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* This fact sheet helps educate primary care physicians and other primary health professionals about collaborating with psychologists. To make photocopies for use in networking and outreach activities, remove the article along the perforated edge. To download this fact sheet and other relationship building tools, visit the Business of Practice section at apapracticecentral.org.
Practicing psychologists continue to raise questions about the new psychotherapy CPT® codes for 2013. Building on a question-and-answer set included in the Fall 2012 special issue of Good Practice, this article provides answers to several common inquiries from practitioners.

When do I use the interactive complexity add-on code, 90785?

The 2013 psychotherapy codes include new “add-on” codes for specific services that can be provided only in combination with other diagnostic evaluation, individual psychotherapy and group psychotherapy services. The new add-on codes may not be used in conjunction with the family psychotherapy codes 90846 and 90847. Add-on codes identify an additional part of the treatment above and beyond the principal service.

Interactive complexity, the new add-on code 90785, refers to specific communications factors that add to the difficulty of service delivery and increase the intensity of effort required of the health care professional in a particular treatment session. This code is intended to reflect added intensity, not added time, involved with delivering a service. Practitioners should not assume that they can bill 90785 for each session they have with a “difficult” patient.

In situations where 90785 may be billed, patients typically have others legally responsible for their care or require the involvement of third parties such as schools or probation officers.

As reflected in the CPT manual, one of the following must occur in order for a practitioner to use the interactive complexity add-on code for that treatment session:

1. The need to manage maladaptive communication – for example, high reactivity or disagreement among family members
2. Emotions or behavior by the caregiver that impede implementation of the treatment plan
3. Mandated reporting such as in situations involving abuse or neglect
4. Use of play equipment or other physical devices, or an interpreter or translator, required because of the patient’s lack of fluency or undeveloped verbal skills

As related to the fourth item above, the Centers for Medicare and Medicaid Services (CMS) has stated that the interactive complexity add-on code 90785 should not be billed to Medicare solely for the purpose of translation or interpretation services. If 90785 were used for this purpose, it would result in higher patient co-payments for the psychotherapy service for a beneficiary who requires a translator compared to a patient who does not need a translator. According to CMS, this scenario violates federal laws that prohibit discrimination on the basis of a beneficiary’s disability or ethnicity.

How do I indicate the add-on code for interactive complexity on my billing form?

Both the principal service code and add-on code should be listed on the billing form. See the illustration on page 3 showing how to bill for the add-on interactive complexity code 90785 in connection with the code for a 45-minute psychotherapy session using the CMS 1500 form.
My psychotherapy session runs a different length of time than the one specified in the three timed psychotherapy codes for 2013 (30 minutes for 90832, 45 minutes for 90834 and 60 minutes for 90837). How do I decide what code to bill?

These psychotherapy services are considered face-to-face services with the patient and/or family member, with the patient present for some or all of the service. The specific amount of time associated with these three code titles may well differ from the actual amount of time you provided psychotherapy. In general, you should select the code that most closely matches the actual time you spent. The CPT manual provides for flexibility by identifying time ranges in the descriptions of the three codes, as follows:

90832: 16 to 37 minutes
90834: 38 to 52 minutes
90837: 53 minutes or longer

The psychotherapy codes should not be billed for any sessions lasting less than 16 minutes.

An important insurance-related pointer: As part of adequate documentation of patient encounters in the record, be sure to note start and stop times for every session of psychotherapy you provide. From an insurance company’s standpoint, if you don’t record these details, you didn’t deliver the service.

I often have additional work outside of the time spent face-to-face with my patients, such as arranging for services, providing reports and communicating with my patient’s primary care providers. Do I include the time spent doing these activities when deciding which psychotherapy code to use?

No, the time spent arranging for services, providing reports and communicating with other health care professionals is not included in the length of the psychotherapy session. Such activity is considered part of the post-service work already built into the psychotherapy codes. This is not something new for 2013, as these activities were considered post-service work under the psychotherapy codes in effect for 2012.
More detailed descriptions of pre- and post-service work for the 2013 psychotherapy codes 90832, 90834 and 90837 appear below.

**Pre-service work:** Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers and family members.

**Post-service work:** Arrange for further services. Coordinate care in writing or by telephone with patient, family and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.

What distinguishes the psychotherapy with patient and/or family member present codes (90832, 90834 or 90837) from family psychotherapy codes (90846 and 90847)?

With the 30-, 45- and 60-minute psychotherapy codes, the focus of the service delivered is on the individual patient (even though the CPT code titles for 2013 no longer include the word “individual” before “psychotherapy”). The codes can be used with the occasional involvement of family members.

With the family psychotherapy codes, the focus of the service delivery is on family dynamics or interactions – or a subset of the family such as parents or children – though the treatment is still intended for the benefit of the patient.

Will Medicare and insurance companies place limits on how frequently a provider can bill the 60-minute psychotherapy code 90837 versus the 45-minute psychotherapy code 90834?

Medicare Administrative Contractors will issue Local Coverage Determinations (LCDs) and commercial carriers will establish coverage policies for private sector health plans related to use of the new psychotherapy codes for 2013. Check your MAC website (see list below) for LCDs if you are a Medicare provider, and look for coverage policies on the websites of any private insurance plans with which you are affiliated.

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### MEDICARE ADMINISTRATIVE CONTRACTOR WEBSITES

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Many of my patients are distressed during their psychotherapy sessions. Under what circumstances do I use the new crisis code rather than a psychotherapy code?

The new crisis code, 90839, requires that the patient be in high distress under complex or life-threatening circumstances that require urgent and immediate attention. One example: a psychotherapy session where you find the patient is suicidal and you must arrange for the patient to be hospitalized immediately.

To use the crisis code, the psychotherapy session must last for at least 30 minutes. If the session lasts for 75 minutes or more, you would use both 90839 and the add-on code 90840 when billing patients and filing claims.

Note: This question-and-answer set was prepared based on information available early in December 2012 and is subject to change as the new codes are implemented. For more questions and answers about the 2013 psychotherapy codes, along with additional information and resources for practitioners, visit our Practice Central website at apapracticecentral.org/codes.
Critical Update: Quality Reporting for Medicare Providers in 2013

**Psychologists in Medicare must begin participating in the Physician Quality Reporting System in 2013 or face payment penalties later.**

Since 2007, Medicare has offered incentives in the form of bonus payments to eligible professionals, including psychologists, who report data on designated outpatient service measures. As a result of the Patient Protection and Affordable Care Act of 2013, Medicare’s Physician Quality Reporting System (PQRS) must switch from awarding bonuses to providers for satisfactory participation to imposing penalties for the failure to successfully report on PQRS measures.

The practical effect of the shift is that psychologists in Medicare who do not yet participate in PQRS must begin doing so in 2013 or face payment penalties starting in 2015.

To help eligible professionals avoid payment penalties, the Centers for Medicare and Medicaid Services (CMS) has taken steps to facilitate reporting for those Medicare providers who are new to PQRS. Psychologists participating in the program for the first time will only need to report one service measure for at least one applicable patient in 2013 in order to avoid penalties in 2015.

However, in order to meet the requirements for bonus payment in 2013, you must successfully report on at least 50 percent of your applicable Medicare cases. Successful reporting involves selecting measures that are appropriate for the patient and service provided. For example, if the measure involves adult major depressive disorder, it may not be used for patients under 18 years of age.

The reporting period for 2013 lasts the entire 12 months of the year. Though you need not necessarily begin participating in January 2013, failure to start early in the year could prevent you from reaching the 50 percent threshold, thereby making you ineligible for bonus payments.

In order for a psychologist to participate in PQRS, you must be enrolled as a Medicare provider under the clinical psychologist designation, have a National Provider Identifier (NPI) and be enrolled in the Medicare PECOS system.

**Steps for psychologists new to PQRS**

Following is a step-by-step basic guide for psychologists participating in PQRS for the first time in 2013.

**Step 1: Determine which PQRS reporting method is appropriate for your practice**

**Critical update: Quality Reporting for Medicare Providers in 2013**

In 2013 and 2014, psychologists who successfully participate in PQRS will earn an additional 0.5 percent payment on all of their Medicare charges. Beginning in 2015, the Centers for Medicare and Medicaid Services (CMS) will no longer provide bonuses but instead will impose penalties on those who do not successfully report PQRS measures. The payment penalties will be 1.5 percent in 2015 and 2 percent in 2016.

Current non-participants may wonder why they need to get involved in 2013 when penalties do not apply until 2015. As a bonus program, Medicare’s payments have been retroactive. Eligible professionals submitted their Medicare claims and were paid for their services with the PQRS bonus payments distributed months later.

But now that PQRS will become a penalty-based program, Medicare must operate prospectively in order to have the time needed to analyze reporting data before applying any payment adjustments. The 1.5 percent penalty adjustments for 2015 will be based on 2013 reporting data, while the 2 percent penalty for 2016 will be based on 2014 reporting data. Penalties will apply to all Medicare charges by a provider.
Although eligible professionals may choose from several methods for submitting PQRS data, most psychologists will use claims-based reporting. This option simply involves reporting measures on the standard CMS-1500 claim form. Other options for PQRS reporting include registry-based, qualified Electronic Health Record (EHR), or a Group Practice Reporting Option (GPRO). Check the CMS website at go.cms.gov/Vkaa8V for information about the latter three options.

Step 2: Select a measure

Review the list of 2013 PQRS measures on page 8 for which psychologists are eligible to report and determine which ones match the services you provide. CMS recommends reporting on at least three measures, but you can report just one or two measures if fewer than three measures apply to your practice. (The reporting period for 2013 is 12 months, January 1 – December 31.)

Step 3: Check the measures worksheets in order to determine the required procedure codes

Measure worksheets are found in the 2013 PQRS Measures Specifications Manual, available in the related links section of the Measures Codes page at go.cms.gov/UmysQS. The procedure code is the CPT® code for the service provided. Be sure to use the new CPT codes for 2013 beginning Jan. 1.

For example, if in Step 2 a psychologist selected Measure 181: Elder Maltreatment Screen and Follow-Up Plan, an acceptable procedure code as listed on page 386 of the PQRS Measures Specifications Manual would be 90791: Psychiatric Diagnostic Interview.

Step 4: Use the appropriate G-code to indicate whether the service was performed or why it was not performed

Quality codes, or G-codes, are used to indicate what action, if any, you took. G-codes can be found on the measures worksheets. Because PQRS is a reporting program rather than a pay-for-performance program, health care professionals may indicate they did not provide the action specified under the measure and still qualify for bonus payments in 2013.

GETTING STARTED IN PQRS: MORE RESOURCES FOR PSYCHOLOGISTS

The APA Practice Organization has produced a two-part video for psychologists providing an overview of PQRS as well as details about how to report PQRS measures related to psychological services. The videos are found in the Quality Improvement Programs section of the APA Practice Organization’s Practice Central website at apapracticecentral.org/reimbursement/improvement/index.aspx.

Additional material found at Practice Central includes questions and answers for psychologists about PQRS along with online versions of the material found in this issue of Good Practice, such as the 2013 PQRS measures list.

CMS provides a list of educational materials for health care professionals found at go.cms.gov/YLTJ1sP.

If you have additional questions, contact your local Medicare Administrative Contractor or the Government Relations office for the APA Practice Organization by phone at (202) 336-5889 or by email at pracgovt@apa.org.
There will be thirteen individual PQRS measures in 2013 that may be used by psychologists depending upon the population they treat and the services they provide. The individual measures are:

- **Major depressive disorder: antidepressant medication during acute phase (#9):** Indicates the percentage of patients aged 18 years and older diagnosed with a new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase. This measure is to be reported for each occurrence of MDD during the reporting period.

- **Major depressive disorder: diagnostic evaluation (#106):** Indicates the percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified. This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period.

- **Major depressive disorder: suicide risk assessment (#107):** Indicates the percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period. This measure is to be reported at each visit for a new diagnosis or recurrent episode of MDD, for patients seen individually during the reporting period.

- **Body mass index (#128):** Indicates the percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documents in the medical record and if the most recent BMI is outside parameters, a follow-up plan is documented. The measure may be reported when a BMI calculation has been performed by another health care provider and is documented in the medical record.

- **Documentation and verification of current medications in the medical record (#130):** Indicates the percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider. This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure.

- **Pain assessment prior to initiation of patient treatment (#131):** Indicates the percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan. This measure is to be reported for each qualifying visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure.

- **Screening for clinical depression (#134):** Indicates the percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure.

- **Unhealthy alcohol use (#173):** Indicates the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use during the reporting period. There is no diagnosis associated with this measure.
Elder maltreatment screen and follow-up plan (#181): Indicates the percentage of patients aged 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan. This measure is to be reported for each initial patient evaluation during the reporting period. When reporting CPT codes 96116, 97803, and G0270 the measure is to be reported each time the code is submitted. The not eligible code can be used to report if it is not an initial evaluation with screening for elder maltreatment.

Preventive care and screening: tobacco use – screening and cessation intervention (#226): Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. This measure is to be reported once per reporting period.

Substance use disorders – counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence (#247): Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12-month reporting period.

Substance use disorders – screening for depression among patients with substance abuse or dependence (#248): Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period.

Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions (#325): Indicates the Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician with communication to the other clinician treating the comorbid condition.

Also available in 2013: Measures group on dementia

Measures groups are a subset of four or more PQRS measures that have a particular clinical condition or focus in common. All applicable measures within a group must be reported for each patient within the sample that meets the required criteria (such as age or gender). Eligible professionals can choose more than one reporting option (individual measures or measures groups), but can only earn a maximum of one incentive payment equal to 0.5 percent of their total estimated allowed Medicare charges.

In 2013 there will be one measures group on dementia that could be reported by psychologists. The Dementia Measures Group consists of nine measures: Staging of dementia (#280), Cognitive Assessment (#281), Functional status assessment (#282), Neuropsychological symptom assessment (#283), Management of neuropsychiatric symptoms (#284), Screening for depressive symptoms (#285), Counseling regarding safety concerns (#286), Counseling regarding risks of driving (#287), and Caregiver education and support (#288). The Dementia Measures Group is reportable through both claims-based and registry reporting.

Psychologists who do not find any measures in this entire list to be applicable to their services and/or patient population are advised to contact the CMS QualityNet Help Desk for assistance. The QualityNet Help Desk is available Monday through Friday, 7 a.m. to 7 p.m. Central Time, by telephone at 866-288-8912 (TTY 877-715-6222). Email inquiries may be sent to qnetsupport@sdps.org.
Helping families face difficult transitions

Practitioner Profile: Lauren Behrman, PhD

Back in the 1990s, Lauren Behrman, PhD, was facing a difficult challenge. In her late 30s and eager to start a family with her then-husband, she got pregnant repeatedly, only to have her hopes dashed. After eight miscarriages, she gave up on pregnancy, but not on parenthood.

“As I was living it, I recognized what a serious need there was for mental health services to help women and couples through this terribly challenging life experience,” says Behrman. “And I realized I had the skills and the wish to help others.”

Today Behrman has a thriving practice in Westchester County, N.Y., that specializes in helping individuals, couples and families navigate infertility, divorce, (and parenting after divorce,) raising special needs children, adoption and other difficult life transitions. She and colleagues have also created an institute to help psychologists at any stage of their career spot opportunities and shape diverse practices just as she has.

“One’s life can inform one’s practice, and one’s practice can inform one’s life,” says Behrman.

Helping families cope

Behrman traces her interest in joining the helping professions as far back as age five, when she began guiding a blind schoolmate through the hallways of their Queens elementary school.

Her first job was as a psychometrician in an early childhood development program for children with special needs. After earning a doctorate in clinical psychology from Long Island University in 1985 and a postdoctoral certificate in child, adolescent and family psychoanalytic psychotherapy from the Postgraduate Center in New York in 1990, Behrman served as a staff psychologist working with children and families at the Postgraduate Center for Mental Health and as a supervising psychologist at the Child Development Center at the Jewish Board of Family and Children’s Services.

Behrman began part-time independent practice in 1986 and launched her full-time private practice in 1994, specializing at first in treating children. Then her own experience and what she saw around her led her to develop an additional specialty: helping infertile women and couples.

“New York has a significant population of women who are spending their 20s and 30s developing their careers and believing they can have children whenever they’re ready,” says Behrman, who got her start in the field by leading support groups for the national infertility associations Resolve and the American Fertility Association. “They’ve been successful in almost everything they’ve tried to do, then find themselves unable to get pregnant.”

The result can be depression. “I help them grapple with the losses they’re facing,” says Behrman. She also uses mind/body approaches to help women overcome the anxiety that comes from being so focused on their menstrual cycles, the disappointment of finding out they’re not pregnant and the fear of pregnancy loss that can arise if they do manage to get pregnant. And she helps couples bolster relationships strained by infertility. Some just need help assessing their options, making decisions and navigating the enormous, complex business that infertility treatment has become.

“Infertility is a huge emotional minefield,” says Behrman. “I help people navigate their way around the mines.”

Behrman’s own struggle with infertility ended when she adopted three children. But that brought its own challenges. She was still working primarily with children and realized that her young patients were available to see her just when her own children needed her most. “I remember very vividly sitting on the floor playing a game with someone else’s child...
knowing my own children were on the other side of the door,” she says.

Her solution was to head to the annual APA Convention in search of a new niche that would allow her to practice between 9:00 a.m. and 3:00 p.m. What grabbed her attention was a panel on alternative dispute resolution techniques in divorce. That niche not only met her practical needs but also felt like the perfect use of her skills.

“As psychologists, we have a diversified skill set including, but not limited to family systems, conflict resolution, child development, communications and problem-solving,” says Behrman, who had been treating many children of divorce in her practice. “I was very interested in the idea that you could help children by working hard with parents to make sure they kept their eye on being parents rather than getting caught up in conflict.”

Now Behrman is a collaborative divorce professional, family mediator and parent coordinator. Behrman explains that collaborative divorce professionals “look at divorce as a problem to be solved, not a battle to be fought. As part of that, couples recognize that divorce is not just a legal issue but has huge emotional and psychological implications.”

Working as part of multidisciplinary teams, Behrman may serve as a facilitator to move the process forward, a professional who helps individuals manage feelings that are getting in the way of a successful divorce negotiation or as a child specialist. After a divorce, she may be called in to help parents follow through on parenting plans and stay focused on their children.

Behrman is so enthusiastic about protecting children by changing the adversarial divorce culture that she helped start the New York Chapter of the Association of Family and Conciliation Courts, and served as the first co-president. She is also the first psychologist to serve on the board of the New York Association of Collaborative Professionals and now helps conduct multidisciplinary trainings. She even provided psychological input to an HBO documentary called Don’t Divorce Me: Kids’ Rules for Parents on Divorce that aired in 2012.

**Promoting entrepreneurialism**

Behrman’s own story shows that both infertility and divorce can lead to happy endings. She is now remarried to psychologist Jeffrey Zimmerman, PhD, and they have five children between them.

She and Zimmerman also work together on a project called The Practice Institute. Along with two colleagues, they help psychologists and other behavioral health practitioners build thriving practices. The institute’s trainings cover such topics as how to identify your skill set, interests and temperament, identify community-based opportunities and market your expertise to create a vibrant business.

“We are hoping to teach our colleagues how to look at their practices as small businesses and see themselves as entrepreneurs,” says Behrman.

One key message is diversification, and understanding that our skills are transferrable, says Behrman. Psychologists have so many skills, she says, and they can apply those skills far beyond the traditional realm of just diagnosing and treating psychological disorders. “Diversifying your practice and accessing the full potential of your skillset are critical for [building] a healthy practice that you can sustain over the long term.”

Behrman shares with early-career professionals her experience of transitioning her practice to operate outside the third-party reimbursement system. At first, managed care was a great way to build her practice. But as the cost of living went up, third-party fees either stayed the same or went down. The amount of hassle increased. And companies began requiring more and more confidential information. “If you reported that your patient was getting better, they would take away sessions; if you reported that your patient really needed treatment, they’d say you’re not making progress,” she remembers. “It was a lose/lose proposition.”

These days, all Behrman’s patients pay out-of-pocket. If someone can’t afford her fee, she is willing to consider adjusting it.

continued on page 18
Dealing with Managed Care Audits

Following these step-by-step pointers can help protect your practice and your patients.

Increasingly, managed care and other health insurance companies seem to be auditing psychologists' client records, especially when the practitioner is an out-of-network provider. Psychologists facing such audits often have questions about how the audit process works and how the practitioner should respond. For example, they may be uncertain and concerned about their rights (see sidebar below) as well as patient privacy considerations.

This article lists steps to follow before and after a psychologist receives an audit notice. The sidebar on page 13 guides practitioners in handling a company's demand for a refund.

Step 1: An ounce of prevention...

The best way to prepare for an audit is to understand the company’s requirements and expectations well in advance of an audit – before you start delivering services for patients insured by the company. This knowledge may reduce your chances of doing something that flags your practice for an audit and will make you better prepared in the event that you are audited. For example, you should understand the company’s:

- Preauthorization and billing requirements and procedures
- Coverage and treatment guidelines relevant to your patient’s diagnosis and condition
- Expectations about treatment plans and patient progress
- Recordkeeping requirements or expectations – for example, what details the company wants for each session, as well as in the overall record

This information should be available in the company’s provider manual or the provider section of the company’s website. If not, contact the company’s provider relations representative.

Step 2: Determine the purpose of the audit

Audits typically start with a letter from the company explaining the purpose of the audit. If not, you should ask the company to clarify the purpose. Common reasons for auditing are:

- To determine the quality and appropriateness of the care provided to the company’s policyholders
- To assess the adequacy of your recordkeeping
- To verify that there has been no billing fraud and abuse.

For many audit situations, the pointers in this article will be sufficient for a psychologist to deal with the audit himself continued on page 14

FOCUS ON OUT-OF-NETWORK PROVIDERS

I'm out-of-network with the company requesting an audit. What right does the company have to audit my records?

More and more audits seem to involve companies looking at psychologists who are out-of-network providers. Such psychologists may ask what gives the company the right to audit when they have no provider contract with the company. (Provider contracts typically require that you comply with the company’s audit requests.)

The answer is that while you may not have audit obligations to the company in this situation, the patient’s contract with the company may require the patient to allow that his or her care and records be audited in order for the patient to be reimbursed or to have further care authorized. The company might also claim that it has the right to determine if your out-of-network services met the medical necessity definition in the patient’s insurance plan. Generally, the patient’s best interest is served by complying with audit requests that are reasonably aimed at determining whether the patient received appropriate out-of-network services.
What steps should I take if the audit results in the company demanding a refund?

In some cases, the audit may result in the company writing you a letter asking you to refund a portion of the money that they previously reimbursed you as an in-network provider. If that happens, take the following steps.

Determine the basis for the refund demand

Any demand letter from a managed care organization (MCO) should explain to you clearly the basis for the company’s refund demand. It should describe exactly how the MCO calculated the dollar amount, perhaps including a spreadsheet that details the individual claims that factored into the calculation. If these details are unclear, you should ask the company for clarification or documentation.

Assess demands based on allegedly inadequate record keeping

In the past, a common ground for demanding post-audit refunds was the assertion that the health care professional’s records were inadequate, such as the demands made by Oxford Health Plans in 2003. In this situation, the company does not dispute that you actually performed the services claimed; it simply contends that your record keeping for those services was inadequate. For example, the company may assert that you did not record sufficient details for certain sessions.

If the refund demand is based on charges of inadequate record keeping, you should review your provider contract, your provider manual and/or the provider section of the company website, and applicable state law for the following issues. If favorable in your case, you can use the following factors to argue against the refund demand:

- Does the company clearly state what type of records it expects psychologists to keep? In some cases, the record keeping guidelines are directed at physicians and may not apply to psychologists.
- If the company claims that notes from particular sessions were not sufficient, did the company make clear what it expected the psychologist to record for each session?
- If the company did not give clear record keeping guidance, what does your state law require? Do your records meet that standard?
- What does your provider contract or provider manual say will happen if records are not adequate? Does the contract specifically make your reimbursement dependent on adequate record keeping? (If not, you can argue that your reimbursement was not contingent on the content of your record keeping.) Does your provider contract allow the company to demand refunds for claims of record deficiencies?
- Remember that if you choose to keep detailed records in your psychotherapy notes, apart from your general clinical records, the MCO is not entitled to these notes. The company should not be able to penalize you for not having details in your clinical record that you have properly protected in your psychotherapy notes.

Determine if the company “extrapolated” to increase the refund demand

In Medicare and Medicaid, regulations often allow auditors to extrapolate from the audited sample of claims across a much larger volume of reimbursement payments. For example, if the auditors sample 10 claims and believe that two of the claims should not have been paid, they can then demand a refund for 20 percent of all prior payments over a certain period of time.

However, those regulations do not apply to the private sector. Therefore, a company dealing with private sector claims would have to rely on its provider contract for the right to extrapolate. Many provider contracts have no provision allowing the company to extrapolate.
or herself. However, you may want to consider retaining an attorney if the focus of the audit is potential fraud and abuse (which may be indicated by the involvement of the company’s special investigations unit), or if the company has demanded a very large refund.

The purpose of the audit may change once it is under way. To give a worst case example, auditors who are looking at quality-of-care issues may find that a provider’s records do not contain any entries for certain dates of service. This omission may shift the focus of the audit to whether services were actually provided on those dates – that is, a possible case of fraud and abuse.

**Step 3: Verify that you have appropriate patient consent**

The next question is whether you have adequate consent from the patient to release any records. This is generally a question of state law governing consent. Under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, release of records for most audit purposes does not require a HIPAA authorization, so state-level consent requirements apply. Under applicable state law, consent may be satisfied by the consent form that the psychologist had the patient signed when applying for or enrolling in health insurance. You should seek to verify that the provisions of the consent form you used are sufficient to cover the audit.

The company may claim that it cannot provide you with a copy of the patient’s application consent form. If so, you might respond by asking the company to represent in writing that it has adequate consent from the patient under state law. If you are uncertain about the adequacy of either your prior consent form or the company’s form, and you are able to contact the patient, you may wish to request the patient’s consent for releasing records for the audit. You should not release the records if you do not believe that you have adequate consent from the patient.

**Step 4: Determine what records you can release for the audit in light of privacy laws**

Other aspects of audits are governed by the HIPAA Privacy Rule. In particular, if you keep separate psychotherapy notes as defined by the Privacy Rule, the insurance company cannot ask for those notes without the patient’s HIPAA-compliant authorization, regardless of the state where you are located.

Further, the company cannot attempt to coerce your patient into providing an authorization to release psychotherapy notes by threatening to withhold treatment or payment. You are only required to give the auditors your separate clinical record containing basic information like diagnosis, symptoms and treatment plan. Practitioners who keep psychotherapy notes separate from the general clinical record report that it makes responding to an audit less burdensome because there are fewer records to provide.

Whether or not you keep psychotherapy notes, the company must follow the HIPAA “minimum necessary” rule and thereby seek only those records necessary to accomplish the purpose of the audit. For example, if the audit focuses on whether you actually saw a patient on particular dates for which you were paid, you could claim that the company does not need to see anything further than your records involving those specified dates. (Importantly, this rule is expected to change under forthcoming regulations governing the federal Health Information Technology for Economic and Clinical Health Act, or HITECH Act, which modifies portions of HIPAA.)

A few state laws, such as New Jersey’s Peer Review Statute and the District of Columbia’s privacy law, provide even stronger privacy protections than the HIPAA Privacy Rule that will further narrow the information you can release in situations where they apply.

For answers to further questions about audits, please contact our Office of Legal & Regulatory Affairs by phone at (202) 336-5886 or by email at praclegal@apa.org. We are particularly interested in hearing from you if you think a company auditing your practice is violating your provider contract, HIPAA or state law.

**PLEASE NOTE:** Legal issues are complex and highly fact-specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time. The information in this article should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.
Both the procedure code and the G-code must be reported on the same CMS-1500 claim form (see image below).

**Step 5: Record the information on the CMS-1500 claim form**

The information noted below must be reported on the claim form.

**Claims information**
- Line 1 Dates of service: Record when the service was provided
- Line 1 Procedures, services or supplies: Use the procedure code from Step 3 (see page 7)
- Line 1 Charges: List your charge for this service

**Quality reporting information**
- Line 2 Dates of service: Record the same information as above – when the service was provided
- Line 2 Procedures, services, or supplies: Use applicable quality code (For example: G8534)
- Line 2 Charges: List 0.00 on this line

A sample CMS-1500 claim form involving a psychiatric diagnostic interview with elder maltreatment screen appears below:

![CMS-1500 Claim Form](image-url)
Teri L. Bourdeau, PhD, came by her interest in the overlap between psychology and medical problems early – as far back as high school. As a teenager, she babysat for an infant who had undergone open heart surgery.

“That was a big part of what made me go into pediatric psychology and health-related issues,” she says. “I became incredibly interested in the psychosocial aspects of different kinds of medical conditions and their impact on families.”

Today, Bourdeau is director of behavioral health clinics and a clinical associate professor of behavioral sciences at the Center for Health Sciences at Oklahoma State University’s College of Osteopathic Medicine in Tulsa. And she’s still fascinated by the psychological factors behind physical conditions, especially Type 1 diabetes, Type 2 diabetes and obesity in children.

Listening to kids

While earning a doctorate in clinical psychology from the University of Tulsa in 2004, Bourdeau pursued her interest in helping kids by doing an internship at Vanderbilt University Medical Center Child and Adolescent Psychiatry and followed up with a postdoctoral fellowship in pediatric psychology at the University of Oklahoma Health Sciences Center in Oklahoma City. During this time, she began to see the importance of healthy eating and activity on kids’ emotional well-being.

Rotating through the endocrinology, oncology, adolescent medicine and other units, Bourdeau realized that eating problems were central in many medical conditions. With Type 1 diabetes, she points out, children have to take medicine every time they eat. With cystic fibrosis, they lack the enzymes needed to absorb food and are underweight as a result. With cancer, they might not be able to eat at all.

Of special concern were the increasing number of kids being diagnosed with Type 2 diabetes and borderline metabolic syndrome. “While they may have a genetic predisposition, their [eating] issues can be positively impacted by helping families make lifestyle changes,” says Bourdeau.

Since coming to Oklahoma State in 2007 after a year in private practice, Bourdeau has made treating kids with weight problems one of her primary areas of specialization. She even assisted in the development of a family health and nutrition clinic along with a physician, nutritionist and physical activity specialist.

“It is important for families to feel they can gain control and work collaboratively to guide the process.”

Using evidence-based strategies that focus on family and motivational factors, she teaches the families how to set limits, instill discipline, reduce screen time, practice mindful eating and find more productive ways of coping with stress than overeating. “I try to emphasize the positive aspects of eating well and increasing movement without the family feeling deprived,” she says.

A common concept Bourdeau teaches her students and other health care providers is: We are inviting patients to change. “It is important for families to feel they can gain control and work collaboratively to guide the process,” she says.

For kids with Type 1 diabetes, who make up another big part of Bourdeau’s practice, she emphasizes the head start they have over other kids. “The way I pitch it to kids with Type 1 diabetes is that eating healthy and exercising got on their radar screens early because they have to think about them more than other kids,” she says.
According to Bourdeau, these children and adults need to understand that no one can eat unhealthy foods in large quantities without it negatively affecting their health. This cognitive reframe can assist patients in feeling more positive about health management and even empower them to become role models for others.

Bourdeau directs clinical services that involve care given by herself, three other clinical psychologists and multiple students. They provide care to patients referred by university clinics as well as other programs throughout the broader community and state. Many of the physicians Bourdeau works with have grown to appreciate what psychologists have to offer, she says.

“Physicians have a tremendous amount of knowledge about what families can and should do, but they do not always have the time or training to communicate with families in ways that are effective enough to create change,” says Bourdeau. In addition to being trained observers of human behavior, she says, psychologists have time to work with patients and families on motivation, problem-solving and effective decision-making.

She points to multiple examples of how her approach differs. “I’ve got families who walk into the clinic and say, ‘We’re here because of you; we come back week after week because my child feels like you really understand the challenges he is facing,’” she says, explaining that these youth are not just obese but often somewhat depressed.

These kids do not want to be told what to do, Bourdeau explains. Instead, they talk about subjects like isolation, hopes and desires, and other topics that go beyond eating. They also talk about strengths, such as academic performance, and how the child or adolescent can build on successes in that area, and apply the same strategies to health and behavior. Most of all, says Bourdeau, her approach is about hearing what they say and making that the starting point.

“Kids don’t want to feel pushed; they want to feel invited,” she says. “I extend that invitation to change and make it so appealing they can’t wait to do it.”

Because Bourdeau and her team can’t be everywhere, she also works to educate physicians – especially the next

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APA FORMS CLINICAL PRACTICE GUIDELINES PANEL FOR OBESITY

The American Psychological Association’s (APA) Board of Directors has named 11 clinicians and scientists to serve on a panel that will draft guidelines for the treatment of obesity. This is the second of three development panels to be established within APA’s clinical practice guidelines development initiative.

Members of the panel are:

- Jamy Darone Ard, MD, Wake Forest University Baptist Medical Center
- Gary Bennett, PhD, Duke University
- Phillip Brantley, PhD, Pennington Biomedical Research Center, Louisiana State University
- Leonard Epstein, PhD, SUNY, University at Buffalo
- Barbara Fiese, PhD, University of Illinois at Urbana-Champaign
- Jane Gray, PhD, Texas Center for the Prevention & Treatment of Childhood Obesity, Dell Children’s Medical Center of Central Texas
- Maria Llabre, PhD (Chair), University of Miami
- Michelle Polfuss, PhD, RN, CPNP-AC/PC, Children’s Hospital of Wisconsin
- Hollie Raynor, PhD, RD, LDN, University of Tennessee
- Delia Smith West, PhD, University of Arkansas
- Denise Wilfley, PhD, Washington University in St. Louis

The APA guidelines initiative advances the association’s Strategic Plan goal to expand the role of psychology in the promotion of health. Guidelines development enables psychology to assume an active role in defining the value of psychological interventions. Otherwise, treatment decisions for patients receiving mental and behavioral health care will continue to be shaped by guidelines from medicine and psychiatry.

For more information about the APA’s clinical practice guidelines initiative, visit www.apa.org/clinical-guidelines.
Helping families face difficult transitions continued from page 11

New directions

Behrman’s personal life continues to suggest new avenues to explore in her professional life. Now 60, she experienced the death of her father a few years ago and started thinking about mortality. “I became acutely aware that people have beginnings, middles and ends to their lives,” she said.

As a result of that realization, she’s now contemplating a new direction for her practice: helping people write their memoirs. She’s considering taking a three-year postgraduate training program in writing with a psychological perspective offered by the Washington Institute of Psychoanalysis.

“One people have amazing stories,” says Behrman, who also hopes to pen a memoir of her own some day. “If they don’t get those stories out in time, they may be lost.”

Combating obesity and diabetes in kids continued from page 17

generation. As a clinical associate professor, she provides direct services through clinics.

Medical students have observed her sessions, she explains, and are usually impressed by how she can get kids to open up to her. “I have had multiple students say, ‘I have seen a child shut down with other providers, but that kid just shared with you that he eats when he’s bored or emotional,’” she says. The medical student can easily see how important that sharing can be for facilitating change.

Bourdeau also gives lectures to a variety of professionals, including physicians, dieticians, other health care providers and patients. She’s also happy to consult with physicians when they have questions. And when they send patients her way, she tells them what she’s working on so that the physicians can reinforce the message in their own offices and even use some of the same language when they talk to children and their families.

Promoting psychology

Bourdeau isn’t just an advocate for psychology at work. As APA’s Public Education Campaign coordinator for Oklahoma, she’s eager to spread the word about psychology’s value. She blogs on APA’s Your Mind Your Body blog. She tweets under the name @DrTeriB. And she gives lectures on psychology topics “all over town,” she says, citing talks at the local Y and the diabetes organization JDRF as just two examples.

Bourdeau is also active within the psychology community in Oklahoma. In September, she was appointed by Governor Mary Fallin as a member of the Oklahoma State Board of Examiners of Psychology, which oversees licensure and ethics issues. Last year, as president of the

“Kids don’t want to feel pushed; they want to feel invited (to change).”

Oklahoma Psychological Association, she worked to increase membership and awareness of what APA, the APA Practice Organization and the state, provincial and territorial psychological associations have to offer.

Bourdeau also represents Oklahoma psychologists as a member of the Medical Advisory Committee (MAC) for the Oklahoma Health Care Authority, the state’s Medicaid agency. “This involves a great deal of advocacy for adequate coverage of psychological services,” she says. During her time as a member of the MAC, psychologists were given approval to bill for health and behavior codes for Medicaid patients under the age of 18.

Even when Bourdeau isn’t officially on duty, she’s still working to promote psychology. In May, for example, she joined a medical mission to Nicaragua. Although her role was more group facilitation with the participants, she found herself called upon to help physicians from all over the United States with such tasks as breaking bad news to patients and helping others cope with medical conditions.

“It was a great way to train medical providers about the value of psychology,” she says.

Bourdeau, a native Oklahoman, doesn’t even stop when she gets home. She has been teaching her husband Jim, a nephrologist with whom she has three adult children, how to give his patients the support they need to adhere to their dialysis regimens. She laughs as she says, “I’m really proud when he comes home and tells me he did psychonephrology.”

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Kids don’t want to feel pushed; they want to feel invited (to change).”

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How Psychologists Can Help Your Patients

A psychologist, either working with you on-site or on referral, can improve patient outcomes through health behavior change. Using evidence-based practices, licensed psychologists can help your patients learn self-management strategies to deal with their chronic health conditions, such as diabetes, cardiovascular disease, and cancer, and adjust to the emotional impact of health problems and situational stress.

By working with patients one-on-one or in a group, a psychologist can provide patients with the techniques they need to follow the primary care provider’s treatment plan.

Psychologists can also assist patients in managing stress. In fact, stress, which negatively affects current and future health, plays a key role in an estimated 75 percent of primary care visits.1

A psychologist can work with patients and family members to:

- Provide on-site consultation, assessment and intervention for mental health conditions
- Deliver mental health services to patients referred from a primary care provider
- Help address challenges in patient adherence to treatment plans
- Assess and intervene with patients and families struggling with behavior problems, difficult relationships and other struggles that interfere with overall health and functioning
- Assist patients in better managing their diet, exercise and medication
- Provide the emotional support patients need to be successful in managing their health
- Assist patients in learning strategies for self-monitoring and goal setting
- Use screening tools and primary prevention programs to detect mental health conditions early
- Present educational sessions for both patients and staff on topics such as weight loss or disease management
- Design and use evaluation methods, such as continuous quality improvement measures and patient satisfaction surveys

By working with psychologists, primary care providers can continue to address both the medical and psychosocial health needs of patients.

PSYCHOLOGISTS’ EDUCATION AND TRAINING

Psychologists use evidence-based practices to address emotional and behavioral health problems. Psychologists are doctoral-level health practitioners trained in:

- Assessment and diagnosis
- Treatment of emotional and behavioral problems and disorders

continued >>
• Patient management of chronic disease conditions
• Consultation
• Program design and evaluation
• Improving the functioning of systems including families, workplaces and communities

BILLING AND REIMBURSEMENT
Patient billing and provider reimbursement for psychologists working in primary care depends largely on the service delivery model. For example, psychologists may be on staff in a primary care practice where they may receive a salary. Or they may practice independently, seeing patients on referral and managing their own billing system. When working in integrated care settings, psychologists can generally bill using health and behavior codes in 15-minute intervals.

Psychological Interventions: Evidence-Based and Effective
Psychologists provide an array of effective, evidence-based interventions to address mental health concerns and behavioral problems. Psychologists integrate the best available research evidence with clinical expertise to intervene with patients, respecting the patients’ values, culture and preferences. In clinical studies of psychological treatments for depression and anxiety, psychological treatments are on par or better than most medications, often with better and longer lasting patient outcomes.  When medication is required, a combination of psychotherapy and medication has been shown to have the best patient outcomes. Additionally, many problems that frequently present in primary care visits have behavioral components, such as insomnia, and these can also be successfully addressed through behavioral interventions.

• Mental health problems (such as anxiety and mood disorders) led to 156 million visits to doctors’ offices, clinics and hospital outpatient departments in 2005 (Agency for Healthcare Research and Quality).
• Major depressive disorder affects approximately 14.8 million American adults (NIMH).
• An estimated 8.9 million adults have co-occurring mental health and addiction disorders (SAMHSA).
• Mental illness is associated with lower use of medical care, reduced adherence to treatment therapies for chronic diseases, and higher risks of adverse health outcomes (CDC).

Resources for your patients: apa.org/helpcenter
Find a Psychologist: PsychologistLocator.org
For state and local referrals: 1-800-964-2000

Special thanks to Robert Ferguson, PhD, Robert McGrath, PhD, Diana Prescott, PhD, Sandy Rose, PhD, and Steven Tovian, PhD, for their assistance with this fact sheet.

“The best way to find yourself is to lose yourself in the service of others.”

Mohandas Gandhi

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