessions’:</td>
</tr>
<tr>
<td></td>
<td>- Start and stop times (not duration)</td>
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<tr>
<td></td>
<td>- The modalities of treatment (i.e. individual, family, group, behavioral, supportive, etc.)</td>
</tr>
<tr>
<td></td>
<td>- Frequencies of treatment furnished (i.e. weekly, monthly)</td>
</tr>
<tr>
<td></td>
<td>Summaries³ of:</td>
</tr>
<tr>
<td></td>
<td>- Diagnosis (ICD-9)⁴</td>
</tr>
<tr>
<td></td>
<td>- Functional status (GAF⁵)</td>
</tr>
<tr>
<td></td>
<td>- Treatment plan (interventions used)⁶</td>
</tr>
<tr>
<td></td>
<td>- Symptoms⁷</td>
</tr>
<tr>
<td></td>
<td>- Prognosis (related to Medical Necessity⁸ decisions)</td>
</tr>
<tr>
<td></td>
<td>- Progress to date</td>
</tr>
<tr>
<td></td>
<td>- Results of clinical tests⁹ (scores, protocols, answers but not test materials such as stimuli or questions).</td>
</tr>
<tr>
<td></td>
<td>Other information can be entered into the Routine Progress Note but is not required by HIPAA.¹⁰</td>
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</tbody>
</table>

‘The information in Psychotherapy Notes must be kept nowhere else in the records. If elsewhere it is not protected by this rule.’

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**Footnotes:**

1. HIPAA expects all clinicians to document, in each note, the medications prescribed for the patient. It may behoove you to devise some standard entries for this and include it explanation and rationale in your practice’s HIPAA Policy and Procedures Manual. Such a manual is beyond the span of this course. See my book HIPAAHelp for guidance. [http://www.hipaahelp.info/](http://www.hipaahelp.info/)

2. In a later Guidance CMS made it clear that “counseling” included and was interchangeable with “psychotherapy.”

3. Note that “Summary” is nowhere defined in the law, regulations, or guidances. You can therefore decide how abstract and obscurely protective to be in your writing and how much detail about time, place, issue, concern, persons, etc. to record. Warning: Do not be so skeletal that you do not meet your state laws about the minimum contents of your notes.

4. This actually means that you do not have to buy the DSM books and lists. This brings the US into conformance with the rest of the world and is likely to save insurers many dollars and cost the American Psychiatric Press the same. For as simple to use list of ICD codes for psychiatry have a look below in section V, F, 1, e.

5. The scales to be used are not specified. You could used the Global Assessment of Functioning (GAF) from the DSM but why not choose a scale with a theme both more precise and more relevant to the kinds of problems you treat? Also a scale with better anchors/definitions will make your ratings more reliable and so more likely to be valid. You have the option of protecting confidentiality behind generic terms for functioning like “average,” “below average,” “well below average,” etc.

6. Again without any definition you can record generic terms for the problems addressed and so maintain confidentiality. You could use phrases like “interpersonal conflict” or “distressing emotions.”

7. What is a symptom? And of what? We have been encouraged to write in behavioral, observable terms for years but it is not required here. Symptoms can be stated at any level of abstraction and generalization, as dynamic forces or as single words, etc. Is “paranoia” a symptom, a disorder, a stance or a result of a trauma? Note: I love Jay Haley’s definitions of a symptom:
It is something you do that you don’t want to do or something you don’t do that you want to do.

8. Defining “medical necessity” is entirely in the hands of MCOs. See page 61.

9. In 2009 the contents protected by being included in “psychotherapy notes” will be expanded to include test responses, protocols, test items, manuals and similar materials as decided by the mental health practitioner. Thus test security is back so its benefits can be maintained and clinicians will make the decisions.

10. While it may seem that a lot of information is required to be divulged in sharing these notes, I think this is actually a very important benefit for privacy because IT SETS A CEILING ON WHAT HAS TO BE DISCLOSED.

c. Location where these notes are kept

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘are separated’¹ from the rest of the record of chart’</td>
<td>Part of the client’s regular medical record²</td>
</tr>
</tbody>
</table>

Footnotes:

1. There is no definition of “separated.” For some ideas see section V, E, 5, below.
2. And therefore readable and so likely to be read by all staff with access to medical records.

Another aspect of “location” concerns record maintenance. HIPAA has requirements for maintaining clinical records over time and making them available to others. These are in both the Privacy and Security Rules and rather complex so they can’t be addressed here. However to be HIPAA-compliant you will have to make and document your efforts to “safeguard” your records against foreseeable threats and risks.

d. Re-disclosure of PHI means disclosing (forwarding) records in your possession which you did not create

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>No re-disclosure without a second and specific Authorization.</td>
<td>Allowed for TPO [Treatment, Payment, or (healthcare) Operations]. State laws and the nature of informed consent may require an Authorization.</td>
</tr>
</tbody>
</table>

- Re-disclosure apparently was allowed in HIPAA because of a general belief on the part of lawmakers and regulators that all of a patient’s medical information ought to be freely available to all of his or her treaters. Seemed reasonable if you don’t know the history of confidentiality of psych records.

- Re-disclosure enables clinician A whose patient file contains records obtained from clinician B to disclose (send on to clinician C, or a Managed Care organization or others) all of the records clinician A has available - including clinician B’s. Presently, in most states, this is not allowed but where state law is silent on an issue, the HIPAA rule will apply. Also, HIPAA requires clinician A to tell clinician C of the location of clinician B’s records if known. If your state law is silent on this issue, this HIPAA rule may apply to you.

- Commonly and currently a Request for Records/Authorization to Release Records must be sent to clinician B by clinician C and clinician A cannot even tell clinician C of the existence of clinician B’s records without an Authorization. Because the current standard procedure seems to be more protective of privacy (more “stringent” in HIPAAese) it should be used. You must know your own state’s laws and regulations.
Advice: Do not rely on the HIPAA “Consent” signed at intake or this HIPAA rule to share records; **always use an Authorization to share records or any client information because of its specificity and clarity.** For example, HIPAA covers the privacy of oral communications (such as phone calls) so you need permission/informed consent to discuss the case with other than CEs.

- I deliberately do not use the terms “Release” of records or “consent to release ...” because they are legally and practically ambiguous. The use of the label “Consent” for the HIPAA-required form signed after the Notice of Privacy Practices (NPP) is offered is a complete (and deliberate) misnomer. It is merely a signed acknowledgement that the client has been exposed to and perhaps informed about the clinician’s rules about handling the part of the client’s records called PHI. For more on this issue and procedure see my book *HIPAAHelp* at http://www.hipaahelp.info/

### e. Access to your records by the client (or his or her “authorized representative”)

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally, no client access. It is allowed but not required; it is a choice by the writer of the Psychotherapy Notes.</td>
<td>Clients have rights to access (read or have read to them), receive a copy of, and request amendment of the Routine Progress Note because it is part of the medical record.</td>
</tr>
</tbody>
</table>

- Client’s granted access are also logically granted the right to request amendments to their records. For how to do this see section V, C, 7.
- Because almost no states formally granted these rights by law, and HIPAA applies where state laws are “silent” on an issue this is a major change for most of us. **This is one of the elements which you should have in your Authorization form.**

### f. Discoverability in litigation usually means that lawyers from both sides can access your records.

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probably not routinely discoverable but it depends on the type of suit, issues raised, the venue, previous decisions (case law), lawyers’ arguments, judge’s preferences, and other factors. Consult your lawyer on your options.</td>
<td>Yes, by the usual methods of an Authorization by the client, a lawyer’s subpoena, or a court-order.</td>
</tr>
</tbody>
</table>

### g. Insurers cannot condition payment upon release of Psychotherapy Notes. “Conditioning” means requiring one action before receiving another. (We would call it making payment contingent on receiving the records.)

<table>
<thead>
<tr>
<th>(HIPAA-protected) Psychotherapy Note</th>
<th>(Routine) Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Failure to allow the release of a client’s Psychotherapy Notes cannot be a reason to deny payment for or access to services.</td>
<td>Yes. Failure to consent to the release of Routine Progress Notes can be a reason for you to decide to not provide services. <em>See the 2nd and 3rd bullets below.</em></td>
</tr>
</tbody>
</table>
• A health plan, “may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization.” This includes all Authorizations and so would cover the Authorization needed to share psychotherapy notes. Thus clinicians can prevent the access by some payers to some information.

• *This is quite protective of the client:* An insurer cannot require the client to release the presumably most private information in a Psychotherapy Note in order to receive payment or to enroll in an insurance plan. **All the insurer can legally obtain is the information in a Routine Progress Note.** (I know I am repeating myself but this is a crucial point.)

However, this legal point will not necessarily stop insurers or managed care folk from seeking additional personal information from you about the client. They will argue that they need more information to carry out some healthcare Operation (such as planning lifestyle interventions or just “collecting data” and that the client agreed to this by applying for insurance. This is all part of a continuing tug of war between commercial forces and privacy-supporting ethics and laws.

• *This is quite protective of the clinician:* A clinician may refuse to provide services if the client will not allow the clinician to get old records, records from other treaters, send the minimal information to be reimbursed for providing services, etc.

• Some clients are reluctant to agree with this blanket release of records granted by HIPAA and indicated in the “Consent” form which is offered for signature just after the NPP. My response is to tell them that:
  - Our state laws are much more restrictive and protective (“stringent” in HIPAA-speak) and so they apply according to HIPAA.
  - My profession’s ethical guidelines are much more restrictive and protective.
  - I will protect their privacy much more carefully than HIPAA requires with my office procedures which are based on my state licensing law and board regulations.
  - I will not release anything without an Authorization (which details what is to be released, to whom, for what, etc.). You might want to say that you will not release any part of your records without their written permission (and informed consent.)
  - Since this discussion usually comes up when the client is presented with the HIPAA “Consent” form it is a good time to discuss the exceptions to confidentiality in your state and practice. It is early enough to prevent a misinformed client from telling you something which they assumed was completely confidential but upon which you might have to act.
  - I would not treat a client who refuses my access to records of previous treatment. I cannot understand the dynamics of treatment without this kind of information. In the case of the ethics complaint I received and mentioned above, if I had gotten old records I would have acted very differently and better.

**E. Summary: Guidelines for Implementing an Improved Records System**

1. **Double records are now allowed** under HIPAA. You can keep both kinds of notes. You do not need to tell the client that you are keeping Psychotherapy Notes.

2. **The information in a Psychotherapy Note must never appear in a Routine Note** (or it becomes no longer protected by the Psychotherapy Notes exception although it would still be protected by other confidentially rules). Thus keeping of these Notes requires you to be very clear about why you want to record and keep (“use” in HIPAA-speak) the kinds of information suited to these notes.

3. **You can choose to keep or not keep Psychotherapy Notes for each client.** You don’t have to keep them for all clients. You do not have to tell anyone that you are keeping such notes.
4. The form and format of the information is irrelevant; it is the content that matters. Handwritten, typed, word processed, photocopied, emailed, faxed, telephoned, and even spoken etc. does not matter in deciding on whether it is PHI protected by HIPAA. Note that any PHI which is in an electronic format is automatically covered by HIPAA’s Security Rule as well as the Privacy rule and so if you create, use, or disclose it you become a CE.

5. The two notes must be “separated” but no definition is offered in the Regulations.
   a. However, based on the reasoning that:
      - Access be limited to the fewest persons in order to protect privacy.
      - The information in a Psychotherapy Note must never appear in a Routine Note.
      - Efforts should be made so that Psychotherapy Notes are never accidentally included when other records are released/disclosed.
   b. Then a reasonable plan would include these rules:
      - Never write both on the same sheet of paper or the same computer file or word-processing document.
      - Use different shades of paper for each kind of note if they are kept in the same folder or chart.
      - Keep them in different computer folders and passphrase-protect at least the Psychotherapy does not require encryption of anything but it will in 2009.
      - Because you cannot legally argue that some of your notes are HIPAA-protected Psychotherapy Notes and others are not without some evidence of difference, put on each page of a Psychotherapy Note a notice like this:

NOTICE: This page is a Psychotherapy Note whose privacy is protected under the HIPAA regulations. It must not be included in or attached to any other part of the client's health care records except to other Psychotherapy Notes. Patients do not have access to these notes and disclosing them to anyone may require the approval of the author of the note and an Authorization from the subject of the Note.

   c. Overall, as HIPAA requires, you will have to decide on methods which best suit your own practice. Again all of this can be more complex and more guidance is available at http://www.hipaahelp.info/.

6. Always write a note for each session so none are “missing” which a lawyer might convince a jury is evidence for their removal and therefore, by inference that they contained material harmful to your innocence.

F. Tighten up your procedures

1. Diagnose!
   a. We all know that DSM/ICD labels are junky because:
      - Almost all have such low reliability as to preclude validity. Only the largest categories such as psychosis vs. neurosis (anxiety and depression disorders) have acceptable reliability but information at that general level is useless for treatment decisions about individuals.
      - They have no life course with a known etiology, consistent dynamics, or response to interventions, and therefore no reliable prognoses are possible.
      - They use multiple and inconsistent criteria. E.g. the mental retardation diagnoses are based on number and duration of symptoms, etc.
      - They are based more on history and theory than on empirical/data or statistical models.
      - They assume mutually exclusive categories (“boxes”) and not spectra (or ranges) as are seen in all other human traits.
      - They are not well related to treatment or outcomes of treatment.

   b. However, offering a diagnosis is part of the professional standard of practice so use the tool properly. Don’t be sloppy.
Formal diagnoses using ICD-9-CM, not DSM, were made the standard by HIPAA. See section e below for more on the ICD.

- Use all five digits. They are required for data analysis and usually for payment.
- Use all five axes of DSM if you choose to use it. ICD-9 does not use axes.
- Diagnoses from Interpersonal theory, Transactional Analysis, or the *Psychodynamic Diagnostic Manual* at http://www.pdm1.org/ are additions but not legal substitutes.

c. Diagnose properly. That means **DON’T:**
   - ‘Tailor the chart’ to meet a diagnosis. The truth is the expectation and is defensible.
   - Offer diagnoses that are incorrect so that payments will be covered by insurance.
   - ‘Upcode’ for diagnoses that pay more or entitle the patient to more benefits.
   - These are unethical, likely to be illegal (fraud) and signs of incompetence not negligence.

d. Use the ICD or more formally the *International Classification of Disorders, Ninth Edition, Chapter 5 (Mental Disorders).*
   - DSM and ICD are not identical. The overlap is perhaps 60% so there are dozens unique to each.
   - Diagnoses may contain extra meanings which you might not want to include. For example, if you offered “DSM-294.1 Dementia” it is due to one of 4 diseases which include HIV+ status. On the other hand, in ICD-9 this number 294.1 is Dementia in “conditions classified elsewhere” and requires you to specify the condition. Using the DSM diagnosis raises the possibility that the client is HIV+ and does not require or allow you to state otherwise. ICD is much clearer.
   - Some older diagnoses which are very descriptive and were in DSM-III are still in ICD-9. E.g. the old but accurate conduct disorders such as 312.0 Undersocialized conduct disorder, aggressive type.
   - For more on these issues see my notes and guidance go to www.TheCliniciansToolBox.com and then, under the **Our Neat Tools** tab, click on ICD-9.

e. Where do I find the ICD? You can buy the set of books or DVDs from the Centers for Disease Control and many other publishers or you can find lists online but they are somewhat hard to navigate or you can buy a neat 4 page, laminated, yet inexpensive reference list at [http://www.theclinicianstoolbox.com/](http://www.theclinicianstoolbox.com/) under the “Our Neat Tools” tab.

2. Offer more specific and tailored **patient education handouts.**
   a. Recall that consent to evaluation or treatment must be:
      - Voluntary, uncoerced, without threat or penalty. While it is unlikely that one can do involuntary psychotherapy, a loss of anything besides the psychological benefit due to discontinuing it can be coercion.
      - Competent in that the client is capable of understanding what is required and what will be done. **Note:** I routinely make an entry in my intake notes like this: *Having interacted with this person for (time) today (or other times) around many topics requiring understanding and recall, based on my clinical judgment and experience I have noted no reason to suspect that this person is in any way incompetent to consent to the proposed course of treatment.* Signature. Date.
      - Fully informed. See 3 b below.
   b. Topics and issues include:
      - The limits of confidentiality re parents and kids, threats and harms, couples and divorce/ custody.
      - Billing, fees, and collections. Collection efforts are a **major trigger for board complaints.**
      - Multiple relationships - never sexual; not “friends” now or later; not business partners or similar; won’t barter; no financial, medical, or legal advice, etc.
      - The limitations managed care places on treatment. See section VII, C, 1 below for a handout on this.
- If you don’t want to write your own patient education materials on these topics do consider buying *The Paper Office* which includes these and more. **Note:** You should regularly train your staff about all forms and procedures, especially confidentiality with regard to state laws, professional ethics, HIPAA, etc. And, of course, document the training.

3. **Your practice’s Client Information brochure will be considered a legal contract.**
   a. The therapy *relationship* has come to be seen as a legal *contract* which involves rights, specifying the issues and your rules reduces the risk of misunderstanding, protects both parties, and creates a foundation of trust (based on openness or transparency) for therapy to develop productively.

   b. Such a written out “social contract” can be the documentation of *informed consent which is the mental condition after a discussion with questions and answers about all issues, risks and benefits that a reasonable person would want to know before proceeding.** **Note:** Remember that consent require voluntariness and mental competence as well as informedness and so if there is any reason to doubt these, document them and your thinking and resolutions.

   c. It is possible to write such a *brochure to be clinically useful* as well as a legal document and a communication device. A brochure can help foster the therapeutic alliance which is responsible for a major part of the benefits of therapy.³

   d. You can construct a complete and written out patient education Brochure on the issues of the client/therapist relationship to be read, discussed, and signed, or **you can read my version** with many options for each point and tailor it to your clientele, style of working, local laws and regulations, etc. I do not want this to be just a sales pitch for my *The Paper Office* so do consider the costs and benefits you can get from letting me do the work or reading the literature and distilling it for you.

   e. **Readable and comprehensible materials** are essential for informed consent. The humorist James Thurber said “A word to the wise is not sufficient if it makes no sense.” All of your written materials for patients should be *written in “plain English”* (the government’s phrase) and at a reading level as low as possible. It may surprise you, as an educated person, but a quarter of our citizens cannot read effectively above a fifth grade level. A study on NPPs have typically found them comprehensible only to those with a college degree (Walfish & Ducey, 2007) and the same has repeatedly been shown for almost all ‘informed consent’ documents in medicine and it has worsened over time. Ensure that the language used in the informed consent is basic English and without unnecessary jargon so that the client or his/her legal representative can understand it. You can run you materials through several online tests. The best source for these is the Wikipedia entry at: [http://simple.wikipedia.org/wiki/Textual_difficulty](http://simple.wikipedia.org/wiki/Textual_difficulty). “Microsoft Word includes the Flesch-Kincaid Readability Calculator that analyzes the reading grade level, reading ease and % of passive sentences you use in your copy. You can activate the Flesch-Kincaid tool when you spell check your document. Click on Tools; then click on "Spell and Grammar." At the bottom of the box you'll see "Options;" click the Options icon. In the bottom of the popup box, you'll see "Show Readability Statistics." Click that box and you're set to go. Every time you run the Spellcheck function, Word will test the readability of your document and display the results when you finish spellchecking your document.” From Eric Gelb at [PublishingGold Blog](http://www.publishinggoldblog.com).

4. **Written Treatment Plans**
   a. If you don’t know where you are going:
      - Anywhere you get to will seem okay.

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³ Because the portioning of the causes of change in therapy can be done in different ways, the percentages vary. Lambert and Barley (2002) attribute 30% of change to the relationship and 15% to techniques. Other research reviewed by Norcross (2002b) showed therapist differences contributing 5-15% of the outcome variance. The whole Norcross (2002a) book is enlightening.
- You won’t know when you get there⁴, and
- Avoidance/denial, confusion, and distraction will get you lost.

b. These plans can be either an extra burden of documentation or they can be part of the therapeutic process. To incorporate the plan into therapy some guidelines are:
   - Make the plan a product of collaborative assessment and planning. Depending on your therapy model, this is siding with the ego, addressing the healthy part of the personality, building on strengths, learning from previous successes, lending your ego, alliance building, etc.
   - Acknowledge that the plan will change with progress and better understanding of the issues. Plans will have to change with success and failure to achieve objectives.
   - A regular habit of reviewing the plan and progress will allow you both to see what is and isn’t working so you can work smarter.
   - Evidence of successful completion of objectives can be reviewed to help shorten periods of doubt and pessimism after a setback, backsliding, or a loss.
   - With repetitions you can show the client where the client is sabotaging/resisting the process of change-making.
   - Plans will help formulate termination and “aftercare” steps.
   - The processes of constructing and monitoring a plan can focus on and teach missing skills. For example, the impulsive can observe the modeling of generating options, thoughtful weighing, and skillful implementation. The hesitant can address on paper his or her reluctances and so put some to rest instead of extended mulling. Writing down concerns that have previously been continually mentally reviewed lessens their burden and power [Zuckerman’s Law #6: You can carry more than you can juggle.] The overly self-conscious and the paranoid can learn to seek and use objective data and feedback. Fill in your own examples here.

c. If you only need to produce a formulaic plan you might want to make up a template with options and edit it for each client. If you want to do more elaborate plans with many components but recognize the burden of creating many such plans, a computer program that would serve as “text library” holding and organizing the best parts of your work would make this more efficient and less burdensome. I have such a program; it is called the Clinician’s Electronic Thesaurus and you can try it out. Go to:
   http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/zuckerman3.htm&dir=pp/CT_series&cart_id=901948.7621
   - and then click on “Download a demo version.” It is a limitless text library, filled with all the text of the whole book. It is three levels deep, Chapters, Sections, and Subsections, but completely re-organizable: delete but not lose what you don’t need now, move content to new locations, add new Chapters, Sections and Subsections. Save all your best stuff under your own headings and find any in a few clicks.

5. Whenever using a technique unfamiliar to the client or in any way controversial or experimental discuss it fully and obtain fully informed consent for the treatment. Address at least these points:
   b. Risks and benefits of the procedure/treatment, including possible side effects.
   c. Risks and benefits of possible alternatives.
   d. Risks and benefits of not receiving the procedure/treatment.
   e. Right to withdraw the informed consent at any time.

6. Respond to all complaints and threats.

⁴ That this matters in clinical work was best captured by Fritz Perls’ advice to “Stop with success.”
a. Never ignore a complaint no matter how petty, irrelevant, unsophisticated, self-serving, obviously incorrect or distorted it seems. It may go away or it may become a licensing board disaster. This is your career, protect it.
b. Respond immediately and fully until is is okay with the complainer (not just with you) or discharge/transfer/refer the patient.
c. Solicit complaints:
   - Ask about ‘What (not ‘Any’) problems with our therapy do you see?’
   - Collect feedback on each session at its end (if the time is planned and used clinically) or at the next session (so some thought may have been give to the last session’s contents).
   - Offer an anonymous Complaint Form in your waiting room.
   - Assess every few sessions: ‘How am I doing?’ (Ed Koch, Mayor of NYC). Do not accept “fine” and go on.
d. Do follow-up on closed cases which will also yield useful guidance about problems.

G. Consult - The rule is ‘Never worry alone.’ Here are some possibilities:

1. Join a peer consultation group which has:
   a. Regular meetings so problems can be brought up early.
   b. Written rules about confidentiality, responsibility for taking actions, etc. to provide structure to the consultations.
   c. Experience and tolerance so that you will get good advice and support.
2. Have expert consultants available to you for each kind of problem.
   a. Your state association is likely to have lawyer consultants or your national society may offer a “legal consultation plan.”
   b. Develop a list of local resources for different problems before they arise.
3. Where appropriate, share the risk by consulting your superiors. Go up the ‘chain of command.’
4. Do it right and pay for it: Do not “consult” with friends, not in the hallway, not over coffee, etc.
5. Document the outcome of the consultations. What was discussed, suggestions, follow-up, etc.
6. Warning: Never consult with your peers about a complaint made against you because these are not confidential/proTECTED conversations and can be used against you in a complaint or a suit. Instead hire a therapist/become a patient and hire a lawyer so what you say is protected.

H. Keep up with the standards of practice

1. It has been estimated that the half-life of a PhD in psychology is 10-12 years (Dubin, 1972). That is, that half of what you learned in graduate school will be outdated, incorrect, useless or worse in just a decade. This may make sense to you but you will not know which half of what you know is not longer “true” and can be relied upon unless you keep up. Be a life-long learner and be proud of it.
2. You must perform at the standard of practice so you must know those standards.
   a. Get CE in newer treatment approaches (even if you don’t adopt them) and issues/concerns (even if they seem unrelated to your current work). I fully recognize that newer is not always or even mostly better. At the least such challenges can make you feel confident in your knowledge and you may rediscover some old techniques.
      - Take risk management courses. Learn the concepts and terms to raise you consciousness.
      - Read the books you buy.
      - Get some credential for any practice or method you use. If there is no certifying body, do some presentations to your peers on the subject, write an article for your professional newsletter, or teach a course.
b. Do not fall for certificates from diploma mills or vanity boards.
   - Those who have earned their knowledge and credentials know the fakes.
   - They will never trust you afterward.
   - It is unethical (in the APA Code section 5.01b [http://www.apa.org/ethics/code2002.html#5_01]) to misrepresent your credentials and so a peer may file a complaint against you. About 25% of licensing board complaints come from non-clients.
   - It can be harmful to your clients if you act without knowledge. Recall “Do no harm”?

   c. You do not need to be exquisitely trained to use techniques but be conservative and thoughtful. Before trying something completely new, ask yourself:
      - “If my peers saw a video of me doing this would an average peer believe that I could do this properly with my current level of training and experience?” “How would more conservative peers review this?”
      - “How many others do I know who are doing this? Am I all alone in this action or belief?”

   d. Join your state and national professional organizations and read what they send you. Members are much less likely to get into trouble. I cannot find the research support for this at this time but some strong indirect evidence is available. Sam Knapp, EdD, the Professional Affairs Officer of the Pennsylvania Psychological Association and a nationally recognized expert on ethics who has published widely reported this:

   “… looking at State Board of Psychology data from 1997 to 2007, PPA members were far less likely to be disciplined than non-members. Non-members were almost three times as likely to be disciplined as members. Non-member males constitute 25% of the total population of licensed psychologists, but represent more than 50% of all disciplinary actions and more than 80% of boundary violations. Is this finding a result of the consulting and educational activities of PPA? Perhaps, we don’t know. But it is consistent with the idea that those who are most isolated from their peers are more likely to get into trouble. Those who are in more regular contact with their peers are less likely to get into trouble.” Personal communication, June 3, 2009.

   Note that this is a correlation and may be due to selective joining of PPA by more sophisticated psychologists but it is at least as likely to be causative: joining and attending meetings may educate members about the ethical rules and procedure and so cause them to offend at a much lower rate.

3. Know at least some basics about psychiatric medications for several reasons:
   a. A significant percentage of your clients will be taking them and so will either have benefits, no effects, worsening, or side effects of these.
   b. You may notice, or have reported to you by your clients, behaviors which may be side effects or effects of toxicity, or other results of using these drugs.
      - You can refer the client back to their prescriber for changes or education on managing these effects.
      - You might mistake the medication effect for a psychological symptom. **Example:** The client reports unpleasant inner restlessness, agitation, malaise or lability. You surely think first of anxiety in all its manifestations but akathisia should be considered. While a common side effect of antipsychotics, and less so of antidepressants, it can also be due to Parkinson’s. The entry in Wikipedia is fun to learn and exceptionally informative: [http://en.wikipedia.org/wiki/Akathisia](http://en.wikipedia.org/wiki/Akathisia)
   c. You may be able to **suggest to a client the need for a medication evaluation.** Remember 70+% of all psych meds are prescribed by non-psychiatrists (Sharfestein, 2006) and the percentage is very likely to be higher in some areas.
   d. **NOTE:** If you are not licensed to prescribe don’t “practice medicine without a license.” What this means to the rest of us is do not tell a client to start taking, increase or decrease the dose, or stop taking any controlled meds. For your safety I would include in this the other drugs people take - vitamins and supplements, over-the-counter drugs, herbals, etc. - unless you have an appropriate and recognized credential.
e. How can you keep up on drugs at little cost and less time? Dan Egli and I maintain a free list (actually several, as you will see) that provides just the basic information you need. Here is a look at the top quarter of it:

<table>
<thead>
<tr>
<th>Trade© Name</th>
<th>Trade© generic</th>
<th>Class</th>
<th>Usual Adult Daily Dosage Range in mg(s)</th>
<th>FDA-approved Indication(s)</th>
<th>Common “Off-label” Uses, if any</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>aripiprazole</td>
<td>Atypical</td>
<td>10-15</td>
<td>Schizophrenia, Bipolar, Agitation</td>
<td>Extra-Pyramidal Symptoms</td>
</tr>
<tr>
<td>Adderall, XR</td>
<td>d- &amp; l-amphetamine</td>
<td>Stimulant</td>
<td>5-40</td>
<td>ADHD, Narcolepsy</td>
<td></td>
</tr>
<tr>
<td>Ambien, CR</td>
<td>zolpidem</td>
<td>Non-benz, hypnotic</td>
<td>5-12.5</td>
<td>DPA, SCD, short-term use</td>
<td></td>
</tr>
<tr>
<td>Amifrazine</td>
<td>clonazapam</td>
<td>Triyclic AD</td>
<td>100-250</td>
<td>OCD</td>
<td></td>
</tr>
<tr>
<td>Anavalese</td>
<td>diazepam</td>
<td>Alchole antagonist</td>
<td>125-500</td>
<td>Manage chronic alcoholism</td>
<td></td>
</tr>
<tr>
<td>Aricept</td>
<td>donepezil</td>
<td>Cholinesterase inhibitor</td>
<td>5-10</td>
<td>Mild/moderate/severe dementia</td>
<td></td>
</tr>
<tr>
<td>Artane</td>
<td>tetrabenazine</td>
<td>Antidyskinetic</td>
<td>1-15</td>
<td>Anti-Parkinson’s</td>
<td></td>
</tr>
<tr>
<td>Ativan</td>
<td>lorazepam</td>
<td>Benzodiazepine</td>
<td>2-6</td>
<td>Anx</td>
<td></td>
</tr>
<tr>
<td>Aventyl/Pamelor</td>
<td>noroxipine</td>
<td>Tricyclic AD</td>
<td>25-100</td>
<td>MDD</td>
<td></td>
</tr>
<tr>
<td>BuSpar</td>
<td>buspirone</td>
<td>Anti-anxiety</td>
<td>15-60</td>
<td>GAB</td>
<td></td>
</tr>
<tr>
<td>Campral</td>
<td>camprosate</td>
<td>Alcohol antagonist</td>
<td>1332-1998</td>
<td>Alcohol dependence</td>
<td></td>
</tr>
<tr>
<td>Catapres, TTS</td>
<td>clonidine</td>
<td>Antihypertensive</td>
<td>1.2</td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Celexa</td>
<td>clozapine</td>
<td>SERT</td>
<td>20-40</td>
<td>MDD</td>
<td></td>
</tr>
<tr>
<td>Cenutra</td>
<td>prazepam</td>
<td>Benzodiazepine</td>
<td>10-30</td>
<td>Anx</td>
<td></td>
</tr>
<tr>
<td>Chantix</td>
<td>varenicline</td>
<td>Nicotinic receptor agonist</td>
<td>0.5-2</td>
<td>Smoking cessation</td>
<td></td>
</tr>
<tr>
<td>Clalis</td>
<td>tadalafil</td>
<td>POE-5 inhibitor</td>
<td>5-20</td>
<td>Erectile dysfunction</td>
<td></td>
</tr>
<tr>
<td>Clozaril/FazaCo</td>
<td>clozapine</td>
<td>Atypical</td>
<td>300-450</td>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Cogentin</td>
<td>benztropine</td>
<td>Antidyskinetic</td>
<td>3-8</td>
<td>Anti-Parkinson’s</td>
<td></td>
</tr>
<tr>
<td>Concerta</td>
<td>methylphenidate</td>
<td>Stimulant</td>
<td>18-54</td>
<td>ADHD</td>
<td></td>
</tr>
</tbody>
</table>
| Cymbalta    | duloxetine     | SNRI | 20-80 | MDD, GAD, Neurotic 
| Dalmane     | flusofazone    | Benzodiazepine | 15-30 | Insomnia, short-term use |
| Daytrana, Patch | methylphenidate | Stimulant | 10-27 | ADHD, ages 6-12 |
| Depakote/Concor | divalproex | Anti-convulsant | 750-3000 | Bipolar, Epilepsy, Migraine |
| Depacon     | lamotrigine    | Stimulant | 5-50 | ADHD, Anorexant |
| Desyin      | methamphetamine | Stimulant | 5-12 | GAB |

Our Famous ‘List of 100 Psych Drugs’ is reviewed every three months and revised as needed. You can download the current version from [http://www.theclinicianstoolbox.com/](http://www.theclinicianstoolbox.com/) and then look under the Free Tools tab at the top. Print out the two page list and have a look at the other useful Free Tools.

4. You must perform at the standard of practice so you must know what your peers are doing.
   a. Join your state association, and read what you are sent. For more join their email lists, participate in committees, and make presentations.
   b. Join a consultation group so you can learn how others practice.

**Homework Exercise:**

Read your Code of Ethics, Licensing Law, and Insurance Policy yearly on the day you make your insurance payment. Put this into your date book now. You will find them instructive even the tenth time around.

5. You must perform at the standards so you must know yourself.
   a. Read and revise your Practice Brochure and Patient Education materials yearly because your way of practicing will drift (it may even improve: :-)).
   b. **Stay within your competencies.** Don’t take cases you can’t handle really well.
   - You are not competent to treat every person or disorder who walks into your office.
   - You are not competent to treat every disorder or person you are licensed to treat.
   c. Try to be realistic, not grandiose, arrogant or defensive. Know your weaknesses. Ask your enemies. **Smugness is a risk factor for error, complaints and malpractice.**

**Research Minute:** It is easy to say, “Stay within your areas of competence” but can we really know our competence accurately? Social psychologist describe the Lake Woebegone Effect: 85% of drivers rate themselves as above average.
Kruger and Dunning (1999) in a series of studies asked for self rating in areas which do not have well-known, clearly recognized criteria such as having a sense of humor, but for which valid test materials were available.

- **Result 1**: Those in the bottom quartile (with a mean at the 12th percentile) rated themselves as above average (58th percentile in humor, 68th percentile in logic).
- **Summary 1**: Mostly were very optimistic and truly uninformed about where they stood in ability. The least able were even more out of touch than the others.
- **Result 2**: What about those who were truly of high ability? The top quartile (mean at 86th percentile) rated themselves as 68th percentile in logic.
- **Summary 2**: Even the capable are not good judges. The authors argue that the most capable are surrounded by other highly capable people and so their standards for comparison are raised and their self ratings are lowered.
- Based on other research Kruger and Dunning concluded that the only cure for the gross optimism of the unskilled was to make them skilled. Only after becoming competent could they more accurately evaluate their ability.
- **Summary 3**: The only cure for this distortion is becoming competent. And that takes work.

I. **Monitor yourself**

1. Don’t take on a case just out of your financial need or from fear of offending referrers or bosses. Just don’t; find another way.

2. **Do not work when you are impaired.**
   a. This does not just mean drunk or high. Any level will impair your judgment.
   b. This means tired or sleepy or having eaten too much or too little or had too much caffeine, nicotine, or your own drug of choice.
   c. Don’t work when you are too aroused, lonely, sad, troubled, scared, angry, etc.

3. Impairment is a slippery slope.
   a. When you get away with minor limitations and lapses you can become convinced you are okay after x happens even when you weren’t and won’t be.
   b. The ability to anticipate, using good judgment, is easily sidetracked.

4. Do not see clients with your problems.
   a. A wise clinician, Harriet Gordon Machtiger, PhD, of Pittsburgh, once said that when you are having problems, it walks in the door.
   b. Even if you think you have overcome the problem, the risks of reactivation, blindness, and arrogance are present. Be very careful and get consultation before and during the treatment episode.

**Take pride in the quality of your work, despite the external pressures to do less than your best at times.**

5. **Learned Unease as a warning conscience.**
   b. ‘Almost everything in life is a lot easier to get into than out of.’ Parenthood, bicycle toe clips, etc.
   c. Most violations are the result of starting out onto ‘a slippery slope.’ Almost all of the situations that lead to ethical problems, board complaints, and malpractice suits started small and were not recognized as dangerous and so not properly responded to.
   d. Become sensitized by continuing your professional education.
   e. Learn the concepts and names so you will recognize the issue.
“... the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals, committed to ethical behavior. But none of us is infallible. All of us can -- and do -- sometimes make mistakes, overlook something important, work from a limited perspective, reach conclusions that are wrong, hold tight to a cherished belief that is misguided. An important part of our work is questioning ourselves, asking "What if I’m wrong about this? Is there something I’m overlooking? Could there be another way of understanding this situation? Are there other possibilities? Could there be a more creative, more effective, better way of responding?" Pope and Vasquez, 2007. (Emphasis added).

J. Making ethical decisions

1. Ethics struggles are often unavoidable. “As psychologists, we often encounter ethical dilemmas without clear and easy answers. We confront overwhelming needs unmatched by adequate resources, conflicting responsibilities that seem impossible to reconcile, frustrating limits to our understanding and interventions, and countless other challenges as we seek to help people who come to us because they are hurting and in need, sometimes because they are desperate and have no where else to turn. There is no legitimate way to avoid these ethical struggles. They are part of our work.” Pope and Vasquez, 2007. (Emphasis added). Sometimes it is easy but it is not uncommon to have conflicts of the code’s rules and applicable laws, among different rules, between principles and practices, and personal values and your organization’s rules. What then?

2. How we are supposed to integrate the issues. How we are supposed to make decisions?
   a. Models of ethical decision making I: The Rational Person: Gather the facts, deliberate, reason using ethics principles, and come to a decision.
   b. Data supporting this procedure in real-life decisions? Nope.

3. How we actually make decisions about ethical issues and conflicts: Models of ethical decision making II: Gut first and often only.
   a. The sequence is:
      - Gut, intuition, a label - first impressions, immediacy.
      - Recall similar situations we can bring to mind easily - the Availability Heuristic.
      - Consider a few options with their consequences.
      - Stop with a “good enough” resolution.
      - Informal peer consultation when we next see them or we may forget to.
      - Regulations and local laws if they are easy to recall.
   b. It appears that a majority of clinicians make decisions on ethical issues using only their personal values. They do not consult and often do not know the relevant parts of the Ethics Code. Unfortunately, if you get into trouble, “my personal values” is not a legal defense.

4. Models of ethical decision making III - Sequential Theories and others.
   a. Those who recall their intro to psych course may recognize the James-Lang Theory’s relevance here: We perceive events which arouse physiological changes and the knowledge of these changes are what we call emotions.
   b. Or does it work the other way? (The Cannon-Bard Theory) Do we understand the situation first, perceive it and then, due to neurohormonal processes, experience bodily sensations which we interpret as our emotions?
   c. Or Schacter and Singer’s Two Factor model: Some element of an event triggers a non-specific arousal and we then search the environment/meaning of the situation for clues to what caused this arousal and then label the emotional arousal.
   d. Or the cognitive-mediational model (Richard Lazarus) in which the cognitive appraisal of the situation’s demands and nature is the cause of the emotional arousal. This is widely used in stress management.
5. Models of ethical decision making III - **Simultaneous Dual Processes**
   a. Instead of the separate rational and the intuitive procedures (as above) it appears that perceiving and evaluating are basically simultaneous.
      - When we taste something we know immediately if we like it or are disgusted.
      - As soon as we see something we feel its beauty or ugliness.
      - Our moral judgments of a situation’s fairness, goodness, or rightness are felt as soon as we perceive the situation.
   b. We often can’t explain why the judgment felt right - suggesting there are two processes.
   c. Social psychology, examining social cognitions such as stereotyping, person perception, and social decision-making has suggested a *dual process model*.

“When a person encounters a stressful life event, there are two sets of processes (i.e., dual-process) that determine how that event will be interpreted. First, there is an automatic cognitive response to the event. When the stressful life event occurs, implicit schemas are activated rapidly and unintentionally. If the activated schemas are negative ..., then a person experiences immediate negative affect.” Haefffel, et al., 2007

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### Characteristics of the Dual-Process Theory of Cognitive Processing in Decision Making

<table>
<thead>
<tr>
<th>Implicit Cognitive Processing</th>
<th>Explicit Cognitive Processing</th>
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<tbody>
<tr>
<td>Rapid, Immediate</td>
<td>Slower, Later</td>
</tr>
<tr>
<td>Processes, information-processing, schemas</td>
<td>Thoughts, contents, products</td>
</tr>
<tr>
<td>Unconscious, out of awareness</td>
<td>Conscious, usually verbal</td>
</tr>
<tr>
<td>Automatic, Spontaneous, Unintentional</td>
<td>Deliberate, Effortful, Intentional</td>
</tr>
<tr>
<td>Heuristic</td>
<td>Systematic</td>
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<tr>
<td>Reflexive</td>
<td>Reflective</td>
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<tr>
<td>Intuitive</td>
<td>Takes account of social and other realities</td>
</tr>
<tr>
<td>Emotion-based</td>
<td>May supersede the implicit decision</td>
</tr>
</tbody>
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“processes that are guided by the automatic activation of stable memory constructs, occur without intention or effort, and do not tax cognitive resources.”

Processes are “characterized by on-line deliberate processing, active and effortful cognitive control, and the expenditure of cognitive resources.”

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d. What shapes these moral emotions? Evolution. Here is what David Brooks, the columnist, has to say:

“Like bees, humans have long lived or died based on their ability to divide labor, help each other and stand together in the face of common threats. Many of *our moral emotions and intuitions reflect that history*. We don’t just care about our individual rights, or even the rights of other individuals. We also care about loyalty, respect, traditions, religions. We are all the descendants of successful cooperators.

The first nice thing about this evolutionary approach to morality is that it emphasizes *the social nature of moral intuition*. People are not discrete units coolly formulating moral arguments. They link themselves together into communities and networks of mutual influence.

The second nice thing is that it entails a warmer view of human nature. Evolution is always about competition, but for humans, as Darwin speculated, *competition among groups has turned us into pretty cooperative, empathetic and altruistic creatures* — at least within our families, groups and sometimes nations.
The third nice thing is that it explains the haphazard way most of us lead our lives without destroying dignity and choice. Moral intuitions have primacy, Haidt argues, but they are not dictators. There are times, often the most important moments in our lives, when in fact we do use reason to override moral intuitions, and often those reasons — along with new intuitions — come from our friends.” Brooks, D. (2009) Emphasis added.

e. However the immediate impression is not the end of the story. The quote from Haeffel, et al (2007) about the dual-processes, above, continues:

“However, a person’s initial schema-driven response may not be their final cognitive interpretation. Research from social psychology suggests that a person also can use deliberative, explicit processes to reinterpret the negative event, which may override the implicit cognitive response.” Haeffel, et al., 2007

- One cannot participate in American culture without acquiring implicit beliefs about other races and ethnicities. Although the atheist may feel fear around Catholics, or the Jew around Germans, or females around males, etc. this is a first reaction usually tempered by the secondary, explicit thought process. We all do this and can learn to do it better, more reality-based, more logically, more fully.
- Cognitive therapy is wise to quote Epicetus: “It is not the facts that cause our emotions and actions but our beliefs about those facts.” By extension, we always have freedom of conscience - choice of attitude and so freedom of mood and thought if not action.
- We can use these insights to guide our ideas and feelings about MC, our next big topic, below.

6. Therefore the often recommended procedure is to make decisions using all four elements: Models of ethical decision making IV: **Factors in sequence. And consider them in that order.**
   
   First   The law - Civil and Criminal legal requirements, local and state, HIPAA and other
   Second  Your Licensing Board’s rules and decisions.
   Third   The Ethics Codes of your profession. A section of the code usually specifies that you
   Fourth   Your personal values (your gut?) Morality - right and wrong. Good and bad.

7. A big complication: What the American Psychological Association’s code says about precedence when conflicts between ethics and organizations or laws arise.

   a. The American Psychological Association’s Ethics Code, 1992 version, stated the issue this way: 8.03 Conflicts Between Ethics and Organizational Demands.
      If the demands of an organization with which psychologists are affiliated conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, seek to resolve the conflict in a way that **permits the fullest adherence to the Ethics Code.** Emphasis added.

   b. Clearly ethics takes precedence. However, after it was completely revised in 2002 it is stated this way: 1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.
      If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, **psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.** Emphasis added.

   c. While it does say “may” this sentence comes at the end of the rule and so seems the final word. Not every authority agrees but this rule can be read as the law taking precedence over morals and ethics. Yet this is exactly what the Nuremberg trials of Nazi war criminals specifically denied. One cannot escape from moral obligations by asserting that one was “only following orders.” Some struggles seem never to disappear. I am grateful to Ken Pope, PhD, for bringing attention to this point.
8. Models of ethics decision making V: A stepwise approach (steps of the wise?)

Psychologists and philosophers have offered many sets of procedures and algorithms to smooth the process of making decisions which meet the highest standards. Below is a summary of the steps recommended by Ken Pope and Melba Vasquez (2007) which addresses all sides of the issues one should consider to make the best decision. Although there are 18 steps, not every step will be relevant to every situation, and the steps may need to be adapted to fit particular situations. For a better understanding of these points please read the original, chapter 9 of their book. In fact, the whole book is easy to read, informative, etc. and will make you a lot smarter.

- Identify the situation that requires ethical consideration and decision-making.
- Anticipate who will be affected by your decision.
- Figure out who, if anyone, is the client.
- Assess our relevant areas of competence – and of missing knowledge, skills, experience, or expertise – in regard to the relevant aspects of this situation.
- Review relevant formal ethical standards.
- Review relevant legal standards.
- Review the relevant research and theory.
- Consider how, if at all, your personal feelings, biases, or self-interest might affect your ethical judgment and reasoning.
- Consider what effects, if any, that social, cultural, religious, or similar factors may have on the situation and on identifying ethical responses.
- Consider consultation.
- Develop alternative courses of action.
- Evaluate the alternative courses of action.
- Try to adopt the perspective of each person who will be affected.
- Decide what to do, and then review or reconsider it.
- Act on and assume personal responsibility for your decision.
- Evaluate the results.
- Assume personal responsibility for the consequences of your action.
- Consider implications for preparation, planning, and prevention.

K. Buy malpractice (Professional Liability) insurance

1. This is a complicated decision and well beyond what we can address here. I know I am repeating myself but I really do cover all of the issues, options, and considerations, with specific recommendations in The Paper Office. To help my fellow clinicians is why I wrote it, not to make money.

2. Some guidelines:
   - Understand the limitations - Get and read the specimen policy, not the ads or mailers.
   - Understand that you need to buy or receive a nose/tail (Prior Acts coverage) when you change insurers, change from Claims-Made to Occurrence, or retire.
   - Raise your coverage level before retiring so that the size of your tail goes up too.
   - Consider buying your professional associations’ Legal Services or Consultation Plan.
VI. Managed Care Practicing

In the movie As Good As It Gets, actress Helen Hunt plays the mother of a chronically ill son. She had asked her HMO for expensive tests that she thinks clearly might have led to a cure for him. She discovers the HMO has just turned down paying for her boy's testing.

"HMO bastards!" she rages. "Pieces of shit!"
"Actually," says the doctor talking to her, "that's the technical name for them."

Obviously the writer expected all members of the audience to know exactly what MC does that is so evil.

Goals for this section:

• If you already do a lot of MC work, this material will very likely validate your experiences with MC.
• If you are new to MC work, this material will provide an expanded picture of MC and its impacts.
• If you are considering MC work you will go into it with your eyes open.

Note: All of the below is based on the last 10-20 years but in some locales and among some MCOs practices are rapidly changing in 2009 due to public anger over abuses, tightening budgets, and changes in laws and law enforcement. You will have to confirm the below ideas for your setting and time frame.

A. Orientation

1. You are all providers. Remember going to Provider School for your degree? No? Of course not. You went to graduate school to become a social worker, counselor, Marriage and Family Therapist, or psychologist and were proud of your achievements. You liked being a part of a helping profession with a positive history and image. Then came managed care where you are treated as an interchangeable part of the machine of the delivery of mental health services (I did not say therapy). Now we are all providers without meaningful distinctions.

Karen Shore wrote passionately about this a few years ago but it is still worth reading to get your feelings flowing. It is titled: Don’t Let Them Take Your Mind and Spirit: On Being Called a “Provider” and can be read at the website of a small but important organization deserving of your membership: http://www.TheNationalCoalition.org/provider.html

2. Have you gotten your National Provider Identifier (NPI) number? This is, I think, the last step in making therapy a machine - we providers are now reduced to just a number. However, it is free, won’t hurt you, and will be needed for identification in the future. For more information CMS has a web page dedicated to the NPI: http://www.cms.hhs.gov/NationalProvIdentStand/. If you did not get your NPI go to: https://nppes.cms.hhs.gov/

B. Background/Taking a History of MC

1. Only in America do we depend on health insurance for health care. The rest of the world gets health care and some buy additional services or insurances. The historical roots are in Walter Reuther and the United Auto Workers’ agreements with the “Big Three” automakers. Giving “benefits” instead of increasing wages did not increase taxes on the worker and were a tax deduction for the employer.

2. The Promises of MC:
   a. Our client’s employers, the ones who actually buy the insurance, were convinced that:
      o There was a lot of wasted money/fat extra profits to the doctors and hospitals in the health care they were paying for.
o The waste was in outpatient services.
   ▪ It was not in outpatient therapy although you could point to Woody Allen in long-term psychoanalysis and some other cases. Phillips (1992) found that over 80% of clients finished their therapy by the 10th visit.
   o But there was certainly waste in inpatient services, especially in long stays for adolescents, and for substance abuse (90 day residential programs were common).
   o Providers and patients could not be trusted to limit costs - there were no incentives for providers to do less (and so be paid less) or for patients to lessen the care they sought (because insurance covered the cost). This is obviously true and the next question is who should impose restrictions and on what basis? Can managed care’s employees know how to do this rationally and justly?
   o Without MC costs would continue to rise as or even more rapidly over time.

b. MC would serve as independent decision makers who would require justification of services and so reduce them and lower costs (to the employer).
   o Needless care would be averted - only “medically necessary” care would be paid for.
   o Only qualified providers would be empaneled and so raise quality.

c. MC would bring a business model to health care:
   o Progressive improvement at lower costs - efficiencies.
   o Professional management of providers.
   o Cost monitoring and control.

   For example:
   o Providers would be required to use the most cost-effective and efficient methods.
   o Drugs costs would decrease due to pharmacy benefit management (PBM), requiring the prescription of only the drugs in formularies with fewer but more effective drugs, and large-scale purchasing at lower cost.
   o The cost of MC would be as small as the old pass-through/reimbursement model of health insurance - The Blues and Medicare, Social Security - 3-5%.

d. Employees would benefit from:
   o More access to care they needed due to the availability of health insurance and the large panels of providers.
   o Case management by protocols so all necessary services will be provided - e.g. vaccinations, intense case follow-up, disease management, etc.
   o Preventative services to improve health and save later costs.

3. The actual results of MC on psychotherapy are manifold. Below I will review some consequences of MC.

C. Overview of the effects of MC

Once, our health care was the world’s envy. It was a growth industry and exportable.

1. Summary: Major damage to health care quality and availability with very minor benefits to patients, only losses to most providers, and enormous increases in waste (costs, delays) due to MCO’s overhead costs.

2. Under served those with chronic illnesses and who will not improve by limiting dollars or visits to an average.

3. Under served those in need of highly specialized care by refusing to pay for high cost services or “experimental treatments.”
4. Under served sick children for the above reasons.

5. Provided worse mental health (MH) care:
   a. Too few sessions to be effective therapy. The research did not show that 8 or 10 sessions were effective. It showed that benefits required about 20 sessions or more,
   b. No integration of provided services:
      - Too few consults to devise the best plans and implement them.
      - Competition of agencies to survive, to own patients and not arrange for needed services that are not available in-house.
   c. Continuous pressure to lower costs reducing quality. Less skilled clinicians because of lower levels of staff training, reduction or discontinuance of in-service training, in-house consultations, etc. due to curtailed payments.
   d. Unavailability of contractually-promised care. The directories of clinicians on a panel who should be available to covered patients are notoriously out of date, inaccurate, and misleading. Russ Holstein, PhD, has documented these “Phantom Panels” at: http://www.division42.org/MembersArea/IPfiles/Fall04/prof_pract/holstein.php and also: http://www.psychiatricnews.org/pnews/00-11-03/its.html

6. Reduced availability of services. **52% of psychiatrists do not take managed care** (Moran, 2004) and so can charge much higher fees - paid out-of-pocket. This percentage is very likely much higher now than in 2004.

7. Killed off psychological testing which could provide better decisions on treatments.

8. Starved research and training by paying only for direct services not the background, future, and variety of services that support health care.

9. Created much more waste in the system - fully 1/3 of health care costs are spent on needless layers of bureaucracy. This is partly why our health care costs three times as much per person as in the rest of the world. “Administrative costs consume 31 percent of US health spending, most of it unnecessary.” Woolhandler, R., et al. (2003). “The US could save enough on administrative costs with a single-payer system to cover all of the uninsured.” Physicians’ Working Group for Single-Payer National Health Insurance (2003).

10. Oh, and health care costs and expenditures have continued to rise faster than other costs.

**D. The Methods of Managed Care Organizations (MCOs)**

1. Historically health insurance was indemnity based - essentially a “pass-through” of health care expenses to the people paying for the insurance. It provided true insurance - risk and cost sharing - so care was not denied to those in need. Administrative costs were small.

2. The initial versions of MC were created by practitioners and worked well. Profits were small and risks were shared. Clients had choices and clinicians were partners. 

   With current MCO policies there is no choice by consumers (who can’t take their money and go elsewhere for care; clients don’t buy the insurance, their employers do) so there are no counter-balancing market forces.

3. MC applied a 19th century capitalist business model (exploitation of workers, the “Robber Barons,” ignoring the costs to others and the environment, unfair competition, monopolies, price setting agreements in restraint of trade) to healthcare. This is no more appropriate a model for health care than it would be for courts, policing, or tax collecting; services we want to be just.
4. MC’s decision making’s goal is to prevent or lower payments (benefits, coverage) and so retain more income (premiums) for profits.
   a. Profit decides treatment; not needs, short- and long-term benefits, outcome research, or professional judgments.
   b. Clinical decisions are made by non-clinicians on the basis of the contract’s rules regardless of benefits. MC insists they do not make clinical/medical/patient care decisions but only payment ones and do so consistent with the contract signed by the client’s employer.
   c. Absence of cost/benefit assessments. All research on the effects of MC has been done by outsiders.
   d. Payment decisions are made on “medical necessity” criteria.
      - Medical necessity has no history before managed care,
      - While some state laws define it for some purposes almost all definitions are made by MCOs. This is clearly self-serving.

Here is an example from a federal report about how a definition can irrationally reduce services:

“Table 2 shows that Highmark, the anonymous managed behavioral health organization (MBHO), and UBH limit the concept of medical necessity to services necessary for the diagnosis or treatment of illness. Thus, a treatment necessary to respond to a condition not regarded as an illness (e.g., a developmental disorder in a child) might fall outside the furthest reaches of the contract no matter how necessary the care or effective the treatment. Similarly, if the treatment is designed to avert deterioration rather than treat illness to a point of significant improvement, it might also be considered outside the scope of coverage.” From US Substance Abuse and Mental Health Services Administration (SAMHSA) Medical Necessity in Private Health Plans’ at http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3790/content04.asp - Accessed June 3, 2009.

Note: Some MH professionals who are not physicians shy away from the use of “medical” and so will write “medical and psychologically necessary” into their evaluations. Try it.

e. Costs are seen only in terms of immediate payments to providers and not in longer terms which would support prevention actions (because the MCO will very likely not be covering the same lives next year).
   f. No attempt is made to simplify the administrative functions of the MCO because that would reduce profits. The heads of MCOs pay themselves enormous salaries. See, for example: http://www.theindustryradar.com/index.cfm?account=radar&page=Healthplan_Executive_Compensation Accessed May 20, 2009

5. MC administrators are not licensed in any health care area, not researchers or teachers, and so have no professional guidelines or ethics to limit their profit seeking, compel consideration of moral issues like justice or human rights, or weight ethical guidelines such as “at least do no harm.”

6. Reducing MCO’s costs by imposing financial barriers to access to care. Requiring copayments, deductibles, yearly limits on dollars or sessions, percentage reductions instead of parity, carve outs, etc. to prevent or discourage access to care increases retained premiums and so profits.

7. Reducing MCOs costs by imposing bureaucratic barriers to care delivery
   a. Complex definitions and policies with new jargon and obscure contract language.
   b. Changes to the procedures for submitting claims, forms, thresholds, etc. without any improvement or gain to clients or providers.
   c. Creating the burdens of applications, billing procedures, requests, authorization and pre-authorizations, denials, appeals, etc. and other delaying and discouraging tactics.

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5 It is possible to make a great deal of money from the interest MCOs collect on the money they hold between receiving it and paying it out - the float. Even 4% on ten billion dollars is a big sum each year.
8. **MCOs have shifted the administrative burdens to providers.**
   a. Requiring fax instead of mail, calls instead of email, paper forms instead of online forms.
   b. Offering inaccurate or delayed responses to providers’ questions through poor quality information systems and undertrained staff. How long would you wait on hold to make a purchase? How long is the average hold time to talk to a claims manager?
   c. Incomplete claims or those with “errors” or those that “did not arrive in time” do not have to be paid. Labeling claims inaccurate was so badly abused that laws in many states had to be passed to assure that “clean” claims were paid in 45 days or interest would accrue.
   d. Deliberately losing submitted paperwork to increase costs and frustration to providers and clients so that legitimate claims would not be pursued. There are no negative consequences to the MCO for lost paperwork and there are large benefits. There are no benefits to the provider and only costs of resubmitting paperwork. Draw your own conclusions. Claims that “did not arrive” at the MCO are frequent.” Losing claims which are among a batch of accepted claims are unlikely unless deliberate. Irv Guyett, a Pittsburgh psychologist adds this: When PHI is “not received” by the MCO, the only place the client authorized its release to, it would be an “unauthorized release” and a HIPAA privacy violation. Unfortunately, only the client can complain to the HIPAA enforcers - the Human Rights Commission at HHS - and the client never knows of this loss.
   e. **Summary:** Micromanagement through bureaucratic and administrative procedures is inefficient so why do it? It must be to frustrate and get rid of providers who are difficult or expensive.

9. **Panels of providers are barriers to access.** Providers must be on a “panel” (list) constructed by the MCO to treat the MCO’s “covered lives” and be paid for services.
   a. MCOs promised to ensure at least minimum quality by requiring panels. However:
      - All providers are licensed and so monitored by public agencies.
      - All licensed providers have appropriate and legally acceptable educations and other qualifications.
      - Panelists are required to seek yearly or biyearly “re-credentialing” by submitting extensive documentation which is almost identical to the paperwork submitted previously so this is an unnecessary burden and serves only the purpose of being able to remove a panelist.

   **Note:** To lessen the paperwork burden the Council for Affordable Quality Healthcare (CAQH), offers a free standard application called the UPD (discussed later in this course).

   b. Panels reduce clients’ options.
      - MCOs will say that the client can go to any provider on their panels. Since the MCO decided who would be on their panels the consumer is given only the illusion of choice.
      - When “panels are full” there is no access to other providers by patients.
      - When panels empty due to opting out and resigning by providers finding a provider with the needed skills become impossible and so the client suffers from inadequate treatment.

   **Note:** Why is client choice crucial? From the MCO’s perspective, all providers are interchangeable and so clients’ choice is irrational and unnecessary. But from a therapy perspective choice is absolutely essential. The research is clear that a good fit between client and clinician is a major contributor to successful therapy. Technique matters much less than relationship (See Norcross, 2002, for evidence and examples). Similarly, “In order to achieve the best fit between patient and psychiatrist and to maximize patients' trust of their psychiatrists, it is necessary to preserve patient choice” APA, 1995. A bad fit results in lessened or no benefit. **Clients must therefore be allowed choice of clinician to receive effective health care.**

   c. Panels can raise client’s costs:
      - Clients can’t use benefits (which they have paid for) to access any willing provider.
      - Clients must pay more to use out-of-network providers.
**Note:** In early 2009 revelations by Attorney General of New York state, Andrew Cuomo, showed that the Ingenix company which provided the data upon which out-of-network (OON) payments were determined systematically and deliberately distorted the facts in order to save MCOs a great deal of money by making consumers pay more of the costs of services. The fine in NY alone was 50 MILLION dollars, with $20 million more from Aetna and UHC (the owner of Ingenix). They also settled a suit by the American Medical Association for $350 million. Connecticut and California are considering similar actions. See: [http://www.nytimes.com/2008/02/13/business/reuters-health.html](http://www.nytimes.com/2008/02/13/business/reuters-health.html)

**Advice:** Carll (2009)
1) Always report actual fees on all insurance forms and receipts, including in-network services, even if you are being reimbursed less by the MCO.
2) If you offer a sliding scale in your practice, indicate the adjusted fee paid by the patient AND the amount of your usual and customary fee.
3) Out-of-network providers are sometimes asked to complete treatment reports, although they have no contract with the MCO. [Very rarely is this actually a part of the client’s contract. Investigate this.]
4) Become knowledgeable about the amount your patients are reimbursed.

d. The panels can exclude:
   - The more expensive providers (those who take more sessions).
   - Those who persist in appealing MC’s denials.
   - Those who are assertive of patient or provider needs or rights.

e. Considering the above points the sole purpose of creating panels is to collect providers who are willing to work for low fees.

10. Requiring a referral to see a specialist (such as a mental health provider) creates barriers. This is the *gatekeeper* function of the Primary Care Professional (PCP).
   a. Specialists usually charge more so reducing visits to specialists is very profitable for the MCO.
   b. Formal referral is an additional step which delays diagnosis and treatment and imposes difficulties of time and transport, etc.
   c. The PCP may be charged for each referral (or lose incentive payments) which leads to fewer MH referrals and perhaps provision of MH treatment outside the competence of the PCP.

11. “Gag clauses” or “no disparagement rules”\(^6\) prevent the client from accessing other services.
   a. The provider can’t tell a client of services that won’t be paid for by the MCO but which the professional believes would benefit the client.
   b. This silence prevents informed consent about benefits, risks, or costs of other, alternative, or additional treatment.
   c. And the provider can’t make critical, adverse or negative: comments about the MCO. This is, of course, curtailing free speech but it also prevents the professional from advocating for clients.

12. Reducing the costs (to the MCO) by refusing to pay for services.
   a. Not paying creates barriers to care and increases profits. MCOs can simply not pay for a service by deciding that it is:
      - Not *medically necessary* - which is a criterion without history, without acceptance outside MC decisions, and without empirical support or even objective definition. It is not a medical criterion. It is not an economic (cost/benefit) criterion. It merely serves to name a service which MCOs refuse to pay for.

\(^6\) In truth, gag clauses have been largely outlawed or abandoned but subtler pressures still exist.
- Not “a covered service” even though the diagnosis is in the manual and the treatment has a CPT code.\(^7\)

**Note:** Under some but not all MC contracts the client and clinician can agree to provide the non-covered service and to pay for it without insurance, respectively. This is done with an *Advance Beneficiary Notice of Non-coverage* (ABN) form and contract. Download the form to see the information required - description of the services, reason Medicare is unlikely to pay for it, referral to alternative providers, etc. If Medicare is unlikely to pay, the client’s secondary or Medicare-supplemental insurer is unlikely to pay for it as well. See the Citations.

b. Only partially paying through the use of deductibles, copayments, carve-outs, and discounts like non-parity\(^8\), etc.
   - Paying late or paying only part of what is due.
   - Paying incorrectly so that more effort by the clinician is required.
   - Paying only after the cost of collecting is high enough to frustrate future payment seeking.

c. Providers are allowed to appeal the MCO’s denials of coverage. However, the judges in this process work for the MCO and are not independent or objective. There is no further appeal process except to sue and that usually requires demonstrating damage.

d. *Clawing back* payments to providers through *retroactive denials* of authorizations. MCOs then require the provider to pay back the monies or have them deducted from future payments even when the errors were made by the MCO.

13. MCOs do no research on health care so they have no basis for making rational or empirically-based decisions. For example, requiring very short term therapy, requiring a course of antidepressants before allowing psychotherapy, etc.
   a. All the research about MCOs and insurance has been done by those outside MC. For example, there are many research studies demonstrating that MC clients, HMO clients, and similar care-restricted services have worse outcomes for clients.
   b. All the research on which MCO treatment decisions supposedly rest has been done in other settings than MC services and may not generalize to MC-covered services.
   c. MCOs do not share their internal data and consider it proprietary; “business secrets.”

**Note:** The picture of MCO procedures painted above is not consistent across the country, across MCOs or across time. MC is evolving under environmental pressures in order to survive and will continue to do so.

\(^7\) CPT is the *Current Procedural Terminology*, a list of all evaluations and treatments recognized by the American Medical Association (and everybody else). More info is available at: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml

\(^8\) The Domenici-Wellstone Mental Health Parity and Addictions Equity Act of 2008 phases in parity between medical and behavioral health coverage over the next year. It can be circumvented in several ways. It does not apply to companies with fewer than fifty employees and companies which find their costs increase more than 1% can avoid implementing it. However it covers all MH diagnoses.
E. The Ethics of Managed Care Organizations

Summary: MC, as currently practiced, has no ethics to limit its actions. Its apparent only goal is to increase its profits at any cost to anyone else. It has no incentive to limit its refusal to pay decisions with procedures, training, or credentials.

1. MC has no ethics rules.
   a. No Code of Ethics or Conduct or similar guide is publicly available at this time—May 25, 2009. I have not been able to find on the Internet any Code of Ethics adopted by MCOs for themselves and their medical decisions, any enforcement mechanism for violations of such a code or any news stories in any medium of any case of violating such a code. I have not found any statement by any MCO on common ethical principles: beneficence, non-harm, autonomy of choice, responsibility to the patient or society.
   b. The organization of health insurers, the Association of Health Insurance Plans web site at http://www.ahip.org did not have any relevant entries when I searched for “ethics” on 3/6/09.
   c. There do not appear to be any ethics consultants or committees in MCO organizations.
   d. As a result MCOs have off-loaded ethical obligations from them onto providers. For example, many contracts contain Hold Harmless clauses - If clinician takes an action that has a bad effect and the client or heirs sue the clinician, the clinician will accept all responsibility for those actions and hold the MCO harmless for its actions. E.g. if a clinician believes a client needs more treatment but discharges the client because the MCO refuses to pay for more treatment and the client suicides the clinician agrees to accept all responsibility for those consequences and has no recourse to the MCO. Such clauses create conflicts between the clinician’s fiduciary responsibility, fidelity obligations to the MCO and the clinician’s self-interests. Refuse to sign contracts with hold-harmless clauses and find other MCOs to work for.

2. MC has no ethics mechanisms.
   a. There do not appear to be any mechanisms for data gathering, for enforcement of any kind, much less real consequences, or for developing guidelines.
   b. Because there is no self-policing, MC is not a profession despite its self-created credentials.
   c. There is minimal oversight of MCOs by states’ or the federal governments.

3. One ethical issue is accepting responsibility for the consequences of one’s actions.
   a. If one refuses to pay for a service one is effectively preventing it. One is making a clinical and professional’s decision but is neither.
   b. The consequences of decisions do not fall on MCOs unless they are sued or investigated by state’s attorneys general.
   c. Another ethical issue is **fiduciary responsibility**: this is the ethical requirement of professionals to put the patient’s needs ahead of anyone else’s, especially the MCO.

4. I think it is accurate to attribute many errors in payment, procedures, and paperwork to deliberate efforts to avoid paying providers and thereby increase the MCO profits - retained income. These errors are far too common to be due to chance, faulty procedures, or inadequate training. These are immoral and likely illegal violations of the contract between the MCO and the clinician.
   a. Americans in general are very trusting. We accept what someone says as true until we are shown that it is not by repeated failures. And even then we are quick to accept excuses and promises of change and to trust again.

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9 Let me be clear. I am not against making a profit, not even a very large one, when the benefit to those who pay me is great. I do believe businesses must attend to their bottom line (profits after costs) but I believe multiple bottom lines are important. In the socially aware for-profit world, you can have multiple bottom lines such as: Profit in dollars (after expenses); Benefit to your community, the less fortunate, etc.; Benefit to the living world; Benefit to your kids and future generations; Benefit to ________ (fill it in for yourself). Decisions are made in this model by addressing all bottom lines simultaneously.
b. We assume innocence until proven guilty. We assume that people tell the truth to us.

c. And as therapists, we are even more accepting of what we are told. We are not detectives.

d. We don’t feel comfortable labeling a group as liars, thieves, or idiots. We are very reluctant to believe that all MCOs and all of their actions are false, harmful, selfish, or evil.

e. All of this makes us very easy to exploit. MC executives and policy makers have taken advantage of our trust. We have been suckers, marks, fools, and victims of deliberate lies and false promises.

f. Exposés and court cases against MC have repeatedly demonstrated the deception and greed of policy makers at MCO. This does not mean that the utilization reviewers clinicians deal with at MCOs are also sociopaths, liars, or out to get us.

5. Instead of ethics, MCOs have focused on “quality” issues with the development of some simple (and therapy-irrelevant) measures of client satisfaction and providers’ performance (not MCOs’ performance) and some data analysis. See for example, http://www.ncqa.org/tabid/59/Default.aspx and HEDIS data.

Online resources about MC Health Administration Responsibility Project: http://www.harp.org/index.html#fad
Accessed May 20, 2009. Clearly anti-MC but with many reports and resources which are otherwise hard to collect.

F. Considerations for Managed Care Contracting

1. Joining an MC panel. Below is a list of “Considerations before Joining a Managed-Care System” from an article published in 1991 (Haas & Cummings). These options seem quaint given how managed care has come to dominate practice. However, they are listed here because they are still of concern even though they may no longer be choices clinicians can make often.

   a. Who takes the risks? The plan, the patient, the provider, the payer (employer, government), society?
   b. How much does the plan intrude into the patient-provider relationship? How much choice is left to the client in terms of choosing a clinician and to the clinician concerning services to be provided?
   c. What provisions exist for exceptions to the rules? For example, what can actually be done when coverage is exhausted?
   d. Are there referral resources if patient needs should exceed plan benefits? How can abandonment be avoided?
   e. Does the plan provide assistance or training in helping the provider to achieve treatment goals? This may seem quaint but why shouldn’t the MCO assist clinicians to learn short-term treatment methods which it requires?
   f. Does the plan minimize economic incentives to hospitalize patients?
   g. Are there ways in which the plan is open to provider input?
   h. Do plans clearly inform their policyholders of the limits of benefits? Clinicians in practice frequently encounter patients who overestimate their “benefits.”

2. You are likely to receive a letter inviting you to apply for a panel every so often.

   a. Never pay to join a panel. Such offers are a scam.
   b. Consider the paperwork involved at each step and routinely.
   c. These offers come from MCOs seeking to generate a list of providers so that they can then try to sell their services to employers in your geographical area. Do not expect to receive any clients for a long time, if ever.

3. All panels are “full” as far as the functioning MCOs are concerned.

   a. They may be willing to consider your application if you can offer some service they need but have no one on their panels who can offer the specific service or to a specific population they cover.
   b. They may consider your application if you are located in an area where they need more providers to service some particular client employer.
   c. Consider taking a referral as an out of network provider to see how the MCO works.
4. The nuts and bolts of MC billing. Below is reproduced a guide from Solutions in Practice Management, a billing service for mental health clinicians. Although I do not presently need their services, you can see from its practicality and comprehensiveness, the quality of its work. I reproduce it here because it is a more positive view of working with MC than my own and is obviously reality-based. I have slightly modified its format to be consistent with this project. Hire the smarts you don’t have.

Note: Rational ignorance. To make the best decision, we have to learn of all the possibilities, and the risks, benefits of each. But learning all of that takes time and energy - it has costs. So, when the cost of learning exceeds the most reasonable likely benefit of using the best solution, it is better not to learn. This is ‘rational ignorance.’

Solutions in Practice Management
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Part I: The “Why’s” and “How’s” of Managed Care Contracting

A. Why do Managed Care (MC) contracting?

1. The problems with a “fee for service only” business model:
   a. It limits your referrers.
   b. It creates roadblocks to providing care. Patients referred to the practice may decline services when the provider does not participate with their plan. When this happens, the patient goes elsewhere and the referral source is not served and discouraged from making further referrals.
   c. Participating with managed care companies eliminates these negatives to practice growth.
2. But, participation should be targeted and based on your patient demographic and the future direction of your practice.

B. How to do MC contracting

1. Correct any false assumptions and beliefs including these:
   a. “I need to participate with every MC company which has an open panels to ensure my practice fills up and will be successful. “
   b. “I must avoid MC work because they...”
   c. “MC dictates whom I see and how I deliver care.”
   d. “MC doesn’t pay very well so I won’t be financially successful If I participate with Managed care.”
   e. “MC doesn’t pay for the services I provide anyway (i.e. marriage counseling, psychological testing).”
   f. “So therefore, I need to build a ‘fee-for-service only’ practice in order to be successful.”

   Better belief: Clinicians should not feel they have to choose one way or the other. The next section is the framework for considering what will be best for the clinician’s unique practice.

C. Be thoughtful and selective

1. What is the minimum reimbursement you will/can accept and still meet all your expenses including your salary? This is your “nut” Always remember it.
2. Review each contract and evaluate the following:
   a. Fee schedule, with all options and details
   b. Authorization and re-authorization process. Complexity, skills needed, time requirements.
c. Reimbursement requirements (how will you be paid). For example, some EAP companies require that all services be rendered before the billing can go in, leaving the provider to bear the upfront expense of treating the patient. Also, some require a specific form. In most cases, claims are paid in 30 days from the date of receipt, but EAP companies may not follow this rule. Sometimes, contracts stipulate that the company has 8 weeks to pay claims/invoices.

d. Time limit for claims filing and delays in claims payment -- Companies may write into the contract that if claims are not received within 60 days from the date of service, the company is not obligated to pay the claim. All companies state they will pay “clean” (complete an accurate) claims in a timely manner. Contracts usually spell out what their responsibilities are if they do not pay a clean claim (usually they will pay some interest). Providers must know what the procedure is for resubmitting a corrected claim, the time limit for responding to requests for additional information, and the additional time allowance the company has to reprocess a claim. As you might guess, these are very complicated.

e. Number of insured lives in your geographic area as percent of total population. You would also like to know how many of your peers on the panel are taking new clients so you can have some idea of referral flows.

f. Are your local and preferred referral sources also providers/panelists for each MC organization?

g. What insurance companies are likely to insure/cover your potential patients and which MCOs do they use? For example, a provider that wants to work with young children and does not want to disenfranchise families of lower income, might consider contracting with a lower-paying MCO.

h. Are there any benefits such as free CE courses? Some MCO’s offer this. Other’s do not. This is incentive for the provider to accept and be comfortable with a lower reimbursement. It’s a good marketing strategy for the MCO).

3. Get exact definitions of all terms in a contract. If necessary, have your lawyer explain the contract to you.

D. Control your income by controlling your schedule - see below

Part II: Billing and Scheduling - Doing it right

A. Be prepared before the patient comes in.

1. Medical insurance vs. mental health insurance
   a. In most cases, the company that provides the mental health coverage is NOT THE SAME as the company that provides the patient’s medical coverage. This is called a “carve out.” MOST PATIENTS ARE UNAWARE OF THIS FACT. Generally MH coverage is at lower rate.
   b. Co-pays and patient out-of-pocket responsibilities vary with the services provided.
   c. The national “Parity Law” will gradually bring these two into parallel over the next few years.

2. Get the name and contact phone numbers for the mental health carrier. It is usually on the back of the patient’s health insurance card. Ask for it by phone call.

3. Verify the patient’s benefits and get an authorization – don’t make this the patient’s responsibility - they can’t or they won’t.
   a. A script and form are available by request. Make notes of all your calls.
   b. If they do not have any insurance or have minimal coverage explore options to full fee
      - Some coverages include out of network benefits. Typically, out of network coverage requires the patient to pay a higher out of pocket amount.

4. Ask the insurance representative if the copayment from the patient is the same for all services you might provide (i.e. alcohol and substance abuse, testing, family therapy vs. individual therapy).

5. Be sure you have received a physical authorization before you provide services.

6. Confirm appointments 24-36 hrs prior to minimize no shows. Even with 48 hrs, patients tend to forget. Also inform patients that if they cancel when they receive this confirmation-of- appointment call, this will be considered a "late cancellation" and a fee may apply.
B. At the time of the appointment:

1. The name and contact phone number for the Mental Health carrier is usually on the back of the patient’s health insurance card.
2. Review coverage (“benefits”) with the patient.
3. Review how much they will need to pay at each session.
4. Review your practice’s financial policies verbally with the patient. AND what your fees are if they do not show or cancel late. THEN have them sign the acknowledgement of financial responsibility.
5. Collect all fees before you start the session.
6. Schedule the patient for follow-up/create several standing appointments to:
   a. Minimize no shows.
   b. Keep your schedule full.

C. At the end of each day:

1. Prepare and mail/send out the billing information. Frequent billing evens out cash flow and catches problems earlier.
2. Prepare and mail/send authorization/re-authorization requests. NOTE: An authorization to request records IS NOT the same as an authorization for services.

D. Choose one or more billing options to suit your practice.

1. Most insurance companies accept the CMS 1500 for reporting services.
2. Some insurance companies require a company-generated billing form. This is usually limited to reporting EAP services.
3. Electronic billing via a claims clearinghouse using Practice Management software vendor.
4. Submitting claims using the carrier’s website.

E. Track claims:

1. Track the number of authorized visits used.
   a. Allow plenty of time to receive confirmation of re-authorization from the carrier.
   b. Keep track using a form in the patient’s chart.
   c. Keep track using computer database or spreadsheet.
   d. Record the date, name of the person and number of the authorization and re-authorization as soon as arranged.
2. Options for tracking claims payments received:
   a. Provider-developed manual systems.
   b. Computer-assisted systems.
   c. “Practice management” software and its Accounts Receivable (AR) reports.
   d. Follow-up any unpaid/unprocessed claims within 30 days (A script is available from us).

F. Understand the Explanation of Benefits (EOB) sent to you.

1. Each EOB format is carrier-specific.
2. Basic information on all EOBS:
   - Patient’s name and some portion of the ID #
   - CPT code
   - Total allowed amount (contracted rate)*
   - Deductible
   - Date of service
   - Total charge
   - Copay/Co-insurance amount
   - Payment amount
*Infrequently, claims will process with an inaccurate rate. It is good practice to know the contracted rate with each carrier. Contact the carrier immediately if a claim is processed incorrectly.*

3. Understanding denial/rejection codes.

G. What to do if a claim is not paid:

1. Don’t get frustrated and give up.
2. Call the carrier to determine why the claim was not paid.
3. Request the claims be reprocessed if possible (internal resubmission) otherwise find out how the carrier would like the claim information to be re-sent.
4. Denied/Rejected claims – Who is responsible for paying for the service?
   a. Claims denied for authorization issues – provider is usually responsible and the patient cannot be balance billed.
   b. Claims denied for timely filing – provider is responsible and the patient cannot be balance billed.
   c. Claims denied for pre-existing, condition exclusions, number of visits reached, patient not eligible at the time of service, etc. – the patient is responsible and the provider can bill the patient the full practice fee for the service.

H. Still have questions? Call SIPM – 866-441-7504

1. SAMPLE FORMS - Available upon request:
   o Patient registration/intake form
   o Progress Notes
   o Authorization to Release Information

2. SCRIPTS - Available upon request:
   o Benefits Verification script
   o Claims follow-up script

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**VII. The Legal and Ethical Issues in Working with MC**

*Read this quotation; do not skip it. You will be wiser.*

Awareness of ethical codes and legal standards is important, but **formal codes and standards cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities.** Codes and standards inform rather than determine our ethical considerations. They can never substitute for thinking and feeling our way through ethical dilemmas, and cannot protect us from ethical struggles and uncertainty. Each new client, regardless of similarities to other clients, is unique. Each therapist is unique. Each situation is unique and constantly evolves. Our theoretical orientation, the nature of our community and the client’s community, our culture and the client’s culture, and so many other contexts influence what we see and how we see it -- every ethical decision must take account of these contexts. Standards and codes may identify some approaches as clearly unethical. They may identify significant ethical values and concerns, but they cannot tell us what form these values and concerns will take. They may set forth essential tasks, but they cannot spell out the best way to accomplish those tasks with a unique client facing unique problems in a specific time and place with limited resources (Pope and Vasquez, 2007).
In the psychological phenomena we engage with every day an array of competing forces are at work. We practitioners work inside and as part of a “force field” of pressures, forces, and influences all simultaneously pulling on us and our practices. The result can be conflict, compromise, or denial among priorities and loyalties because the forces do not align. We will explore these now.

**A Field of Forces Pressing and Pulling on the Clinician**

![Diagram showing a field of forces pressing and pulling on the Clinician](image)

Competing forces are very like a multiple relationship in which each role has different expectations, requirements, and demands.

... issue of ethical importance concerns **divided loyalties**. Third-party payment arrangements always elicit such issues, but never so clearly as in managed mental health care plans. The **principal of fidelity** (Beauchamp & Childress, 1988) demands that the provider or professional be loyal to those with whom he or she has a contractual relationship. Thus, if a therapist agrees to work in a managed health-care program, he or she should believe in the service philosophy it endorses. If the therapist agrees to work with a particular patient, he or she should be loyal to that patient's interests (this is part of what is meant by a **fiduciary** relationship) (Haas, 1991).

**A. Loyalty to the best interests of the client - the welfare of the consumer**

1. **Confidentiality** is unlikely to be preserved (see VII, B, 1 for more details)
   a. Managed care companies, although they are CEs under HIPAA have not been investigated for “unauthorized release of PHI” when PHI sent to them is “not received in this office.” Instead, HIPAA investigations have focused on fraud and lost laptop computers. **HIPAA enforcement statistics** have been made easily available to us by Dennis Melamed at [http://www.melamedia.com/StatsSubscribe.htm](http://www.melamedia.com/StatsSubscribe.htm) - Accessed May 22, 2009. Free registration required.
b. Re-disclosure is allowed by HIPAA. Provider A can forward records received from provider B to provider C without additional releases. However, state laws are often more “stringent” in protecting privacy and so are deferred to by HIPAA.

c. Your state’s laws and specifically those of your profession also should affect your practices in releasing records.

2. Services needed by your clients may not be covered by their MC contracts.

a. Many kinds of services may be needed but not covered by MC. For example, hospitalization avoidance programs were successful in the past - replacing high-cost inpatient service with lower cost intensive outpatient care and preventing unnecessary and stigmatizing inpatient care. If your clients can use such services you really should join your peers in political actions to push for more covered services/different services.

b. Specialized evaluations may be beneficial but not covered e.g. educational, vocational, or neuropsychological evaluations.

c. Marital and relationship counseling is rarely covered despite its health values and personal benefit.

3. Services that are covered may not be available.

a. Psychiatrists’ services are often unavailable because a majority of psychiatrists have opted out of managed care panels.10

b. Due to “Phantom panels” psychiatrists are rarely available. Most in practice have left the MC panels11 and so the lists of panel members produced by the MC organizations contain large numbers of names who are no longer providing services and not available. See: http://www.division42.org/MembersArea/IPfiles/Fall04/prof_pract/holstein.php and also: http://www.psychiatricnews.org/pnews/00-11-03/its.html Of course, MCOs have no financial incentive to maintain such panel lists correctly and strong reasons to show long lists to prospective purchasers of their services.

4. Services may be covered and available but denied as not medically necessary.

a. Denial of hospitalization when a highly unstable or complex case needs respite or clarification through consultation, period without meds, etc.

b. Denial of sufficient hospital time to resolve the crisis or stabilize the patient.

c. Appealing denials:

- Formally appealing an MC denial of services you judge necessary is usually unsuccessful but your ethical and legal obligations (Wickline12) to the patient may compel you to make these appeals.

- For some, appealing all denials on principle is a proper path and for others appealing only some based on clinical judgment is proper.

- Questions for the clinician:
  - Is it possible to discover if the MC is denying a percentage or using some rules? If rule-driven, can you learn the rules?

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10 According to Moran (2004) 52% of psychiatrists have been able to opt out of managed care. For a more current but personalized report see Siegel, (2009).

11 Psychiatry Leads Specialties in Opting Out of Managed Care. Psychiatric News, September 1, 2006. Volume 41, Number 17, page 13. “A report from the Center for Studying Health System Change (HSC) released in May notes that the percentage of physicians who do not have contracts with any managed care plans has taken its first jump after remaining stable for a number of years—from 9.2 percent in 2000-2001 to 11.5 percent in 2004-05.”

"... according to the HSC survey, 34.6 percent of psychiatrists have chosen to opt out of managed care. This contrasts with 9.4 percent of primary care physicians and 10.5 percent of all medical specialists.”

“... more experienced practitioners may have a patient base and reputation enabling them to bypass managed care plans.

12 The famous case Wickline vs State of California (239 Cal. Rptr. 810 [Ct. App. 1986] taught that denial must be appealed in order for the MCO to be held responsible for later negative consequences. However, consult your lawyer.
5. Services may be covered, available, and allowed but not clinically needed.
   a. MC may require a medication assessment and then push for med prescriptions.
   - Even when the patient has good reasons for not wanting medications they are required.
   - Even when the meds have been shown ineffective or minimally effective. The below are generalizations but supported by the literature which makes generalizations.
   - Meds have not been shown beneficial for personality disorders. Meds for children have not been shown to be effective except for stimulants. Even stimulants for ADHD are less effective at six month follow-up than psych interventions. Meds for dementia are very minimally effective. SSRIs are not more effective than the older and cheaper tricyclics. Feel free to add additional cautions.
   - Even when the meds will be costly to the client (in co-payments). The offering of “free samples” until a script is filled raises clients’ costs because the only samples offered to prescribers are of the latest and most expensive meds which are then continued. (Pho, 2009)
   - Even where meds have been shown to be effective for a diagnosis the research support for psychotropics includes too much variation in choices of design, criteria for entry, outcome measures, and ties of the researcher to the funding pharmaceutical company which raise questions about the value of the findings.
   - Even when the meds available in the formulary may not be the best for the client.
   - And side effects are not weighed into the risks of requiring meds.
   - Non-compliance/non-adherence. Due to side effects, cost, or regimen complexity and forgetting meds are very often discontinued before a fair trial has occurred. How long is needed for SSRIs? How often should the dose be raised if ineffective?

Advice: Dan Egli, PhD (Personal message, 5/3/09): suggests that antidepressants take at least one month on average to show benefits. Dosages should be raised every 2-3 weeks if not effective. Each SSRI for anxiety or depression should be tried for at least one month (if they do not have to be changed due to side effects) at full doses before deciding it had no effect or partial effect and then considering a different SSRI.

   b. Frequent updating and revision of treatment plans is not clinically beneficial.
   c. Add your own examples here:

B. Loyalty to the viability of your practice.

1. If managed care referrers are a major source of a clinician’s income the following could lead to receiving fewer referrals (being kept on a panel but not used) or being dropped from a panel (“no-cause termination” which is very likely allowed in your contract. Read it):
   a. Refusing a case referred to you by MC or an insured person’s calling you for an appointment when you have valid reasons for refusing the case.
   b. Asking for more sessions than allowed in the first authorization but still allowed by the contract.
   c. Arguing for more or different kinds of treatment.
   d. Arguing for consults or evaluations.

2. A retrospective review of MC authorized payments is likely to lead to MCs requesting a refund or threatening to take the money out of the practice’s future payments.
3. Fees which have not been raised in proportion to the cost of living effectively lower the practitioner’s income. Gordon Herz, PhD, of Madison, WI has documented (2009) the facts and numbers and explained what and why these patterns have occurred. He also explains what must be done for independent practice to survive:

“Given what is known about increases in health care premiums, increases in out-of-pocket expenses for consumers, and increases in the overall costs of health care, it is clear that reimbursement to evaluate a person with a mental health diagnosis continues to be artificially suppressed in the managed care environment, even in relation to cost-contained increases seen in the public sector.

The same is occurring for the reimbursement for doctoral provision of psychotherapy (see Figure 2). Ten years ago, actual UCR [Usual, Customary, and Reasonable charge] was $148 for psychotherapy (PMIC, 1999). Based on that value, the consumer price index estimates the value would have peaked at about $191 in 2008 dollars, an increase of about 29%. During the same time period, reimbursement for psychotherapy decreased by 6 to 14%, possibly as much as 33%, if figures for 2008 – reflecting almost 15,000 actual claims paid – are representative (CarePaths, Inc., 2008).”

**Managed Care Reimbursement for 45-50 Minute Psychotherapy**
**Compared to Changes in Consumer Price Index (CPI), Actual Charges Submitted (Real UCR), and Medicare**

![Image ofManaged Care Reimbursement for 45-50 Minute Psychotherapy](image)

4. Here is very similar data in a different form (source unknown to me).

Inflation estimates and effect on psychological fees.

**Fee charged for one hour of psychotherapy (90806)**

<table>
<thead>
<tr>
<th>Year</th>
<th>COLA(1)</th>
<th>Fee with COLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>3.1%</td>
<td>$82.48</td>
</tr>
<tr>
<td>1986</td>
<td>1.3%</td>
<td>$83.55</td>
</tr>
<tr>
<td>1987</td>
<td>4.2%</td>
<td>$87.06</td>
</tr>
<tr>
<td>1988</td>
<td>4.0%</td>
<td>$90.54</td>
</tr>
<tr>
<td>1989</td>
<td>4.7%</td>
<td>$94.80</td>
</tr>
<tr>
<td>1990</td>
<td>5.4%</td>
<td>$99.92</td>
</tr>
<tr>
<td>1991</td>
<td>3.7%</td>
<td>$103.62</td>
</tr>
<tr>
<td>1992</td>
<td>3.0%</td>
<td>$106.72</td>
</tr>
</tbody>
</table>
1993 2.6% $109.50
1994 2.8% $112.56
1995 2.6% $115.49
1996 2.9% $118.84
1997 2.1% $121.34
1998 1.3% $122.91
1999 2.5% $125.99
2000 3.5% $130.40
2001 2.6% $133.79
2002 1.4% $135.66
2003 2.1% $138.51
2004 2.7% $142.25

**Actual Managed Care Allowable for this service= $75 ?**

**Fee for a full psychological testing battery in 1985 (2)**

<table>
<thead>
<tr>
<th>Year</th>
<th>COLA(1)</th>
<th>Fee with COLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>3.1%</td>
<td>$773.25</td>
</tr>
<tr>
<td>1986</td>
<td>1.3%</td>
<td>$783.30</td>
</tr>
<tr>
<td>1987</td>
<td>4.2%</td>
<td>$816.20</td>
</tr>
<tr>
<td>1988</td>
<td>4.0%</td>
<td>$848.85</td>
</tr>
<tr>
<td>1989</td>
<td>4.7%</td>
<td>$888.74</td>
</tr>
<tr>
<td>1990</td>
<td>5.4%</td>
<td>$936.74</td>
</tr>
<tr>
<td>1991</td>
<td>3.7%</td>
<td>$971.40</td>
</tr>
<tr>
<td>1992</td>
<td>3.0%</td>
<td>$1,000.54</td>
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<tr>
<td>1993</td>
<td>2.6%</td>
<td>$1,026.55</td>
</tr>
<tr>
<td>1994</td>
<td>2.8%</td>
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<td>1996</td>
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<tr>
<td>1997</td>
<td>2.1%</td>
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<tr>
<td>1998</td>
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<td>2001</td>
<td>2.6%</td>
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<tr>
<td>2002</td>
<td>1.4%</td>
<td>$1,271.81</td>
</tr>
<tr>
<td>2003</td>
<td>2.1%</td>
<td>$1,298.52</td>
</tr>
<tr>
<td>2004</td>
<td>2.7%</td>
<td>$1,333.58</td>
</tr>
</tbody>
</table>

**Actual Managed Care Allowable for this service= $300 or less**

5. And some more data for comparison:

**U.S. Medical Cost Inflation 1999-2008**

Source: U.S. Bureau of Labor Statistics

1999 = 3.50%
2000 = 4.1%
2001 = 4.6%
2002 = 4.7%
2003 = 4.0%
2004 = 4.4%
Cumulative U.S. Medical Cost Inflation
1999-2008 = 50.30%

From http://www.halfhill.com/inflation.html  Note: This page kept crashing my browser. Accessed June 3, 2009

6. Seeing twice as many patients for half-fee is much more demanding (and for our purposes here, more risky) than seeing half as many at full fee.

7. Accepting a lower fee leads to lower fees for all professionals.

C. Loyalty to the quality of the services you offer

1. You may not be the best treater for this client or his/her problems and should refer but will lose the income. Seeing every referral will exceed your areas of competence.

2. You may have to under-treat a fragile or dangerous person.

3. You may not have the sessions needed to form a therapeutic alliance. Without that leverage your other therapeutic efforts may have little to no impact. Citation: For example, “The data also suggested that patients who had a poor initial response to treatment eventually had positive outcomes, provided that they remained engaged in treatment. This finding suggests that outcomes can be improved by identifying at-risk patients and proactively keeping them engaged in treatment” Brown & Jones (2005).

4. MC’s therapeutic aim is only to return clients to their previous level of functioning; their supposedly premorbid condition. There are no expectations nor support for full relief of symptoms, for growth or relapse prevention.

5. Having to continue to see a client whose benefits have been exhausted (and so you will not be paid more) may exhaust you or cause premature termination.

6. Completing excessive paperwork and phone calls takes time away from clients and yourself. Citation: A recent survey by an independent organization found physicians have to spend 3 full weeks per year of their time on MC (along with nurses and clerical who spend a much higher percentage) (Casalino, et al., 2009. At http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w533 ) and have to hired a 2/3 time clerical per physician to help (Sakowski, et al. 2009. At http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w544 ).

7. Becoming dependent on a supply of referrals which can easily be cut off will lead to anxiety. Such anxiety may distort your work decisions.

8. Although this is not yet applied to therapists it is true for physicians and so it may happen to therapists: Becoming dependent on incentives from MC to “successfully treat” an increasing percentage of clients in “fewer than eight sessions” will not likely increase the quality of your services.

9. Professional ethics
   a. The principle is beneficence or non-malfeasance - doing good and avoiding harming. Primum non nocere - At least, do no harm. This means that it is sometimes better to do nothing than something that may cause more harm than good. Clinical implication? Your work must be better than no treatment. For example, most (dysthymia? reactive?) depressions recover in 6-12 months without treatment. So just keeping a client in treatment will give you a, say 75% cure rate. Therefore, to charge for your services, ethically, you must produce faster, better, more thorough, beyond-recovery, etc. outcomes.
   b. But, if you cannot cure but can palliate, ameliorate, or preserve a quality of life, then Primum succurrere – “First, hasten to help” – is more appropriate.
D. Loyalty to your profession

1. The research does not support the effectiveness of extremely brief treatment (say 8 to 12 sessions) for most cases as often allowed by MC so you are not applying the best treatments (unless you are faithfully using brief treatment approaches which have been validated for effectiveness on the kind of client and the kind of problems presented). While many clients report improvement in morale and energy after the first few sessions (This has been called the flight into health. For more see Frick, 1999. Abstract at http://jhp.sagepub.com/cgi/content/abstract/39/4/58). But this is found even in placebo treatments and cannot be attributed to receiving therapy. Longer term analyses do not show symptom improvement without therapy.

2. Many effective specialized treatments have been developed (e.g., Dialectical Behavior Therapy) but require approaches and efforts that MC’s will not cover. Generic/standardized payment schedules won’t cover your costs of providing these. Part of the business case for MC is to standardize treatments (as well as providers). The claim is that by doing so all services will be at the highest level. Does this seem possible given monetary constraints?

3. Presenting too-limited treatment as normal and even adequate treatment lowers outcomes and so lowers the value and impact of the therapy which we can offer. The public, seeing poor outcomes, will lose confidence in our ability to help.

4. Seeking approval from those with less knowledge than you is demeaning of your profession’s standards. For example, having your well thought-out treatment plans for a complex case denied by those who do not understand it.

5. To MC all “providers” are interchangeable and identical. In being lumped along with others with different training, skills, approaches, etc. you are losing your professional identity and its undermining its value.

6. Refusing to participate in MC results in being unable to treat many whom could benefit from your skills. This abandoning of the needy is contrary to our professions’ value systems.

E. Based on your knowledge and experience - add more issues or concerns.

And please email them to me at edzuckerman@gmail.com for discussion.

VIII. Coping with the Legal and Ethical Issues in Working with MC

A. Overview

(1) MCO have no scruples or ethics at present, but you do. All the ethical responsibilities of patient care have been off-loaded onto those with ethical obligations.

(2) Pretty much the only game in some towns, so acknowledge the issues and learn to live with the limitations. Play a bad hand you have been dealt well or move on to another game.

(3) Caveat emptor - let the buyer beware - applies when you buy into the MC system. It is their game and they make the rules.

B. Review of the problem areas

Some legal, ethical, professional concerns highlighted in MC work are:

1. Confidentiality is threatened by:
a. The permanency of records. Future applications for other insurances and other presently-unknown uses will have access to this data.
   i. It is likely that all medical records will become Electronic Medical Records (EMRs) or Electronic Health Records (EHRs, preferred for its more comprehensive meaning) available in computerized systems and some subpart (or with a different focus) will become Personal Health Records (PHRs) in the possession of the patient.
   ii. Confidentiality is threatened by EMRs because:
      - MH records will be merged with others without the higher protections.
      - Information in EHRs is simplified to categories/codes.
      - Information can be inaccurate and incomplete because it is based on selective data. For example, it may be based on services billed such as lab tests but not on diagnoses made.
      - Thus if you were tested for a condition, that condition will be recorded in your record despite the test finding of the absence of the condition. Here is a famous example of these errors:
        Accessed June 3, 2009
      - Although procedures will be developed for their confidential disposal it is much simpler just to keep them forever.
      - EHRs will be kept at multiple locations to ensure their availability.
      - Paper and phone have legal protections not extended to EHRs.

b. The sharing information with MCO reviewers on paper or fax, phone, email, etc. Intakes, treatment plans, progress notes, closing summaries, consultations, testing reports, questionnaires, etc. The ability of MCOs to assure confidentiality is unknown. Since HIPAA rules are not being enforced, there is no incentive to spend money on methods or training to secure records.

c. Lost records - “never arrived” at the MCO.

d. Access by the client’s employer when the employer is self-insured or by the human resources department or by the Employee Assistance Program (EAP).

e. Access by the client and subsequent distribution.

2. Getting fully informed consent about all the relevant issues is difficult. See 3 to 6, below.
   a. Long-term effects: Future effects on insurability and costs.
   b. Confidentiality: Who will be allowed to know of the therapy, of notes’ contents, diagnosis, progress, etc.?
   c. Limitations on treatment in the various contracts.

      - Dose\(^\text{13}\) (frequency, number, length of session).
      - Limitations on methods.
      - Limited providers.
      - Treating conditions which do not have a recognized treatment with short term therapy.
   b. Additional treatment sessions are denied when they are reasonably expected to be productive.
   c. The clinician has continuing responsibilities at financially-compelled terminations.
      - Temptation to rationalize away continued need: “A vacation,” “try it with out training wheels,” “meds are enough”
      - Continue treatment pro bono?
      - Terminate?

• Refer?
• Cream and dump\textsuperscript{14} leads to premature termination, or a sudden full-fee burden.
• Continue to see as private-pay patient? (This may be forbidden by the MC contract)

d. Enforcing the client’s responsibility to pay.
• Collecting co-pays on all patients or infrequently but with careful documentation of rationale for not doing so.
• Energetic and respectful collection methods.

e. Finding and arranging covered specialized treatment and referrals. Specialists may not be available on a MCOs panels.
• MCO’s requirement for medications (Note: Requiring a referral for medications is not the current practice in PA.)

4. Quality of services
a. All providers are equivalent (not equal) and therefore interchangeable (replaceable, fungible) so:
• Any provider can treat any diagnosis.
• Any provider can provide any treatment.
• All treatments are equivalent.
• Any provider can treat even the most complex problem.
• Any provider can treat a treatment-resistant client.
• So the client can be transferred to the cheapest provider.
• There is no need to fund or provide more skills, training, expertise or change treatments offered. (Note: “I don’t know of any healthcare or consulting service (other than managed care) that touts that their practitioners provide the same service regardless of experience and training.” Elizabeth Carll, PhD, Long Island, NY. Posted to Div. 42 List May 29, 2009 and reprinted with permission.)

b. Poor quality services which cause clients to drop out of treatment are profitable to MCOs because, by paying out less money to treaters, more of the premiums they received are retained as profit. This is an inherent conflict of interest between the goal of paying for health care and a profit-based health care system.

c. Decision making on inadequate information. MCOs may require a diagnosis and treatment plan before adequate time is made available to do a meaningful assessment at intake and the MCO may decide on the parameters of treatment on the basis of that incomplete or inaccurate information.

d. Financial and contractual pressures on a clinician to treat all referrals.

e. No requirement for competence in time-sensitive treatment methods.

f. No rational basis for treatment selections. Questionable or harmful treatments are allowed and effective treatments are not required.

5. Billing issues
a. Changing the diagnoses to reimbursable ones.

b. Supplying a least pathological diagnosis because of permanent records and future employment, insurances despite its being inaccurate.

c. Ignoring personality diagnoses despite their importance.


e. Intrusive and arbitrary practice audits by the MCO.

f. Retroactive denials by the MCO and financial losses to the clinician.

6. MCOs have offloaded the financial risks from themselves to the providers.

a. The clinician must accept the losses from unpaid bills because of plan changes, inaccurate information given by the MCO on coverage, failure of client to pay their copayments, etc.

\textsuperscript{14} This is the practice of seeing clients until their insurance runs out and abandoning them. They may be cases needing extensive treatment or those who could be terminated earlier but are kept in treatment.
b. Billing the patient for the difference between what MC will pay and the clinician’s usual fee - called balance billing - is almost always prohibited by the contract with the MCO for panel members but those out of network providers can often bill for the difference. Some states preclude this but it is common in health care and is a continuing conflict. Physicians attribute the need for balance billing to systematic underpayment for services by MCOs and quite deliberate decisions by MCOs regarding emergency care (ACEP, 2009).

c. The clinician must agree to provide any needed care after coverage runs out. In some cases the clinician is forbidden even to accept payment for such services when the patient can pay.

d. It is the clinicians’ responsibility to collect co-payments which are devised and set by the MCO.

e. The clinician must often seek permission from the MCO to provide and be paid for (by the client) even for services the MCO refuses to pay for - non-covered services. See ABN in the Citations.

7. Low fees

a. Fees get lower over time due to inflation, competition of providers, fiat by MC, closing off of other employment options for providers, etc.

b. MC pays only for services provided and not the costs of billing, supervision, for consults, for second opinions, for CEs, for training all of which are part of healthcare.

8. MCOs have enormously increased the burden of paperwork through micromanagement

a. Re-credentialing

b. Authorizations, Certification, Pre-certification, verification of coverage, tracking sessions, appeals, etc.

c. Treatment plans and reviews of them.

d. Intrusive, irrelevant and unused information gathering - demographics, intakes, insurance and income information, extensive histories (medical, educational, vocational, family, social history, birth circumstances, etc.), progress notes with other information, etc.

e. Client questionnaires and surveys required by MC.

C. Coping I: Issues --> Tactics and strategies for coping

We are all faced with a series of great opportunities brilliantly disguised as unsolvable problems.
- John William Gardner

Below each issue is presented paralleled by some ways of addressing the issue.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Response/Tactic/Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Getting fully informed consent for treatment under MC.</strong></td>
<td><strong>Consenting</strong>(^{15}) is a continual process so negotiate. See Nuts and bolts section.</td>
</tr>
<tr>
<td>a) Re MC limitations on treatment quantity, diagnoses, payments, future impacts.</td>
<td>Discuss and get agreement BEFORE providing services. Make continual notes on issues of limitations. Use the <em>Advance Beneficiary Notice of Non-coverage</em> (ABN) form and contract when you believe insurance will not cover the services. See the References. Use patient education handout(s). Read, review and discuss.</td>
</tr>
</tbody>
</table>

Following is a two page handout listing the major limitations on treatment imposed by MCOs. Before you use it, read it carefully so that you can explain the issues in more detail and modify it to suit your practice, procedures, clients, and

\(^{15}\) While “informed consent” is the most common term, in psychotherapy where the relationship is primary, the doctor/patient hierarchy is down played, and the services continual rather than discrete, a better term would be “informed collaboration.”
principles. Permission to copy and tailor it to your practice is granted. You may remove the copyright notice.
What You Should Know about Managed Care and Your Treatment

Your health insurance may pay part of the costs of your treatment, but the benefits cannot be paid until a managed care organization (MCO) authorizes this (states they can be paid). The MCO has been selected by your employer, not by you or me. The MCO sets some limits on us, and you need to know what these are before we go further.

Confidentiality

If you use your health insurance to help pay for psychotherapy, you must allow me to tell the MCO about your problem and give it a psychiatric diagnosis. You must also permit me to tell the MCO about the treatment I am recommending, about your progress during treatment, and about how you are doing in many areas of your life (functions at work, in your family, and in activities of daily living). I am not paid separately for collecting, organizing, or submitting this information, and I cannot bill you for these services. All of this information will become part of the MCO’s records, and some of it will be included in your permanent medical record at the Medical Information Bureau, a national data bank that is not open to the public including you or me. The information will be examined when you apply for life or health insurance, and it may be considered when you apply for employment, credit or loans, a security clearance, or other things in the future. You will have to indicate that you were treated for a psychological condition and release this information, or you may not get the insurance, job, loan, or clearance.

All insurance carriers claim to keep the information they receive confidential, and there are federal laws about its release. The laws and ethics that apply to me are much stricter than the rules that apply at present to MCOs. There have been reports in the media about many significant and damaging breaches of confidentiality by MCOs. If you are concerned about who might see your records now or in the future, we should discuss this issue more fully before we start treatment and before I send the MCO any information. You should evaluate your situation carefully in regard to confidentiality. For some people and some problems, the privacy of their communications to their therapist is absolutely essential to their work on their difficulties. For others, their problems are not ones that raise much concern over confidentiality.

Treatment

The MCO will review the information I send it and then, basically, decide how much treatment I can provide to you. The MCO can refuse to pay for any of your treatment, or for any treatment by me. Or it may pay only a small part of the treatment’s cost, and it can prevent me from charging you directly for further treatment even when we agree to it. Finally, it can set limits on the kinds of treatments I can provide to you. These limited treatments may not be the most appropriate for you or in your long-term best interest. The MCO will approve treatment aimed at improving the specific symptoms (behaviors, feelings) that brought you into therapy, but it usually will not approve any further treatment. The MCO will sometimes require you to see a psychiatrist for medication evaluations (and prescriptions), whether or not you or I think this is appropriate.

When it does authorize our treatment, the MCO is likely to limit the number of times we can meet. Your insurance policy probably has a maximum number of appointments allowed for outpatient psychotherapy (usually per year, though there may be a lifetime limit as well), but the MCO does not have to let you use all of those. It may not agree to more sessions, even if I believe those are needed to fully relieve your problems, or if I believe that under-treating your problems may prolong your distress or lead to relapses (worsening or backsliding).
If the MCO denies payment before either of us is satisfied about our progress, we may also need to consider other treatment choices, and they may not be the ones we would prefer. We can appeal the MCO’s decisions on payment and number of sessions, but we can only do so within the MCO itself. We cannot appeal to other professionals, to your employer, or through the courts. This state does not have laws regulating MCOs — that is, laws about the skills or qualifications of their staff members, about limiting access to medical and psychological records by employers and others, or about the appeals process.

You should know that my contract or your employer’s contract with a particular MCO prevent us from taking legal actions against the MCO if things go badly because of its decision. My contract may prevent me from discussing with you treatment options for which the MCO will not pay. I will discuss with you any efforts the MCO makes to get me to limit your care in any way.

The particular MCO in charge of your mental health benefits can change during the course of your treatment. If this happens, we may have to go through the whole treatment authorization process again. It is also possible that the benefits or coverage for your treatment may change during the course of our therapy, and so your part of the costs for treatment may change.

Lastly, even if we send all the forms and information to the MCO on time, there may be long delays before any decisions or payments are made. This creates stressful uncertainty and may alter our earlier assumptions about the costs and nature of your treatment.

Our Agreement

If, after reading this and discussing it with me, you are concerned with these issues, you may have the choice of paying me directly and not using your health insurance. This will create no record outside of my files. This possibility depends on my contract with your MCO.

I have read and understood the issues described above and willingly enter treatment accepting these limits. I give my therapist permission to submit information in order to secure payment for the mental health services to be provided to me.

- Yes, I want you to:
  - notify me and review with me or
  - send me copies of any written materials you send to my MCO.
- No, that is not necessary.

___________________________________ ________________________________________ _________________
Signature of client Printed name of client Date

HANDOUT 3. Patient handout for education about/informed consent to managed care. From The Paper Office. Copyright 2008 by Edward L. Zuckerman. Permission to photocopy this handout is granted to purchasers of this book for personal use only in their practices.
Relevant research: Does explaining the limitations and procedures of MC affect client’s views and participation in therapy? Perhaps a fully informed client can participate more freely knowing the facts? The effects of informing prospective clients of these limitations were evaluated by Andrew Pomerantz (2000). When informed of the issues like those presented here and told of a potential therapist’s views on these issues the “participants were significantly more likely to believe that managed care would have a negative impact on treatment and significantly less likely to see an independent practitioner, use insurance benefits, expect to benefit from treatment, expect a strong working relationship, and trust that the practitioner would work in their best interests.” Do recognize that these were college students and not persons suffering and seeking treatment, that there was no discussion and negotiation, and that no benefits were discussed.

Threats to Confidentiality:

a. Permanent records:
   - Record minimal content.
   - Use abbreviations, acronyms, initials.
   - Use of idiosyncratic terms and references.
   - Omit content irrelevant to present treatment.

b. Sharing information with reviewers:
   - Discretion because they have no confidentiality rules.
   - “Discretion is the better part of valor.” Valor: strength of mind or spirit that enables a person to encounter danger with firmness. Personal bravery.

c. Lost records:
   - Send stuff Certified Mail, with Return Receipt or even with Restricted Delivery (to a single person).
   - Confirmed fax delivery is available.
   - Use online bill submission programs.

d. Sending Progress Notes:
   - Discretion - review and black out sections?
   - Redact notes.
   - Use MC’s forms when they are less revealing.

e. Access by employer when ERISA (self-insured):
   - Check contract for what info you agreed to provide.
   - The EAP should keep separate files from employers, provide employer with only statistical information.

f. Access by client and distribution:
   - Use only Authorizations - do not rely on HIPAA’s “Consent” form.
   - Do your discussions/explanations during session.
   - Make clear statement of the limits of your responsibility.
   - Warn of the end of HIPAA protection.
   - Copies sent to a lawyer are no longer protected.

g. MCs requirement for data on client’s functioning in all areas of life:
   - Discretion
   - Share with the client the forms MC will want to have completed.
   - Share the completed forms with client. Consider adopting as your policy that “Nothing about you leaves this office without your knowledge, understanding, and approval.”
h. Explain the limits of confidentiality before anything risky is shared with you; it cannot be unsaid or unheard.
   - Never promise unconditional confidentiality unless you are willing to face the legal and practical consequences.

**Threats to Treatment**

a. Constraints on treatment “dosage” number, frequency, length:
   - Review approvals, contract, forms, etc. and inform the client.
   - If the policy/coverage/insurer changes during an episode of treatment, new authorizations, etc. will be needed and coverage may change or need to be negotiated. Arrange your tickler to ask about changes at least quarter-yearly.
   - The MCO may simply change its rules and procedures. Read every message from the MCO and on their emailing lists.
   - When one MCO buys another the rules may change. You may not be told of such changes until after you have billed using the old methods and they have refused to pay you. Join and use the email lists of your profession and state because with concerted actions rules can be rescinded and options clarified.
   - Treat diagnoses which lack an accepted brief therapy approach? Refuse case? Refocus treatment?
   - Constraints on methods. No coverage for: clinical hypnosis, parent coaching, the non-married couple, school visits to observe and consult, etc. Others?

b. Additional needed treatment sessions:
   - **Appeal all denials unless the contract is clear on the number of sessions covered.**
   - You may win 90% as MC may have no rationale for the denial. Appeals will require several follow-up calls and pursuing the claim.
   - If the client or employer is going to contact the MC or the carrier they should know that you have done your part and filed an appeal of the denial. Also, the MC may require that you file and appeal before going to any next steps.
   - It may be possible to exchange covered inpatient days for outpatient sessions. Ideally the ratio would be based on dollar cost.

c. Clinician’s responsibilities at compelled termination:
   - Discontinuing needed treatment can be malpractice. You can’t discontinue in an emergency. It is called abandonment.
   - Rationalize away continued need. Be sensitive to such modes of thinking in yourself and others.
   - *Pro bono*, sliding scale, termination, referral? Evaluate and screen at intake/on phone. Prepare your options ahead of time: resources, clinics, etc. Because insurance has been exhausted there are fewer referral options. Discuss options at intake. Continue to treat at low fee and document your rationale.
   - See privately? Only if allowed in your MC contract. Discuss with client. If you believe that insurance will not cover the services then use the *Advance Beneficiary Notice of Non-coverage* (ABN) form and contract. See the References.

d. Requirement to demonstrate progress to justify continuing payment for treatment:
   - If the client improves treatment may be no longer covered. If the client no longer meets the diagnosis treatment may no longer be covered.

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16 The famous case Wickline vs State of California (239 Cal. Rptr. 810 (Ct. App. 1986) taught that denial must be appealed in order for the MCO to be held responsible for later negative consequences. However, consult your lawyer.
e. Requirement for medications:
   - Not required in some locales and for some diagnoses.
   - Unless you are the prescriber your responsibility is limited.
   - However, MC and HIPAA may require you to make some observations or notes about medication at each visit. If so, incorporate this into your note forms.
   - Clarify your responsibilities with the prescriber. Only assume responsibilities you can legally and effectively carry. For example, asking and noting side effects is complex. Asking about and noting adherence\(^\text{17}\) to the regimen is simpler.
   - When possibly beneficial. Decide on risks/benefits of taking the case.

Note: Medication Consults

If a psychiatrist is consulted for medications, those meetings will be charged against the contract’s MH sessions and so reduce the number available for therapy. Similarly, neuropsychological evaluations count against MH visits. However, if a patient’s PCP provides medications, this will not reduce the number of sessions available for therapy as most plans allow unlimited PCP visits.

   - If client refuses medications  - Call the PCP? **Note:** PCP = Primary Care (non-emergency, usually not a specialist) Provider but also used are Practitioner, Physician, and Partnership. Types of PCPs: General practitioners, Family practitioners, Pediatricians, Internists, Obstetricians/gynecologists, Nurse practitioners (NP) and physician assistants (PA).
   - If previously harmed - Advise client to discuss with prescriber and note this. Contact prescriber? Pharmacist? Psychopharmacologist?
   - If client is non-adherent to regimen - Ask client to contact prescriber and discuss. Document this. Contact prescriber?

f. Need for specialized treatment:
   - Do thorough initial assessment regardless of amount paid.
   - Triage knowledgeably.
   - Refer and explain to MC.
   - Learn and use MCO’s standards for:
     * “levels of care” = services
     * “medical necessity criteria” for each level of service

Quality of Services

a. All providers are equivalent so any provider can treat any case or client:
   - Document differences to MC reviewer when relevant. **Note:** In a diversely skilled group practice this may not be a significant limitation.

b. MC may transfer the client to a cheaper provider:
   - It happens.

c. Decision making on inadequate information, testing, time:
   - Do quality assessment at intake. **Note:** All other human services require and include testing: education, medicine, rehabilitation, nursing, etc.

\(^\text{17} \) "Adherence" is preferable to "compliance" as it is more respectful of patient autonomy and less hierarchical.
d. Pressure to treat all referrals:
   - Good triage.

e. Competence in time sensitive treatment methods.
   - Get training or don’t sign MC contract.
   - Clinical hypnosis? Time-limited Treatment methods? EMDR? Energy Therapies?

f. Questionable or harmful treatments.
   - Document and explain to MC.

g. Offering “support” as treatment e.g. Get client active with community, employer, training, etc.
   - Use Motivational Interviewing? Document need for support. Refer for supportive services.

h. Minimal time left for treatment after writing treatment plans, and progress notes, repeated assessments of risks, noting meds, etc.
   - ?

## Diagnoses, Fees, Billing and Payment

a. Know your MC contracts.
   - Set a tickler to read these at least yearly. Perhaps when you renew your professional liability insurance. This is also a good time to read your professional liability insurance policy and review your state’s licensing laws.
   - Do not assume that your contract is:
     - The same as that offered to your peers or as your previous contract
     - A standard one
     - Non-negotiable

b. Do not rely on telephone promises or assurances of coverage, payments, or procedures by MCO employees.
   - Make a note of all calls to MCO with date, time, names, phone numbers, issue, etc.
   - Get it in writing. Have authorizations faxed immediately. Note: The opposite of paranoid is stupid when dealing with untrustworthy others.

c. MC won’t pay for supervision or for second opinions or for consults and collaboration time.
   - Professional growth is an ethical and personal training commitment.
   - Get the kind and intensity of consultation you need and pay for it.
   - Perhaps make phone calls to consultants during the sessions.

d. Fees get lower over time due to inflation and competition.
   - Generate a matrix of different payers and services.

e. MC requires a diagnosis before full evaluations.
   - The initial diagnosis is tentative for the client but not MC.
   - Remember to change it as soon as possible with the MCO.

f. Changing a diagnosis to a reimbursable one? Offering more diagnoses than are present?
   - Unethical because incorrect diagnosis is substandard practice. It is fraud because you are misrepresenting what you are treating. Note: MC may or may not pay for an Adjustment Disorder diagnosis. Some states require more extensive coverage for Severe and Persistent Mental Illness (SPMI) diagnoses.
g. Offering the least pathological diagnosis because it will be in the client’s permanent records and will affect future employment, insurance, etc.
   - Likely unethical if it is clinically inaccurate and so below the standard of quality.

h. Dual diagnosis treatments are not appropriately covered. Each is only covered exclusively.
   - Negotiate for both kinds of services.

i. Not treating Axis II conditions despite their effects on treatment.
   - You can still treat what is not the primary diagnosis.

j. Changing the CPT codes for reimbursement.
   - If you bill for what you did not do it is fraud. A felony. Loss of license is usually automatic on conviction.

k. Enforcing the client’s responsibility.
   - Repeated presentations of this message to pay on cards, bills, office signs, handouts, etc.
   - Inform clients of the consequences of not paying (debt collection through small claims court, collection attorney, garnish wages, etc.) **Note: Do not offer deferred payment plans or charge interest** because of legal entanglements such as the Red Flag rules from the Federal Trade Commission (2009) and the Truth in Lending Act (1968). You can charge a re-billing fee. The Red Flag rules as applied to typical psychotherapy cases will be changing in late 2009.
   - Collecting co-pays - Describe your methods and rules in your Policy and Procedures Manual. Make efforts to collect and document them. If you decide to forgo the co-payment document your rationale. Do this as rarely as possible; it must always be an exception. **Note: Collect all fees at the time of service** with cash, check or credit card. If the client didn’t pay they must do so the next day by calling with a card number or dropping off of the payment or there is a $10 fee which is not covered by insurance.

l. Practice audits:
   - Learn of and use record keeping methods that meet MCO’s, state, and profession’s standards.
   - Assure that notes justify the level, frequency, and kinds of treatment you provided, document progress, etc.

m. Retroactive denials:
   - Ask peers if these are happening in your area. If so, plan for the loss of income.

**MC created and then offloaded the burdens of paperwork onto us. Once upon a time we had only to do scheduling.**

a. Micromanagement: Authorizations, Certification, Pre-certification, verification of coverage, etc.
   - Automate, delegate, use a medical claims biller.
   - Use payer’s online bill submission program (Navinet, etc.)
   - Use computer billing and office management programs.
   - **Note: When should I hire an office manager?** Simple: As soon as cost of the hours you spend on billing (at your actual collected therapy rate) exceeds what an office manager would cost. Disregard taxes.

b. Re-credentialing:
   - If you are on only 2-3 panels just complete their forms.
   - If you are on, or expect to be on, many panels get the UPD.
- **Note:** The *Universal Provider Datasource* (UPD) which was the “Universal Credentialing DataSource” is from the Council for Affordable Quality Healthcare (CAQH), a nonprofit collaboration between health plans, networks and trade associations. The UPD is a standard credentialing application, which many health plans now accept. You need to enter your data only once, and your information will be stored securely on the site and sent to all the health plans you select. There is no cost and it is good for two years but be warned that is 43 pages. Go to: [www.caqh.org](http://www.caqh.org) after getting on a panel.
- Avoid vanity and phony credentials.

### D. Coping II: Self-care

**Citation:** *Cura te ipsum* - Take care of your own self - is from *Doctor, heal thyself*. From Luke 4:23 who quotes Jesus: And He said to them, “‘No doubt you will quote this proverb to Me, ‘Physician, heal yourself! Whatever we heard was done at Capernaum, do here in your hometown as well.’” *New American Standard Bible* (1995).

1. **Z’s Twelfth Law:** Over the long run you can only give about 10% more than you get.
2. **Use reminders, prompts, and redirections when working gets hard.** Choosing the long-term over the short-term payoff is made easier when the long term payoff is made present.
   a. Put your diplomas and license on a wall where you can see them to remind yourself of your efforts, achievements, and skills and to remind yourself of why you are able to do what you are doing.
   b. To remind yourself of what is threatened post pictures or mementos of your:
      - Family, dog, kids, etc. - whoever depends on you.
      - House or other achievement or goal to keep focus on long term not short term goals.
      - To remind yourself of coping methods post some personal graphics where you, but not clients, can see them.
   c. Keep a record of your victories over MC. Have your office manager document these, document them in a folder on your computer, a notebook you can refer to, or a box with notes inside you can open and read a few when frustrated. Celebrate in the office, tell peers.
3. **Use humor.**
   a. MC jokes: With links to several websites: [http://www.addictionrecov.org/paradigm/P_PR_SP99/LightenUp.html](http://www.addictionrecov.org/paradigm/P_PR_SP99/LightenUp.html) or do a Google search.
   b. Objectify struggles with MC:
      - Get hula hoops to practice for MC’s making you jump thorough hoops to get anything.
      - Get a panic button for your desk. Notice that pushing it does nothing to improve the situation.
   c. Managed Care is a Borg:
      - Part machine and part human. Add synthetic components.
      - “Resistance is futile.”
      - “You will be assimilated.” No negotiation or reasoning.
      - Rapid adaptability
      - They have a hive mind
   d. All MC companies have lost their shareholders lots of money in the last few years. Several CEOs have gone to jail. *Schadenfreud*. The pleasure we take (privately, and may be embarrassed to acknowledge) in the misfortunes of others. It is especially keen when our enemies suffer. Often ironical. And, yes “freud” means “joy.”
   e. Assorted slogans/bumper-stickers:
      - On decision making: Yiddish saying: Don’t let the little head do the thinking for the big head (and not only for males).
4. **Self care should include a hobby or two (and TV watching or video games are not hobbies) and a sport.** What have you found?
E. Coping III: Using Better Cognitions

Dealing with Mangled Care can cause conditions of MC-itis (from just irritated to inflamed) and MC-osis (abnormal state or disorder). Our goal in this part is to tailor ideas below or develop even better cognitive coping strategies to reduce stress/anxiety/depression and increase creativity and productivity for therapists. Please add other examples...ideas from your practice?

1. **Therapeutic Modesty.** We may expect too much of therapy. Our hopes, best intentions, general optimism, overconfidence in our tools, the client’s hopes or neediness, and even MC’s promises may lead us to unrealistic expectations which are then dashed. Disappointment, even disillusionment can sap our energies. Instead we can benefit from therapeutic modesty.

   a. As Freud put it, psychoanalysis can only offer the possibility of transforming neurotic misery into common unhappiness. **Citation:** “I do not doubt that it would be easier for fate to take away your suffering than it would for me. But you will see for yourself that much has been gained if we succeed in turning your hysterical misery into common unhappiness” Freud and Breuer, 1895.

   b. Being a “Good-enough Mother” as a goal. **Citation:** From the name it might seem that Donald Winnicott, the late British psychiatrist, is cautioning about not being perfectionistic. When you read more you realize he is offering a model for the ideal therapist. “The good-enough mother tries to provide what the infant needs, but she instinctively leaves a time lag between the demands and their satisfaction and progressively increases it. ... “The good-enough mother’s behavior can be described with another Winnicottian concept, namely graduated failure of adaptation. Her failure to satisfy the infant needs immediately induces the latter to compensate for the temporary deprivation by mental activity and by understanding. Thus, the infant learns to tolerate for increasingly longer periods both his ego needs and instinctual tensions.” Read more at [http://en.wikipedia.org/wiki/Donald_Winnicott](http://en.wikipedia.org/wiki/Donald_Winnicott) - Accessed May 23, 2009.

   c. “A good plan today is better than a perfect plan tomorrow.” General George S. Patton, USA.

2. Acceptance

   a. The Serenity Prayer: “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.” **Citation:** Not actually written by Reinhold Niebuhr but good guidance for yourself and your clients and so you might display it where you can both see it.

   “Life consists not in holding good cards but in playing those you hold well.” Josh Billings

   Similar is “Don’t push the river; it flows by itself” Title of Barry Steven’s book from the 70’s.

   b. Accept and protest/fight. Accept that this is the reality for now, for this client, for you as a therapist. And that it can and will change. And the change might be for the better. All this will pass. It may pass sooner with less harm if you actively join the fight.


   c. Albert Ellis, PhD, and his Rational Emotive Behavior Therapy comes down hard on “demandingness” as a major cause of personal unhappiness. He also called this king of thinking “musturbation” and “shoulding on others.” This is insisting that the world (especially others) be the way you want it to be for your convenience and psychological comfort and feeling angry when it is not. The world is the way it is for thousands of good, historical, and irrational reasons and no amount of oughts, musts, shoulds, have to’s, or need to’s will change it.
3. Constraints are imposed by MC. MC is inherently restrictive, rationing care, limiting access, etc. in order to lessen their (immediate) costs. This need not be so harsh if third-party payer programs consider long-term costs, disease trajectory, medical offset, and costs borne by others and the environment.

   a. Coping with Managed Care's constraints on treatment. **Limitations are inherent in all human activities. Believing anything else is a fantasy.** Can you play tennis without a net? No. Some rules are needed, some limitations, boundaries. “Anyone could carve a goose, if it were not for the bones.” T. S. Elliot. You are trained and experienced carvers. “If all you have is lemons, make lemonade.”

   b. **Time constraints may be used for clinical benefit.** Why these rules? Historical and irrational rules.
      - Why ten? Why weekly? Why 50 minutes? Is 10 too few or too many? “Well, 10 is for the average client. Are you average?” “Do you need all ten or can you work harder and get out of here earlier?” “Do you need to use all ten/3 months or can you get our earlier and suffer for a shorter time period?”
      - “I am not the problem; my spouse/kid/parent is.” “Okay, then five for you and five for them.”
      - “I don’t need to be here/I am not coming back/I have nothing to say.” Okay, then will you come twice alone and then 3 times with them.” “Do you want to get cured now and still have a few sessions in reserve for later?”
      - “When are you actually going to make the change?” We are all going to die sooner than we want. All relationships, including therapy end. “What do you want and need from this relationship now?” “How can I help you?”

   c. **On the use of crises:** Rahm Emanuel, White House Chief of Staff, Feb. 9, 2009. "You never want a serious crisis to go to waste. And what I mean by that is an opportunity to do things you think you could not do before.” **Seek tipping points, inflection points, leverage, in therapy.**

   d. **Integrated Review: The nuts and bolts of coping with constraints:**
      - Verify coverage and limitations.
      - Offer patient education handouts.
      - Have a discussion, clarify choices and options, make decisions and plans.
      - Achieve acknowledgement/assent/consent/ “informed collaboration.”
      - Document the consent as informed, voluntary, and competent.
      - Continued awareness of the process and need for discussion and consent.
      - Revise the consent when any change of techniques, new techniques, experimental techniques.

4. Use “rules of thumb” to simplify decision making. Fast and frugal (of brain power).

   a. There are dozens of books and hundreds of articles on cognitive biases and the way they produce bad outcomes, contradictory decisions, and just errors. **Decision under uncertainty** by Kahneman and Tversky is the classic. Plous, Scott (1993) is very readable, and comprehensive yet relatively small. There are many current books on behavioral economics and decision making and Dawes, (1988), and Piatelli-Palmarini (1994). For applications of these ideas to clinical work see Garb (1998) and Turk and Salovey (1998).

   b. There is some research on the positive values of such algorithms most notably by Gert Gigerenzer. *Gut feelings: The intelligence of the unconscious.* (2007). *Simple heuristics that make us smart.* (1999).
c. Some examples of Rules of Thumb:
   - Never worry alone
   - If it might make a mess, make a note
   - Think out loud for the record
   - “Nothing about you leaves this office without your knowledge and approval” as policy?

d. Clinical versions:
   - “Never take down a fence until you know why it was put up.” Gilbert K. Chesterton or Robert Frost or Warren Wiserbe. (Umm. This has something to do with defense and resistance, right?)
   - Your clinical wisdom, please. And send them to me at edzuckerman@gmail.com for discussion.
     (1)
     (2)
     (3)

5. Doing cognitive self-therapy - **Non-productive, counter-productive and self-harming thoughts, emotions and actions vs. coping cognitions and the resulting productive emotions, and actions.**

   a. Whining
      - Recounting the latest MC horror. There will always be one more insult, injustice, and example of incompetence.
      - Yelling that it is not fair. MC is not just or fair; it is selfish and has its own goals. It is what it is and does what it does.
      - Prolonged venting. Time limited complaining to your “bitching group,” just “blowing off steam.”
        **Story:** My paternal grandparents and the 7 kids and lots of immigrating relatives lived in a small apartment above the hardware store they operated. This was in Montreal where the windows were closed tight from September to June. Sometimes someone would complain to my grandmother about the smells. She would say, “So smell your share and leave the rest.”

   b. Helplessness.
      - Don’t just sit there, do something.
      - Write a letter to government.
      - Send money.
      - Email and post.
      - “It is better to light one candle than to continue to curse the darkness.”
      - Colleague supporters - make, use, and extend your personal list of resources and contacts.
      - Political action, community action, small steps.

_Research Minute: Attributions and Helplessness_

“However, not all of the dogs in Seligman’s learned helplessness experiments became helpless. Of the roughly 150 dogs in experiments in the latter half of the 1960s, about one-third did not become helpless, but instead managed to find a way out of the unpleasant situation despite their past experience with it. The corresponding characteristic in humans has been found to correlate highly with optimistic; however, not a naïve Polyannaish optimism, but an explanatory style that views the situation as other than personal, pervasive, or permanent.”

“People with pessimistic explanatory style—which sees negative events as permanent ("it will never change"), personal ("it’s my fault"), and pervasive ("I can't do anything correctly")—are most likely to suffer from learned helplessness and depression (Peterson, Maier, & Seligman 1993).”
“Young adults and middle-aged parents with a pessimistic explanatory style are likely to suffer from depression (Chan & Sanna, 2007). People with a pessimistic explanatory style tend to be poor at problem-solving and cognitive restructuring, and also tend to demonstrate poor job satisfaction and interpersonal relationships in the workplace (Welbourne, Eggerth, Hartley, Andrew & Sanchez, 2007; Henry, 2005). Those with a pessimistic explanatory style also tend to have weakened immune systems, and not only have increased vulnerability to minor ailments (e.g. cold, fever) and major illness (e.g. heart attack, cancers), but also have a less effective recovery from health problems” (Bennett & Elliott, 2005). The above is selected from the article at: http://en.wikipedia.org/wiki/Learned_helplessness

- Feeling victimized and exploited
  - Dayanu - An attitude of gratitude. **Note:** Dayanu means “It would have been enough if He had just ______________.” Jews repeat this word, and sing a song, at the Passover Seder to remind them that God went above and beyond in leading them out of slavery in Egypt, parted the Red Sea, provided manna from heaven, led them to the Promised Land, etc.
  - Z’s 17th Law: You don’t get the kind of marriage you deserve, need, work for, wish for, earn, etc. You get the kind of marriage you tolerate. Co-dependent, Enabler, or ?

- Escapism, fantasizing
  - “The Perfect Work World of Independent Practice”
  - Autonomy and choice
  - Immediate retirement
  - Hitting the lottery, getting a big inheritance, selling your invention, etc.
  - Moving on to … (the new frontier)
  - Revenge fantasies

- Procrastination
  - Set time limits or small tasks
  - Delegate
  - Hire a biller

- Denial - “sweet lemons,” the opposite of sour grapes
  - Face as much as you can. Write it down in your datebook so you will be reminded to deal with it again.

- Dependency/submissiveness
  - Assertiveness?
  - Resign from the worst MCO panels

- Guilt for exploiting the weak and needy by charging for your services
  - I charge for my time and use of my expertise as does every worker.
  - Charging so much when they have so little.

- Perfectionism or inappropriately high or unusual standards and expectations
  - Appropriate expectation: Z’s Seventh Law: You can’t do anything new well or without anxiety.
  - Learn by trial and error. By experimentation. “If you can’t make a mistake you can’t make anything.” A carpentry trainer.
  - The best is the enemy of the good – Voltaire. “Best” is your imaginary, ideal, training induced, book-based, laboratory/internship expectation fantasy.
  - You are not in control of the outcome so do not use it to assess your worth, value, quality, etc. Instead base these judgments on your efforts (input) not the outcome. Parallel is dieting (controlled eating) vs. weight loss.
F. Coping IV - Where From Here?


IX. References

Advance Beneficiary Notice of Non-coverage (ABN) form and contract. For Medicare see: [http://www.cms.hhs.gov/CMSForms/](http://www.cms.hhs.gov/CMSForms/) Note that there is a new form as of March 1, 2009


A web page of ethics codes, standards of care, and practice guidelines in the areas of therapy, counseling, forensics, and assessment. “There are now over 120 links to complete copies of codes, standards, and guidelines addressing: a) specific...
areas of practice (e.g., online psychotherapy, forensic, rehabilitation, neuropsychology, school psychology, group therapy, body work, hypnotherapy, employee assistance, pastoral counseling, trauma work, biofeedback, disaster response, custody evaluations, diminished capacity assessments, end-of-life decisions); b) specific aspects of practice (e.g., supervision, managed care, duty to protect, record keeping, email communication with patients) c) specific theoretical orientations (e.g., Feminist Therapy Institute; Christian Association for Psychological Studies; Canadian Psychoanalytic Society); and d) different professions (e.g., psychologists, psychiatrists, social workers, counselors). Currently the links are only to documents that are in English and are free and accessible to everyone (i.e., no fees).


X. Feedback

I really don’t know everything. I suppose that is not a surprise to you after coming this far, but I would love to hear from you about what more I should consider, know, and address.

- What have you learned about MC that you want to share? Problems, tricks, strategies?
- Other examples of MC issues from your practice?

Email me at edzuckerman@gmail.com

XI. About the Author:

Edward Zuckerman, PhD, earned his doctorate in Clinical Psychology from the University of Pittsburgh. He has more than 30 years of clinical experience working in community mental health, with developmentally disabled adults, as a program evaluator, in full-time private practice, and as a claims reviewer for Social Security Disability. He taught courses at the University of Pittsburgh and at Carnegie Mellon for 15 years and edits the Clinician’s Toolbox Series at Guilford Press in New York. His writing is not from the ivory tower of academia, but demonstrates an understanding of clinicians’ work environments and needs based on his extensive experience. In his writing and workshops, Dr. Zuckerman provides invaluable consultation, practical information, and usable forms and tools for the support functions of clinical practice.