

## Offer nets new members, early renewals

Nearly two dozen LCSWs took advantage of a special offer and joined the Missouri Society of Clinical Social Work.

This was the second year that the Society sent out a mass mailing to St. Louis-area LCSWs. Last year's recruitment drive netted six new members. This year, new members were offered a special \$120 rate to join before Oct. 15.

"The Society is somewhat of a well-kept secret," said MSCSW Board Member Linda Pevnick. "We have a lot to offer the clinical social work community and at the same time, more members give us a stronger voice. We're delighted to welcome our new members."

In addition, about a third of existing MSCSW members took advantage of the special offer to renew their membership early at the discounted rate.

"Many people probably don't realize the time and money our membership renewal process takes," said MSCSW Treasurer Al Barton. "We save money by not having to send out renewal notices, so we passed that savings on to members." In addition, the Society continues to add value, Barton noted. "Last year we introduced a billing and insurance hotline and a new web site.

*(Continued on page 5)*

### *Benefits of Membership*

- At least 18 hours of Continuing Education programs included in the cost of membership
- Access to a nationally recognized billing/insurance expert
- Mentoring program
- Opportunities to interact with your clinical colleagues
- Updates on legislation and other issues of concern to clinicians
- The satisfaction of knowing you are helping to maintain the standard of excellence in your profession
- And much, much more!

## New state law adds two license tiers, prompts concern

### Inside this issue:

Practice management	2
Clinical topics	4
Member profile	5
State committee membership	4
New members	6

At its Sept. 11 meeting, the State Committee for Social Workers, the government body which oversees LCSW licensure, expressed concern that new legislation could require some LCSWs to obtain an additional license.

MSCSW Executive Director Stacy Ross, Past President Barbara Edelman and member emeritus Susan Newman attended the meeting to learn more about the legislation, Senate Bill 308.

The legislation, makes changes to the laws governing numerous licensed professionals, including social workers. It adds two new levels of social work licensure -Licensed Advanced Macro Social Worker and Licensed Master Social Worker- and removes language regarding the scope of practice for LCSWs.

State Committee President Jenise Comer said she felt "blindsided" by the final bill. Comer said she had been

assured there would be no changes to the scope of practice in a meeting prior to the bill's passage.

Specifically, the words "community organization," "planning" and "evaluation" have been removed from the description of the scope of practice for LCSWs. Those same phrases are included in the scope of practice of the new Licensed Master Social Worker and "community organization" is included in the scope for Licensed Advanced Macro Social Worker .

State Committee Director Tom Reichard said that could be interpreted to mean LCSWs who perform those functions would be required to get the new LMSW license in addition to their clinical license.

The Licensed Master Social Worker scope is defined as "assessment, treatment planning, implementation and evaluation, case management, media-

tion, information and referral, counseling, client education, supervision, consultation, education, research, advocacy, community organization and development, planning, evaluation, implementation and administration of policies, programs, and activities.

The Licensed Advanced Macro Social Worker scope includes: "the professional use of self to community and organizational systems, systemic and macrocosm issues, and other indirect nonclinical services; specialized knowledge and advanced practice skills in case management, information and referral, nonclinical assessments, counseling, outcome evaluation, mediation, nonclinical supervision nonclinical consultation, expert testimony, education, research, advocacy, social planning and policy development, community organization, and the development,

*(Continued on page 5)*

## Practice Management

# When is it time to enlist your patient's

By Susan Frager, LCSW

If you're a participating provider with any managed care panels, your contract most likely states that you must accept assignment, i.e. accept payment directly from the insurance company for your services. You cannot bill the patient except for any applicable deductibles, co-payments, or coinsurance. If there are claims problems, you are expected to resolve them with the insurance company; you cannot simply tell the patient to "pay up and handle it yourself."

Managed care companies, of course, put this provision in their contract for a reason. They want to make sure their patients get care without having to pay more than is their responsibility under their policy. At the same time, although it is never formally acknowledged, insurance companies hope that by putting a number of obstacles in the way of claims payment, a certain percentage of providers will simply write off the charges and not pursue the claims; thus saving the company money and earning them more in interest.

So, is it ever appropriate for you to expect your patients to take care of their own claims issues if you're a contracted provider? Actually, there are times when the answer is yes. (*Please note this only applies to private, commercial insurance - government payers have their own rules*). Certain situations cannot be handled by a practitioner's office; by definition, therefore, they are a patient's responsibility:

1. Eligibility/COBRA
2. Coordination of Benefits (COB)
3. Full-time student status
4. 4. Pre-existing conditions

Eligibility may seem obvious. If the patient's policy has terminated or was never eligible to begin with, your contract with the insurance

company does not apply. But there's sometimes more to the story. What if the policy is supposed to be active, but there's a computer glitch? It happens frequently, especially at the start of the year. Apparently, even in the age of real-time computer communication, benefits have to be "loaded" the old-fashioned way, from eligibility tapes received from the patient's Human Resource department. HR sends the info to the insurer, who then must send it on to the mental health carrier, if the mental health benefits are "carved out" (*i.e. administered separately from the medical plan*). During this delay, a patient may show as not eligible. COBRA policies work similarly. When patients elect to continue coverage through COBRA after leaving a job, getting divorced, or some other circumstance, they have until the end of the following month to pay the premium for the preceding month. In other words, patients have until October 31<sup>st</sup> to pay September's premium. Then, when the COBRA premium is received, the insurer has to process it and notify the mental health vendor. This could take up to an additional two weeks. Thus, claims for September dates of service could be processed long before the second week in November - and denied as "not eligible"

Why is this the patient's responsibility? Because providers certainly are not able to influence when or how Human Resources communicates with insurance companies, or when insurers communicate with mental health vendors, or the processing of patients' COBRA premiums.

Good management of accounts receivable means staying on top of what patients owe, why insurers are not paying, and intervening promptly before the amount of money owed gets to be too large. At the first hint of any eligibility snafus, it's best to get the patient involved. Often problems can be determined by a phone call to verify benefits prior to or just after the first appointment. If there's an eligibility

problem, a phone call from a patient – *particularly one with a bill in hand!* – might resolve the issue. When clients elect COBRA coverage, it's a good idea to explain how COBRA works. While you should not bill the patient if they have stated their intent to pay their COBRA premiums, it is important to follow through with the patient with regard to when payments are sent. If after 2-3 weeks that COBRA premium is not processed and claim(s) continue to deny as "not eligible," the patient needs to get involved.

"Coordination of Benefits" is the process used by insurers to determine, in the event a person has more than one policy, which policy should pay first. There are formalized rules the industry has agreed on; patients cannot simply choose which policy they prefer. Here are a few of the most common guidelines/situations, although keep in mind this is certainly not an exhaustive list and there will always be special situations that occur:

1. Medicaid is ALWAYS the payer of last resort (bill Medicaid last in all situations);
2. Following from #1, if a patient has both Medicare and Medicaid, then that is the order you file the claims.
3. Medicare can be either primary or secondary if the other insurance is commercial; it depends on the situation and must be determined by the Medicare Part B carrier's Secondary Payer Unit.
4. If a retired member of the military has Medicare and Tricare, that is the order to file the claims (*the Tricare claims go to a special unit called Tricare For Life*).
5. When a patient has Medicare but has a spouse that is still working, the commercial insurance policy of the working

# help in getting your claims paid?

spouse is primary to Medicare.

6. When two spouses each carry their own insurance and each policy also covers the other spouse: If you are treating the husband, you would first bill his policy, then bill his wife's. If you are treating the wife, you would first bill her policy, then bill her husband's.
7. When a child is covered under both parents' policies (*non-divorced parents*): The "Birthday Rule" applies: the policy of whichever parent is born first in the calendar year is the one that is primary. Not whichever parent is older; whichever birthday comes first. In other words, dad might have a birthday of 9/1/56 while mom was born 3/12/60. Dad is older, but mom's policy would be primary because March comes before September.
8. When a child is covered under both parents' policies (*divorced parents*): In the absence of a court order specifying which policy is primary, the Birthday Rule applies. However, frequently the divorce decree spells out whose insurance is to be primarily responsible, and it is not uncommon for parents to have to present copies of the court order to their insurances in order to establish who is to pay first. It gets trickier still when the parents have remarried and children are covered by step-parents; always ask if there is a court order.

Given these and the myriad of other situations, it is clearly not always easy to determine which is the primary payer. When in doubt, do not try to figure it out yourself and do not depend on the patient either. How can anyone possibly know all the arcane rules? When you

guess, you have a 50% chance of being wrong – and having to re-file all the claims, sometimes years later, can not only be a headache but could cost you money in takebacks. Instead, tell the patient that s/he needs to fill out a "Coordination of Benefits" (COB) questionnaire with both insurers. Most insurers will have a copy of their questionnaire available online, or the patient can call to get one mailed out. This process will determine the correct filing order.



Often, the first claim of the year or the first claim to an insurer that indicates the existence of another policy will trigger a COB questionnaire being mailed out to the patient. Keep in mind...if there is even the remotest

possibility that another carrier is responsible, naturally an insurance company is going to try not to have to pay! If the COB process occurs after claims are filed, it is the patient's responsibility to comply. Many times patients aren't sure what the COB letter means when they get it, so they throw it away. When that happens, you won't get paid. Insurers are required by law to notify you, either through a letter or on a remittance advice/explanation of benefits (EOB) form, that there will be a delay in processing the claim. The notification will state they are waiting for information from the member about other insurance. That should be your cue to contact the patient immediately to make sure they are cooperating with the COB request.

Ignoring COB could be costly for you; patients tend not to pay your bill because they believe (and rightly so) that it is the insurance company that should pay, and the insurance company won't pay until it is determined which carrier is primary.

Verifying full-time student status is a frequent cause for delays for anyone treating young adults. Between ages 18 and 25, policies often specify that a young adult must be a full-time student in order to qualify for benefits under a parent's policy. So, insurers demand proof of student status, usually in the form of a letter from the school's registrar's office. If they don't get it, they won't pay! Here too, the law requires that insurers notify providers who have submitted a claim that the claim is delayed pending submission of student status proof. And once again, it is the provider that is frequently the financial loser-unless the issue is dealt with while the young adult is still in treatment. Often sending a bill provides the impetus necessary for the young adult patient to take responsibility to prove student status to their insurer. Don't wait until the unpaid bill gets too large!

Denials of benefits due to pre-existing conditions, contrary to popular belief, are not illegal. HIPAA severely curtailed this practice, but did not eliminate it entirely. The law states that for patients transitioning from one group policy to another (including COBRA), pre-existing restrictions are illegal if there was no gap in coverage greater than 63 days. However, patients often have to prove there was no gap by sending a certificate of coverage from the old insurer to the new one. It is a matter of routine that upon termination of an insurance policy, a carrier will send this certificate; however, patients often don't know what they are supposed to do with it! Practitioners are powerless to affect pre-existing denials; the only way to get

(Continued on page 6)

## Clinical Topics

# It's, like, what are you really trying to say?

By Nicki McClusky, LCSW

We hear this all the time... "It's, *like*, well, we went to, *like*, the mall."

Did you or did you not go to the mall is the question. **Was it a real experience or "like" a real experience?**

I don't know about you, but as a voice coach and a promoter of excellent speaking (in everyday conversation and in one's professional world), it drives me a little batty to hear "like" twice or more in one sentence when that word is not being used to point out a *simile*.

As a voice therapist and psychotherapist, I hear something else going on other than a popular speech pattern being used; at least I *think* something else is going on, and I usually inquire at some appropriate point. The inquiry is about what in reality is painful or being moved away from, for some reason.

"Like" is a step removed from "what is." When something is "like" something else, it is *similar*...not the same, not quite the real thing.

One day I sat with a young client who was describing a difficult interaction with her family. "Like" was front and center, all over the description. I could barely concentrate on what was being said, for "like" appeared about every fifth word.

After she'd had a chance to 'download' the experience, I asked her if she thought she'd become aware of or expressed her deepest feelings about what had happened.

She was quiet and then said, "No...because if I did, I think I'd explode!" She was absolutely furious

with them. She was angry with herself that she hadn't found a way to take care of herself more than she had amidst the relating. And, under the anger, we discovered, was enormous pain. "Like" signaled me to listen for what was *not being said* about her deeper inner reality; I thought that it must be quite painful, also, since "like" was so predominant, telling us she'd moved away and away and away from what was most real for her.

She later asked me how I knew she had other deep feelings that remained unexpressed during the description of the interaction; I told her that I thought her frequent use of the word, "like" told me she was several steps away from what was most real and difficult for her to feel and name...her real anger and her real and deep pain. My client then said she thought she was using "that word" a lot and didn't know why. She felt embarrassed to use it so much, even though she felt compelled to do so.

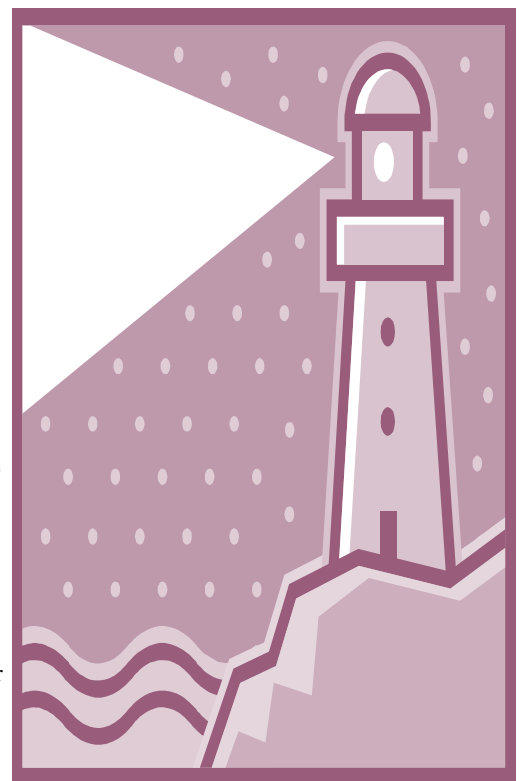
We talked about "like" as something she could now utilize---it could become a noticing tool for her: if she could hear herself saying "like" more than once in a conversation, then at some point in the near future, she'd know to go inside herself and see what she might be truly feeling, truly thinking, truly experiencing. "Like," seen in this light, could be utilized as a beacon to illuminate the reality of her inner world. It was an important clue.

For many of us, hearing "like" used a lot in a sentence interrupts the flow of conversation and is very distracting. The real meaning of what needs to be said seems hidden.

If you find yourself in this spot, listening to "like" a lot, you might simply inquire in a respectful way, as to what is truly meant or felt. Some young folks do not realize that more is being expressed than simply a repeated and popular "speech pattern"---they are hiding truth. It is a powerful communicator.

Perhaps we can encourage them or anyone who uses "like" a lot, to speak their truth and tell us what they really mean. The truth (as we know), can actually "set us free."

*Nicki McClusky is a psychotherapist, life and voice coach.*



*'Like' is a step removed from 'what is' When something is 'like' something else, it is similar...not the same, not quite the real thing.*

# Member Profile: Zenobia Edwards

**By Susan Newman, LCSW**

Zenobia Edwards is passionate about helping clients regain their sense of balance and well-being. She understands that while low self-esteem, anxiety and anger cross races and cultures, the resulting devastating, empty feelings can work special mischief on African-Americans.

Middle-class black kids, who attend county desegregation programs, often deal with poor treatment from white teachers by disrespecting their black peers, Edwards notes. She is studying the effects of self-hatred, the kind that blacks manifest toward each other by claiming that someone looks or speaks “too white” to fit into the group. In

fact, this is the subject of her doctoral dissertation that she’s earning from the Institute for Clinical Social Workers in Chicago.

“From the time I was a kid, I always wanted to be a therapist. It seemed to me that the mind is like a puzzle; and people need to take the time through the therapeutic process to figure out how the pieces fit together,” Edwards continues that she wanted to be a therapist from the time she was little. Since her parents weren’t able to relate to her need, she became her own therapist, exploring and weighing every part of an issue.

She earned a dual master’s in counseling and social work from Washing-

ton University and has been in clinical practice since 1983. In her private practice in Clayton, Edwards often works with children, families and adolescent groups. Her learning informs her work.

Wounds from self-hatred are deep and pass from generation to generation. “I try to put myself in their shoes,” Edwards says. She wants to support patients on their road to self-examination. “I don’t believe in quick fixes or just managing behavior. My goal is for my patients to resolve the problem,” she says.

*Susan Newman is a retired therapist and freelance writer.*

---

*The mind is like a puzzle; and people need to take the time through the therapeutic process to figure out how the pieces fit together*

---

The Board would like to extend a BIG Thank You to members **Barb Edelman, Zenobia Edwards and Carolyn Zacarian** for helping with the new member solicitation mailing. We couldn't have done it without you!

## **Membership**

*(Continued from page 1)*

This year we plan to increase marketing opportunities for members.”

The MSCSW membership year follows the calendar year of Jan. 1 to Dec. 31. Anyone who has not yet renewed their membership but does so by Dec. 31 will receive the 2007 membership rate of \$125. After Dec. 31, the membership renewal rate will be \$130.

Members who have not yet renewed will receive their renewal notice in the mail shortly. Payment can be made by cash or check and members can renew online through the website: [www.msosw.com](http://www.msosw.com).

Contact Stacy Ross at 314-719-2902 with membership questions.

## **Legislation** *(Continued from page 1)*

implementation and administration of policies, programs, and activities.” Both LMSWs and LAMSWs are precluded from treatment or diagnosis of mental or emotional disorders unless under the supervision of an LCSW.

Proponents of the bill argued that the change doesn’t say LCSWs can’t perform organizing, planning and evaluation. However, the State Committee’s attorney, David Barrett noted that when a change is made in a statute, there is a presumption that there is a reason for the change, “especially when you’re taking something out.”

Ultimately, the State Committee

will draft rules that will determine how the legislation will be implemented. A subcommittee will meet in Jefferson City on Nov. 27 to develop the new rules.

“It’s really important that Missouri Society members make their opinions known,” said Executive Director Stacy Ross. “I would really love to see a strong contingent of MSCSW members attend this meeting.

If you are interested in attending this meeting, please contact Stacy Ross at 314-719-2902.

The full text of SB 308 can be found at: <http://www.senate.mo.gov/07info/pdf-bill/tat/SB308.pdf>

## Who We Are, How to Contact Us

The Missouri Society for Clinical Social Work is a non-profit professional membership organization representing the interests of Licensed Clinical Social Workers. We are affiliated with the Clinical Social Work Association, based in Washington, D.C.

### Board members

**Albert Barton**, Treasurer; (314) 727-7799 [bartonaa@aol.com](mailto:bartonaa@aol.com)

**Vince Marino**, Secretary; (314) 644-5055 [vmarino@familysupportnet.org](mailto:vmarino@familysupportnet.org)

**Tina Dale**, (314) 477-8751, [tinamdale@sbcglobal.net](mailto:tinamdale@sbcglobal.net)

**Susan Frager** (636) 464-8422 [susan@psychadminpartners.com](mailto:susan@psychadminpartners.com)

**Mary Lutz** (314) 725-6552

**Linda Pevnick**, (314) 567-5360 [pevnick@sbcglobal.net](mailto:pevnick@sbcglobal.net)

**Susan Toelle**, (314) 567-5360

**Executive Director:** Stacy Ross

**Contact us at:** (314) 719-2902 or [mcschw@swbell.net](mailto:mcschw@swbell.net)

2806 S. Brentwood, St. Louis, Missouri 63144

or visit us online at [www.mcschw.com](http://www.mcschw.com)

### Send Us Your News!

Have you earned a new degree or certification? Did you win an award or receive recognition for your professional achievement? Or maybe you have been promoted.

Let us know! We want to celebrate our members' accomplishments.

Send your news to [mcschw@swbell.net](mailto:mcschw@swbell.net) or call 314-179-2902.

### Share your expertise with your colleagues!

Are you interested in writing an article for *In Touch*? Let us know!

Raise your visibility and help keep your clinical colleagues informed.

Contact us at [mcschw@swbell.net](mailto:mcschw@swbell.net) or call 314-179-2902.

### Accountability *(Continued from page 3)*

pre-existing limitations waived from the new policy is 1) if the patient's policy qualifies under HIPAA; and 2) the patient must send the certificate of prior "credible" (i.e. HIPAA-eligible) coverage from the first carrier, to the new carrier (*and of course, follow up on its receipt and processing*). Another option, if the patient complies and there is no pre-existing history, is to go through the medical record review process. However, this takes time during which the unpaid bills are multiplying.

If the gap between policies was longer than 63 days, or if it is individual insurance (*legalized discrimination against the self-employed!*), denial of claims for any condition determined to be "pre-existing" is legal for the first 12 months after the policy effective date. Typically, "pre-existing" is defined as any condition for which treatment was sought in the 6 months prior to the policy effective date.

These situations can be costly to practitioners if left unresolved, but as long as the

patient does his/her part, they don't have to be. Good practice management means being proactive and communicating with your patients about financial and insurance issues in a timely manner. Therefore, it's important to identify these situations early, to prevent the accounts receivable from getting too overwhelming. Verifying benefits either prior to or soon after the first visit can uncover potential problems, as can prompt claims filing and follow-up. Patients tend to disappear from treatment when bills get too high; it's important that if you send a bill, you discuss with the patient what his/her options are and how s/he can participate in the process of getting the claims paid.

*Susan Frager, LCSW, is a nationally recognized managed care expert. To access the Billing Hotline or to suggest future newsletter column topics, call Susan at 636-464-8422, or email: [susan@psychadminpartners.com](mailto:susan@psychadminpartners.com). © Susan Frager 2007.*

### Welcome New and Returning Members!

Jama Anthony-Petter

Sherri Ardekani

Tasha Arrington

Shirley Booker

Robyn S. Cherry

Robin Chervitz

Shirley Crenshaw

Laura Cummings

Maureen Ellis

Mike George

Judith A. Hoffman

Mark C. Hunyar

Diane Kashuba

Peggy Keilholz

Christine M. Nolle

Michael Orihuela

James P. Rudden

Rosette M. Signorelli

Norman Thomas

Linda Lee Vawter

Michelle Vollmar

Debra K. Wicker