Targeting Reimbursement

New efforts to secure proper and timely payment for psychologists under the new psychological and neuropsychological testing codes

Advocacy Successes in the States

How To Bill for Opioid-Related Work

Empowering Patients With Opioid Use Disorders
A new fully digital test that provides a fair and accurate assessment of receptive vocabulary ability for both English speakers and English learners.

- Easy, visually engaging, and standardized administration
- Can be used with any child or youth no matter what their first language is
- User-friendly reports included to make assessment interpretation fast and clear
- Unique dual norms for both English speakers and English learners

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FROM APA’S CHIEF OF PROFESSIONAL PRACTICE
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I’ve observed that almost all APA members, from graduate students to fully licensed psychologists, share a desire to use their skills and knowledge to make a positive impact on the field of psychology and in the communities where they live and practice. But in today’s era of health care—characterized by changes to reimbursement and licensure policies, as well as increased pressure to save money and prove our value—it’s easy to lose sight of the goals that brought us to psychology in the first place.

How will we navigate these challenges while identifying opportunities for the field that help us to maximize our impact?

APA’s new strategic plan provides a framework and a three- to five-year roadmap. Approved by APA’s Council of Representatives in February, the plan positions the association to move the dial significantly on the most pressing issues for psychology and for society.

The plan’s four strategic priorities are to:

» Utilize psychology to make a positive impact on critical societal issues.
» Elevate the public’s understanding of, regard for, and use of psychology.
» Prepare the discipline and profession of psychology for the future.
» Strengthen APA’s standing as an authoritative voice for psychology.

By advancing these priorities, we can raise the visibility of psychology...and help ensure psychologists are able to practice to the full extent of their training and are paid adequately for the services they provide.

As a former practitioner, I know that payment for psychological services is a major factor driving clinical practice. I have heard practitioners’ stories about the financial pressures they face. That is why, in line with APA’s new strategic priorities, the association is re-envisioning its Office of Health Care Finance to address issues related to reimbursement, as well as broader issues, such as increasing access to psychological services and promoting a model of integrated care that recognizes the full scope of psychologists’ training.

By using our strategic priorities as the lens through which we view the practice landscape, we can better articulate financially viable models of care with a strong evidence base, such as the integrated care model. Psychologists who practice as part of integrated care teams will be part of new reimbursement models that focus on quality of care and patient outcomes. Moving forward, APA will take an even more active role in shaping public policy around promoting new, evidence-based models of care that will make a positive difference in the lives of people and provide fair financial support to psychologists.

During the development of its strategic plan, APA invited its 118,000 members to identify the top issues that the association should address. A sincere thank you to the many of you who took the time to weigh in. Your thoughtful feedback and recommendations have helped to co-create a plan that will position psychological practice for the future, strengthen our entire field and maximize the positive impact that we can have on people’s lives.

Learn more about APA’s strategic priorities at apa.org/about/apa/strategic-plan
State laws and policies have a significant impact on psychologists’ ability to practice. Here’s a snapshot of the latest successes, many of them enforcing mental health parity laws.

**NEW MEXICO**
Lower fees: The New Mexico Board of Psychologist Examiners has reduced the fee for initial licensing applications by more than 50%.

**WYOMING**
Strengthening parity: A new Wyoming law requires insurance plans to comply with parity—and the state’s insurance commissioner to enforce it.

**ILLINOIS**
A reimbursement win: BlueCross BlueShield of Illinois, both commercial and Medicaid plans, will now reimburse for covered services provided by supervised doctoral psychology interns and postdoctoral fellows.

**NEW YORK**
Enforcing parity: New York enacted the Mental Health and Substance Use Disorder Parity Report Act (Parity Report Act), which requires insurers to report on their compliance with parity laws. Those reports will be published in a consumer guide that will rank insurers’ parity compliance from best to worst.

**GEORGIA & OKLAHOMA**
Expanding Care: Georgia and Oklahoma are the latest states to join the Psychology Interjurisdictional Compact (PSYPACT) enabling licensed psychologists to engage in telepractice and temporary in-person practice across state lines.

**NEW JERSEY**
Parity compliance: A new law in New Jersey requires insurance companies to follow the federal Mental Health Parity and Addiction Equity Act and gives state regulators more enforcement authority. The law requires insurers to submit annual reports to the state outlining how they ensure parity compliance.

**COLORADO**
Protecting patients: Advocacy by the Colorado Psychological Association helped to defeat legislation that would have established continuing professional competency requirements for unlicensed and unregistered psychotherapists.

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More states are signing on to PSYPACT, an agreement that is advancing the use of telehealth and making it easier for psychologists to practice in other states.

BY HANNAH CALKINS, MA

Psychologists in a growing number of states will soon be allowed to practice in states where they are not licensed, thanks to the Psychology Interjurisdictional Compact, or PSYPACT, developed by the Association of State and Provincial Psychology Boards (ASPPB). Through PSYPACT, licensed psychologists in states that join the pact will be able to gain credentials to see patients in other compact states legally—via telehealth, or in person on a temporary basis—without obtaining a license in those other states.

PSYPACT was designed to become operational once seven states enacted compact legislation. That happened on April 23, when Georgia Gov. Brian Kemp (R) signed House Bill 26 into law. Oklahoma also enacted PSYPACT legislation on April 29.

“It represents a new beginning for psychologists who have been increasingly expressing the need to become more mobile service providers,” says Anita Brown, PhD, chair of the Legal and Legislative Affairs Committee at the Georgia Psychological Association (GPA).

At Good Practice press time, 10 states had joined PSYPACT: Arizona, Colorado, Georgia, Illinois, Missouri, Nebraska, Nevada, Oklahoma, Texas and Utah.
NEXT STEPS

But licensed psychologists in compact states can’t practice under PSYPACT just yet, says Janet Orwig, MBA, CAE, associate executive director for member services and executive director of PSYPACT at ASPPB.

First, the licensing board in each compact state must designate a representative to serve on the PSYPACT Commission, the body that will oversee the implementation and administration of the compact. “The commissioner could be a board member, an executive director of the board, another staff member or state designee—it depends on the state,” says Orwig.

The commission is a permanent group that will grow as more states enact the compact, but the original seven commissioners are the ones who will establish the compact’s bylaws, rules and regulations. The commission plans to hold its first meeting later this year.

Once that’s done, Orwig says, psychologists in compact states must apply for the necessary certifications to practice under PSYPACT’s telehealth or temporary in-person provisions. For telehealth, that’s the E-Passport. For temporary in-person practice, it’s the Interjurisdictional Practice Certificate. Both certifications are administered by ASPPB.

ASPPB expects to process applications in two weeks or less after receipt, says Orwig. Once their applications are approved, psychologists can begin practicing under PSYPACT.

FILLING IN THE MAP

Meanwhile, PSYPACT advocacy is picking up steam across the country—and the more states that participate, the better.

The District of Columbia is one of the jurisdictions nearing the finish line. The PSYPACT bill is awaiting action by two D.C. City Council committees. Washington, D.C., psychologists are seeking to join PSYPACT because many of them move and work across state lines in neighboring Virginia and Maryland. In addition, many area residents face similar barriers to care—limits to transportation, family obligations and unpredictable work schedules—similar to those people in rural areas do.

“This legislation will improve both the quality and continuity of care for patients who currently receive psychological services and will reduce barriers to care for many people in D.C. who may previously have had difficulty connecting with services,” says Laura Myhr, PhD, of the DC Psychological Association.

ADVOCATES AND ALLIES

While each state has unique needs and issues to consider, PSYPACT’s core tenets—expanding access to care and facilitating ease of licensure—appear to have near universal appeal to legislators.

“I’ve been so pleased by the bipartisan support PSYPACT has received in states across the country,” Myhr says. “It’s made me think that there are still goals that people across the political spectrum can work together on.”

Still, the reasons for supporting PSYPACT in one state may be quite different from the reasons in other states. While one state may be attracted to the idea of expanding access to care for its rural populations, other states may see it as a way to ease licensing restrictions or to maintain continuity of care via telehealth.

In Georgia, State Rep. Dave Belton (R) sponsored PSYPACT legislation as a way to expand access to care for military service members and, as a side benefit, to allow military spouses who were also practicing psychologists to conduct interstate practice via telehealth or temporarily in person. The bill passed both the Georgia House and Senate by high margins.

Belton, a veteran, says he was honored to join the effort. “The compact will increase access to care for citizens in Georgia and other compact states while also creating more consumer protections,” he says.

Psychologists who are interested in adopting PSYPACT in their own states can visit psypact.org, which offers the latest information on which states are joining the pact, as well as model legislation, a PSYPACT legislative resource kit, FAQs and the ability to join the PSYPACT listserv for updates.

“One thing I’ve learned during this process is how important it is [for state psychological associations] to develop and nurture ongoing relationships with politicians and government staff,” said Myhr. “Instead of seeing our government as distant and unreachable, I’ve realized how possible it is to make connections that end up being beneficial in so many ways.”

“It represents a new beginning for psychologists who have been increasingly expressing the need to become more mobile service providers.”

ANITA BROWN, PHD
Chair of the Legal and Legislative Affairs Committee at the Georgia Psychological Association
The sheer number of mental health apps available to smartphone users makes finding the right one a daunting task for patients and psychologists. Most apps are reasonably priced, or free, and offer a wealth of resources to choose from. Unfortunately, many do not have peer-reviewed research to support their claims. Additionally, some offer questionable business models and potential privacy/security concerns.

We asked a panel of psychologists to review three mobile apps that practicing psychologists could potentially recommend as resources for their clients. Each app focuses on using meditation and/or mindfulness for varying purposes such as reducing stress and anxiety or improving mood, sleep or attention.

For each app, we first provide guidance on several background factors that should be considered in selecting mobile apps. Next, our panel shares their own ratings and reviews of the apps based on several key factors such as purpose, appropriateness of content and ease of use.

Apps were reviewed March 2019. This article has been edited for length. Visit APAServices.org for more information on the privacy and security risks, evidence base, cost, business models and user feedback associated with each app.
The Headspace mobile app is intended for anyone who wants to learn meditation as a means of reducing anxiety and stress, or to help improve attention and awareness.

**JOANNA ROMERO CARTAYA, PhD:** Headspace is a fairly streamlined, user-friendly and encouraging application which features training and psychoeducation to its users. It also features short informational videos, which can be shown in session to further discuss meditation and explore with clients how a meditation practice could be beneficial given their therapy goals. There are some challenges with usability and function though. For example, if a user initially chooses a morning time and would like to change to an evening reminder (while in the set-up phase) for meditation the application does not allow the user to go back—rather, the user has to go into settings and reset the reminder; and the user can only choose one focal area to begin rather than choosing two or more reasons for engaging with the application. With that said, Headspace is one of the apps that I feel good about recommending to clients who are interested in further integrating a meditation program within their lives but do not have time to attend a meditation group and also are seeking support.

**KRISTI K. PHILLIPS, PsyD:** Headspace can be a fun and easy tool to support clients while they are adopting a regular meditation/mindfulness practice and can be discussed as part of the client’s therapy session as it pertains to identifying any barriers that might get in the way of daily meditation. The app offers an easy jumping off point for clients to be mindful at any point in their day, whether it be starting off on the right foot, managing stress or promoting calmness throughout their day, or helping them wind down at the end of their day.

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**KEY TO PSYCHOLOGIST RATINGS**

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<thead>
<tr>
<th>Categories are rated from 1 to 5, with 5 being the most positive score</th>
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<tbody>
<tr>
<td><strong>PURPOSE</strong></td>
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<tr>
<td>What is the proposed intervention, or what does it claim to do?</td>
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<tr>
<td>Is it likely to do what it claims?</td>
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<tr>
<td><strong>APPROPRIATENESS OF CONTENT</strong></td>
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<tr>
<td>Is the content appropriate?</td>
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<tr>
<td>Does the content match the description and purpose?</td>
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<tr>
<td>Were any clinical/psychology experts involved in the development of the material?</td>
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<tr>
<td><strong>CULTURAL RESPONSIVENESS</strong></td>
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<tr>
<td>Were a variety/range of cultural factors (e.g., age, race, ethnicity, gender, gender identity, sexual orientation, ability levels) considered in the app/software’s development?</td>
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<tr>
<td>Is the app/software likely to appeal to people from different cultural backgrounds?</td>
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<tr>
<td>Is it available in multiple languages?</td>
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<tr>
<td><strong>EASE OF USE</strong></td>
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<tr>
<td>Is it easy to navigate?</td>
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<td>Is it customizable?</td>
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<tr>
<td><strong>FUNCTIONALITY</strong></td>
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<tr>
<td>Does it perform well?</td>
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<tr>
<td>Does it need the internet to work?</td>
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<tr>
<td>Can you export/download your data?</td>
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<tr>
<td><strong>OVERALL RATING</strong></td>
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<tr>
<td>Would you recommend this app to other psychologists?</td>
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<tr>
<td>How often would you use or ask a client to use this app?</td>
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<tr>
<td>What is your overall rating of this app?</td>
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<tr>
<th>CARTAYA</th>
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<tr>
<td>Purpose</td>
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<tr>
<td>Appropriateness of Content</td>
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<td>Cultural Responsiveness</td>
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<td>Ease of Use</td>
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<td>Functionality</td>
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<tr>
<td>Overall Rating</td>
<td>4</td>
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The Calm mobile app promotes relaxation through meditations, sleep stories, nature images and sounds, and is designed to reduce anxiety, improve sleep and help users feel happier.

JOANNA ROMERO CARTAYA, PhD:
This is a visually beautiful application with lots of nice features; however, it can be challenging for someone who is new to meditation or mindfulness as it provides limited psychoeducation and information regarding developing and integrating meditation practice. The app boasts lots of different options with experts and some star-powered performers to deliver its content—but it is unclear whether content is effective given the lack of research—especially regarding sleep stories and how this option may assist users in having better rest. While I enjoy this application, it is one that I would recommend only to clients or other psychologists who have experience with meditation, like a lot of customization and options, and would like to have either additional options to expand their already developed meditation practice skills, especially to invest in access to all the content. I also would only recommend to those clients who are high functioning, looking to expand their practice or gain additional tracking and accountability, and also have resources to invest in the application.

KRISTI K. PHILLIPS, PsyD:
Calm’s guided meditations, Breathe Bubble exercise, music, mindful body exercises, bedtime stories, master classes, are all helpful tools to encourage and reinforce positive thinking practices. I like the breadth of content, which includes content for children/adolescents and adults and is available in English, Spanish and German. I found the content of the Calm app is likely to help patients manage stress and anxiety better and the added ritual of adding a sleep-time story can help to create a peaceful environment for a good night’s sleep.

The Stop, Breathe & Think (SBT) mobile app is intended to help users cope with stress, anxiety, depression and insomnia through mindfulness and meditation.

CHARMAIN F. JACKMAN, PhD
The SBT app is an excellent way to help clients build a mindfulness practice. Once your clients understand the concepts of mindfulness, using SBT is a great way to help them build a sustainable practice outside your sessions. The data collection component allows both you and the client to track their mindfulness activities between sessions, which can be helpful as you design interventions for the client. SBT offers many options of sessions and activities; it would be a long time before clients will fatigue with the content.

KEVIN D. ARNOLD, PhD, ABPP
If you’re a therapist who uses ACT or other interventions that rely on relaxation and mindfulness this app could be useful in both facilitating homework and tracking progress of those interventions. Since anxiety treatment is based on exposure protocols, it would likely not be useful for those patients, nor would it seem well suited for depressed patients. However, to create a useful stress management program, this app likely would work quite well. Like so many apps in this genre, the ultimate question is how long your patient might use it after the first few sessions. Research on user data indicated that in a 13-month period from 2016 to 2017, 10,000 users completed 10 or more sessions, which is impressive.

Let’s Get Technical is a new column where psychologists rate and review the various software and mobile applications available to practitioners for their professional use. The column is published quarterly in the PracticeUpdate e-newsletter and on APAServices.org. The views expressed in this column are the views of the authors and do not reflect the views of the American Psychological Association or any of its divisions or subunits. All authors have no financial interests in the apps or software discussed. APA does not recommend or endorse any practitioners, products, procedures, opinions or other information that may be mentioned in this column; those who use these applications or products do so at their own risk. Please direct updates and feedback about apps to Communications Office Staff.
TARGETING REIMBURSEMENT

APA Services is working to secure proper and timely payment for psychologists under the new psychological and neuropsychological testing codes.

BY NICOLE OWINGS-FONNER, MA
On Jan. 1, 2019, changes to the billing codes that psychologists use to get reimbursed for neuropsychological and psychological testing services took effect. The new codes and a new coding structure, adopted by the Centers for Medicare and Medicaid Services (CMS), seek to more accurately describe the multiple hours of technical and professional work performed by psychologists and neuropsychologists while conducting assessment services.

The changes were intended to improve the way that providers are reimbursed. But when psychologists started using the codes in January, they reported a range of problems, including uncertainty over how to bill and insurers’ lack of preparedness for the new codes, which led to low payment, delay in payment and even no payment for some psychologists.

Fortunately, the process has been steadily improving, thanks to APA Services, Inc., outreach by state psychological associations, and insurers getting up to speed on the changes, says APA Chief of Professional Practice Jared Skillings, PhD, ABPP.

“We’re moving through predictable glitches at the level of third-party payers,” adds Radhika Krishnamurthy, PsyD, ABPP, a professor at the Florida Institute of Technology and member of the Testing Advisory Group, a multidisciplinary group of assessment experts that has worked with APA Services throughout the development and rollout of the new testing codes.

CHANGES IN THE CODES
APA Services has been an invited participant in the American Medical Association’s CPT® Editorial Panel and Specialty Society Relative Value Scale Update Committee (RUC) (See the related infographic: How Your Services Are Valued.) These committees, created by the AMA and comprising stakeholders from health-care organizations, are responsible for creating and revising CPT codes and their values. As a member of the RUC for over 25 years, APA Services has advocated for modern, fair and accurate coding and reimbursement for all services psychologists provide, including testing services. In addition, APA Chief Executive Officer Arthur C. Evans Jr., PhD, and Past President Tony Puente, PhD, met with CMS officials to explain the value of neuropsychological and psychological testing services.

The new set of codes provides a clear differentiation between professional and technical services (i.e., technical test administration and scoring services versus professional evaluation services). The codes also delineate the work performed by a psychologist or neuropsychologist who personally administers tests and the work of a technician who administers tests under the supervision of the provider.

The new codes are also part of a modernized coding structure that includes stand-alone base codes describing the primary service, as well as add-on codes that describe additional work and time associated with the primary service. This structure is a departure from the previous system where multiple units of the same original code were billed for additional time required to complete the same service. In addition, the new coding structure now uses 30-minute increments rather than one-hour time units for test administration and scoring services. Practitioners must pay close attention to the units of time stated in each testing code descriptor, as they now vary from 30 minutes to one hour.

SETTING THE STAGE FOR IMPLEMENTATION
In the six months leading up to the new codes’ implementation in January, APA Services conducted an educational campaign on the new codes for practitioners and insurers.

For psychologists, APA Services created resources including descriptions of the new codes, a comparison guide with crosswalks between the old and new codes, Q&A documents, instructional webinars and more. (Visit APAservices.org and search for “testing codes.”)

For payers, APA Services’ psychology and coding experts held a live 45-minute webinar...
Each year the American Medical Association’s CPT® Editorial Panel creates new and updates existing CPT® codes that psychologists and other providers use to bill insurers for treatment. Specialty societies, such as APA, work with the panel to ensure that the codes are clinically relevant. Every code corresponds to a service you provide. Here’s how payment rates for those services are set.

1. **YOUR INPUT IS CRITICAL**
   You share input via surveys about the time and complexity/intensity of the services you provide.

2. **APA ANALYZES DATA**
   APA collects and summarizes the data, then uses it to create value recommendations for each service.

3. **COMMITTEE REVIEW**
   APA presents its recommendations to the AMA Relative Value Scale Update Committee (RUC) for consideration.

4. **FEDERAL AGENCY ASSIGNS VALUES**
   After reviewing data from APA and other health-care organizations, AMA submits value recommendations for CPT codes to the Centers for Medicare and Medicaid Services (CMS). CMS has the authority to accept or amend the values.

5. **PUBLISHED BENCHMARK**
   CMS publishes proposed value recommendations for each service in the Medicare Physician Fee Schedule. After a public comment period, CMS releases the final values, which take effect each year on Jan. 1.

6. **INSURANCE DECIDES PAYMENT**
   Private insurance companies set reimbursement rates for psychological services, and other health-care services, using values published in the Physician Fee Schedule as a benchmark.

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Insurers either were not aware of any changes or couldn’t provide any specifics on their payment policies under the new code set. That meant that in early 2019, many psychologists faced long delays in posting fee schedules, rejected claims, payment delays, low reimbursement rates and poor communication.

“We did our due diligence and figured out these new codes and we were ready to roll on Jan. 1. It’s extremely frustrating that huge insurance companies couldn’t also be prepared,” says Greg Perri, PsyD, a neuropsychologist at Compass Counseling and Psychology Services in Kentucky.

To further complicate matters, APA Services learned about a glitch that was exacerbating the confusion. The National Correct Coding Initiative (NCCI)—an entity developed by CMS to control the use of improper coding leading to inappropriate payment of Medicare and Medicaid claims—issued a problematic “edit” to the new codes. (The edits are rules that govern how different codes can be billed together. They are updated quarterly based on changes to the AMA’s CPT® Manual, national and local policies, and current coding practices.) In the edit, the NCCI did not allow the base and add-on codes for test administration and scoring and testing evaluation services to
be billed on different dates of service. That led to payment problems and confusion among psychologists on how to bill.

In response, APA Services reached out to the NCCI to help them better understand standard practice in conducting testing services, which typically involves multiple service dates spread over an episode of care, such as testing sessions and interactive feedback. APA Services’ advocacy efforts led the NCCI to reverse its position, and the problematic edit was suspended in early April retroactive to Jan. 1.

**TURNING THE TIDE**

After hearing psychologists’ concerns, APA Services contacted payers who were not paying practitioners, paying low rates or otherwise creating reimbursement problems, to help educate them on how to properly implement the new testing codes.

For commercial insurance, APA Services first contacted major national companies using established connections with Aetna, Anthem, Blue Cross and Blue Shield, Cigna, United/Optum and Beacon. APA Services described reported problems, worked to establish paths for resolving billing issues, and offered resources to help companies figure out tricky issues with the new codes. As of late May, all major national insurers appeared to have new codes loaded and were processing claims.

For Medicaid, problems have been reported with the implementation of the new codes in 27 states: Arizona, Connecticut, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Texas, Washington and Vermont.

APA Services collaborated with state psychological associations and individual members to address the specific issues in their states. By the beginning of June, issues had been resolved in 10 states: Arizona, Connecticut, Massachusetts, Mississippi, Montana, North Dakota, New Hampshire, Pennsylvania, Washington and Vermont. APA Services is continuing its advocacy efforts in the 17 remaining states.

APA Services is continuing to educate insurers about the new coding structure. APA Services developed guidance documents for commercial and governmental
insurers about the new code set in an effort to help them generate and sustain more uniform billing, coding and payment policies. Collectively, these developments mean the situation is improving, say APA Services attorneys, coding experts and providers.

“Nobody could have anticipated how ill-prepared some payers would be in their implementation of the new codes,” says Connie Galietti, JD, legal and professional affairs director at APA Services. “With our advocacy and educational outreach to payers, they appear to be solving their problems; however, our members have suffered. As insurers start paying late claims, we encourage members to demand payment of interest in accordance with their respective state laws.”

A number of psychologists say that their payers are now properly applying the codes and appropriately processing reimbursements. Psychologists are also reporting to APA Services that they see the benefits of the new codes. Some providers say the distinction between the technical tasks of test administration and scoring versus professional evaluation services like test integration, interpretation and feedback sessions is an improvement. Another benefit, they say, is that they can now bill for the time they spend on scoring tests and on report generation.

“Some of the changes seem to be in the right direction payment-wise,” says Perri. At the same time, other psychologists report it is too soon to know what the financial impact of the codes will be.

### STAYING ON IT

APA Services will continue to fight for the timely and proper reimbursement of psychological and neuropsychological testing services. Specifically, the team of attorneys and coding experts are:

- **Educating payers** that are incorrectly applying the new testing codes.
- **Continuing to advocate** that payers increase the maximum units allowed, to take into consideration time for integration of complicated data, report writing and feedback with patients.
- **Retaining its seat** on the AMA CPT® Editorial Panel and RUC to represent psychology’s interests at the six annual meetings.
- **Closely monitoring** all updates to NCCI edits to ensure they are implementing correct coding methods and that practicing psychologists are properly reimbursed for the services they provide.
- **Preparing for future coding changes.** A new Health Behavior Assessment and Intervention code set will be released this summer in the Medicare Physician Fee Schedule proposed rule. APA Services is prepared to help the profession handle these changes before they take effect on Jan. 1, 2020.

APA Coding & Payment Policy Officer Meghann Dugan-Haas contributed to this report.

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### Learn More

**APA SERVICES, INC.**
The main resource page for testing codes including news, webinars, and crosswalks. [apaservices.org/practice/reimbursement/health-codes/testing](apaservices.org/practice/reimbursement/health-codes/testing)

**UP TO CODE**
The Up to Code column is geared toward informing practicing psychologists about issues that affect billing and reimbursement rates. [apaservices.org/practice/reimbursement/health-codes/up-to-code](apaservices.org/practice/reimbursement/health-codes/up-to-code)

**WEBINARS**
APA Services, Inc. hosts regular webinars on billing and reimbursement, legal issues and other topics of interest to practicing psychologists. To register or to view past programs online: [apaservices.org/practice/news](apaservices.org/practice/news)
For psychologist A. Tom Horvath, PhD, treating opioid use and other substance use disorders isn’t about encouraging patients to surrender to a higher power. While there are many advantages to the 12-step approach, including the large number of groups available, Horvath and his patients prefer to emphasize self-empowerment instead of powerlessness over their disorders.

“In the powerlessness approach, you let it go to a higher power and your sponsor,” says Horvath, president of a private practice called Practical Recovery in La Jolla, California. “In our approach, you build up your own capabilities.”

BECOMING A “GO-TO” PRACTICE FOR ADDICTION TREATMENT

Horvath says he “just fell into” specializing in substance use treatment. After earning his doctorate at the California School of Professional Psychology in 1981 and spending three years in the Navy, he set up his private practice in 1984. “I quickly realized that without some kind of specialty, I would have a tough time,” he says. After discovering that many clients with substance use problems weren’t interested in the traditional 12-step programs he was referring them to, he decided to take on their cases himself. He founded Practical Recovery in 1985.

Back then, says Horvath, there was practically no training available in treating substance use. “APA’s Div. 50 (Society of Addiction Psychology) wasn’t even established until the early 1990s,” says
Horvath. Instead, Horvath learned as he went. “I told people I wasn’t a specialist, and they said, ‘That’s OK, let’s see what we can do together.’”

Specializing in patients with alcoholism, drug addiction and behavioral problems like porn, gambling or shopping, the practice now offers outpatient treatment and a less expensive, less disruptive alternative to traditional inpatient treatment called the Individualized Intensive Outpatient Program. The practice employs two other full-time psychologists, plus a part-time staff that includes a drug and alcohol counselor, a hypnotherapist and a meditation instructor. The practice also shares space with a psychiatrist and works with an outside recovery coach, a massage therapist and an acupuncturist, among other practitioners.

Patients come via two primary routes: the practice’s website and word of mouth, especially referrals from other psychologists. The practice’s more affluent patient population expects a range of holistic services akin to what they would find at a spa, says Horvath. And these holistic providers offer patients an appealing break from talk therapy, especially for patients in the Individualized Intensive Outpatient Program. “If you’ve got two or three psychotherapy sessions per day, it’s good to add one more session in there that’s less oriented toward talking and more oriented toward a more physical type of experience,” explains Horvath. Opioid users find these types of appointments especially helpful, he adds.

“They’re looking for a holistic experience because opiate use is kind of a holistic experience,” he says. “They need some substitutes.”

Meanwhile, the drug and alcohol counselor and the recovery coach both focus on relapse prevention, with the counselor helping patients plan for post-discharge life and the coach working with patients outside the office. The coach might accompany a former opioid user on a drive through the neighborhood where he or she used to buy drugs in a process of desensitization, for example.

Horvath stopped taking most insurance more than 15 years ago. Insurers typically pay less than the open market rate, require lots of paperwork and often deny claims, he says. The one exception he makes to the practice’s cash-only policy is for veterans at the VA San Diego Healthcare System and students at the University of California, San Diego campus. Both of these institutions are located across the street from Horvath’s practice and have easy-to-work-with insurance plans. “I’m a veteran myself, and students are a fun population,” he says. “You get the sense that you can really make a difference in their young lives.” Not accepting insurance for most patients hasn’t hurt the practice, says Horvath. In fact, he says, “we’re one of the go-to practices in San Diego when it comes to addiction.”

While alcohol problems predominate among the practice’s patients, opioid use disorders account for about 10 percent of the patient population. For some, their opioid addiction has its roots in medication prescribed for pain. Others have “worked their way up from marijuana or other substances,” says Horvath. Many are using opioids to help themselves cope with adverse childhood events or more recent traumas. “When these folks [use an] opioid for the first time, they have an experience of, ‘Wow, this is what life should be like. I never feel this way,’” he says.
TREATING UNDERLYING ISSUES
Addressing the underlying issues that make people turn to opioids and other substances is a key part of Horvath’s approach. While 12-step programs focus on addiction, he says, mental health practitioners often go too far in the other direction, focusing on mental health problems while overlooking addiction. What’s needed, says Horvath, is a balanced approach.

“We have to support them while nudging them to make positive changes,” he says. “Our focus is on helping people set limits for themselves and then stay within those limits.” That could mean abstaining entirely, moderating use or taking steps to reduce potential harm.

The practice’s treatment for opioid misuse and other substance use disorders focuses on several broad areas: identifying motivations to change, curbing cravings, finding new ways to solve problems, addressing any co-morbid issues, improving relationships, creating a balanced lifestyle, and finding a greater sense of meaning and purpose in life.

Uncovering patients’ reasons for wanting to change is critical. “Telling people what to do is not the way to get them to change,” says Horvath, who credits his understanding of how to motivate people to his long-ago job as a music teacher of often-reluctant children. “They need to discover their own motivation.”

While some treatment programs require abstinence, Horvath encourages patients to use methadone or Suboxone to help them first work out their underlying psychological problems. “Most of the time I encourage people to be on medication-assisted treatment and tackle their problem one step at a time instead of jumping in over their heads and then possibly relapsing or dying from an overdose,” says Horvath. “The medication just makes such a big improvement so quickly.”

Although motivational interviewing and cognitive-behavioral therapy (CBT) are the predominant strategies the practice uses, an approach called community reinforcement and family training, or CRAFT, is also useful. “It’s a behavioral approach in which parents or partners become reinforcers for positive change for their family member,” explains Horvath. “Family members learn how to reward positive change and ignore undesirable behavior and gradually shape behavior in the right direction.”

While this approach can take a while to work, family members can have a huge influence on helping people find new meaning in their lives. “Sometimes it’s just as simple as having a family member stop paying for opioids, pot, alcohol or whatever the person is using,” says Horvath. The goal is twofold: reducing opioid use and building a better, healthier way of living.

Many patients also attend SMART (Self-Management and Recovery Training) Recovery groups. SMART Recovery, which Horvath helped to found almost 25 years ago, offers mutual support sessions plus tools based in motivational interviewing, CBT and other approaches to improving participants’ lives.

While Practical Recovery doesn’t officially track its patients’ success rates, ongoing contact with many former patients suggests the approach is working.

“When people ask us about our success rate, we say our success rate is comparable to the gym you sign up for or the college you enroll in: It depends on the effort you put into your exercise or your studies,” says Horvath. “If you like our approach, we’re a good fit.”

“Telling people what to do is not the way to get them to change. ...They need to discover their own motivation.”

LEARN MORE
APA’s June Monitor on Psychology features a special report on the ways psychologists are expanding their approaches to address the epidemic, including:

» Improving treatment with behavioral interventions.
» Teaching people to manage pain without drugs.
» Expanding social supports.
» Developing better screening tools.
» Advocating for changes to opioid policies and practices.

Read the June Monitor report at: apa.org/monitor
If you’re seeing patients with opioid use disorder, keep these pointers in mind for billing third-party payers:

Use the right codes when billing Medicare. If the patient has both a substance use disorder and a mental health diagnosis and you’re addressing both in a psychotherapy session, you can use the Current Procedural Terminology® codes for psychotherapy, says Diane Pedulla, JD, director of regulatory affairs at APA. You can also bill Medicare for providing Screening, Brief Intervention and Referral to Treatment (SBIRT)—services to identify and address substance use disorders—with codes G0396 (15 to 30 minutes) and G0397 (over 30 minutes). Check with your Medicare Administrative Contractor for more information on coverage of inpatient and partial hospitalization services for substance use disorders.

Consider the Health & Behavior (H&B) code set if it’s available to you. Targeted toward patients with physical health problems, this set of CPT codes covers health and behavior assessment and intervention. “H&B codes are a good option because there is often a physical component to substance use problems,” says Caroline Bergner, JD, legal and policy affairs officer for APA, citing the physical aspects of withdrawal as one example. “Substance use is a physical problem, too, so an H&B code could be used to help treat it.” Not every payer accepts these codes, however. Medicare reimburses providers for all but one of the codes. Medicaid programs in 35 states accept the H&B codes. Some private insurers are starting to reimburse for these codes, too.

Be aware of upcoming changes to Medicare. Changes to Medicare will soon expand the opioid-related services eligible for Medicare reimbursement, says Scott Barstow, director of congressional affairs for APA. The SUPPORT (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment) for Patients and Communities Act of 2018 included a provision that dramatically increases telehealth eligibility for Medicare beneficiaries with substance use disorders. Previously, Barstow explains, only Medicare beneficiaries who lived in rural areas with shortages of health-care providers were eligible for telehealth services. Plus, patients had to be in a physician’s office, clinic or similar facility when they received the telehealth services. Thanks to the SUPPORT Act, Medicare beneficiaries with substance use disorders who live anywhere in the country will be eligible for telehealth services starting Jan. 1, 2020. And they can receive those services from the privacy of their own homes. “That should open up access to treatment,” says Barstow. “This could be pretty big.”

Make Medicaid part of your practice. Medicaid is already a major player in paying for opioid-related services. In 2016, for example, Medicaid covered 40 percent of nonelderly adults with opioid addiction, according to a 2018 Henry J. Kaiser Family Foundation briefing report. That coverage greatly improves access to opioid misuse treatment, the report found, with those covered by Medicaid twice as likely to undergo treatment as those with no insurance and those with private insurance. And access to treatment for Medicaid beneficiaries with opioid misuse disorder is increasing, too, says Bergner, with many states using waivers that suspend some of the normal Medicaid requirements and give states greater flexibility as they combat the opioid crisis. Although psychologists can face some challenges in participating in Medicaid, Bergner urges them to get involved, too. “We encourage eligible practitioners to make Medicaid a small part of their practice as a way of addressing the opioid crisis,” she says. “Psychologists have a call to help people, and this could be a way to assist.”

HOW TO BILL FOR OPIOID-RELATED WORK

BY REBECCA A. CLAY
A MULTIDISCIPLINARY APPROACH TO TREATING OPIOID USE DISORDERS

As a psychologist at a residential treatment center, Monika E. Kolodziej, PhD, addresses patients’ co-occurring conditions.

BY REBECCA A. CLAY

The typical patient with opioid use disorder doesn’t just have an addiction problem, says Monika E. Kolodziej, PhD, until recently the director of psychological services at Fernside, a 30-day residential drug and alcohol treatment program of McLean Hospital in central Massachusetts (see Editor’s Note on page 19.) Co-occurring mental health problems, such as mood disorders and post-traumatic stress disorder (PTSD), are common, says Kolodziej, explaining that depression and anxiety can render people vulnerable to opioid use.

In addition, patients may have chronic medical conditions. “They might have migraine headaches, for example, which is how they get into trouble with opioid use,” says Kolodziej, who is also an instructor of psychology in the psychiatry department of Harvard Medical School. “Or their opioid use may have put them at risk for HIV or hepatitis C.”

Historically, says Kolodziej, substance use treatment programs haven’t always addressed patients’ co-occurring conditions. But treating these overlapping problems—substance use, mental disorders and medical conditions—is the very purpose of Fernside.

“In the past, the trajectory was to first treat the substance use and then address the psychiatric issues once the person was no longer under the influence,” says Kolodziej. “Hopefully now people will find a service provider or clinic where both are integrated together or at least simultaneously.”
As she finished her training, she worked as a health psychologist, working with substance use disorders made a lot of sense: It’s a behavioral change process.

“With my training as a health psychologist, working with substance use disorders made a lot of sense: It’s a behavioral change process.”

When patients are admitted, each team member tackles his or her own responsibility. Kolodziej, for instance, conducted psychosocial assessments, communicated with family members and reached out to patients’ usual mental health practitioners for information and possible collaboration.

After each team member completes an initial assessment, the team sits down to develop a plan of action. Once the patient agrees to that plan, treatment—with medications used to treat opioid use disorders playing a key role—begins. When the 30 days are up, the team collaborates with the patient on a new plan for the often-difficult transition phase, which may include living in a halfway house and getting family members involved to increase accountability.

Kolodziej also emphasizes the importance of collaborating with other healthcare professionals and with patients themselves as she trains the next generation of psychologists by supervising postdoctoral fellows. One key message? Just how common these problems are.

“Opioid use disorder and other substance use disorders are pretty prevalent in our society, but only a small number of people will seek treatment,” she says. “We have to give a message of encouragement to the person who has the courage to get into treatment.”

Kolodziej and her colleagues at McLean are transforming their multidisciplinary approach into an app. As winners of a 2017 innovative technology competition sponsored by McLean’s parent company Partners HealthCare, the team is working with technology experts to create a smartphone app that will improve access to treatment for individuals with co-occurring mood and substance use disorders.

Editor’s Note: Kolodziej recently transitioned into a new role as director of psychological services at McLean’s Ambulatory Treatment Center at Naukeag, which features shorter stays for patients.
EXPANDING OUR PRACTICE ETHICS

Let’s challenge our ideas about who are our “patients” and how we can have the most impact

BY JARED L. SKILLINGS, PhD, ABPP

As practicing psychologists, we are bound by a code of ethics that sets the standards for our professional conduct. It helps us treat our patients effectively and safely. However, as integral as this code is to our work, it has limitations. The ethics code, by design, is relatively static. Its principles and standards are meant to be fixed and constant, and that’s a good thing. But that also means that the code can’t always keep pace with the rapid changes that define modern health care. New trends and developments in technology, for example, may begin influencing your practice before you’re prepared for them, and before professional organizations like APA can provide guidance on how to deal with them.

Consider payment apps, like Venmo or Paypal, which can be wonderfully convenient for both providers and patients. Is it ethically necessary for providers to ensure these apps are private? Or is it enough to inform the patient of privacy risks and obtain consent before using the app? We don’t yet have clear answers to those questions.

Big, industry-driven shifts may also leave you wondering about what it means to have an ethical practice. For instance, in 2018, Boston-based behavioral health company Beacon Health Options opened a mental health clinic in a Texas Walmart store, with plans to open additional clinics in other retail locations nationwide. While some psychologists may applaud this move as innovative, others may be concerned about Beacon’s business model, patient confidentiality, quality of care and what this means for traditional psychological services.

Expanding access to care is a good thing—but how we do it also matters. I believe that this crisis of access is a problem that psychologists have an ethical responsibility to help solve. In fact, I think we should be the leaders in this area.

By some estimates, more than 24 million Americans who are experiencing mental illness are going untreated. What would it look like if psychologists thought of ourselves as ethically responsible for whole communities, including marginalized groups, that need our services but have little or no access to them? What impact could we have if we developed care models not only for our patients, but also for people who are disengaged from health care, such as those in deep poverty?

I am not suggesting that psychologists should be held responsible for care of patients they have never seen. However, if ethics are foremost about doing good in the world, I do want to challenge our mental framework about who is our “patient” and how we have the most impact. It’s up to us to begin exploring, as a profession, what it means to practice ethically right now and in the future. In fact, APA’s new Ethics Code Task Force is undertaking development of an Ethics Code that is transformational, future-focused and responsive to modern complexities.

For our profession, reform is an incremental, collaborative process that begins with careful assessment of the status quo and thoughtful exploration of what we might change. Given how quickly the world is evolving around us, it’s time for us to begin. •
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