

'07-'08 Continuing Ed schedule finalized

The 2007-2008 continuing education schedule has been finalized and once again we have a terrific lineup—with a huge debt of gratitude to our talented members and other professionals who will be presenting.

We'll see some familiar faces as well as several new ones. We will open the schedule with a fun networking event in September that will include a wine and cheese social following the program. Once again we'll be offering a three-hour ethics workshop that will fulfill the state

requirement. A schedule with detailed descriptions will be published in August.

The following is a complete list of programs for the upcoming year:

September – Speed Networking/Marketing

October – Susan Frager, Managed Care

November - Nicki McClusky , Life Coaching II (see related article on page 3)

December – Joe Pickard, The Myths and

Realities of Aging

January – Joy Allen, Gottman Couples Therapy

February – Ann Desmond, topic TBA

March – Barb Edelman and Christine McNaughton, Recovering from Mental Health Disaster Relief

April – Peggy Keilholz , Ethics

May - Dr. Arturo Taca, Addictions

How can Generalist and Clinical Social Workers get along?

By Laura W. Groshong, LICSW

Through the course of my work on social work licensure, which took me to more than 30 states, I have repeatedly encountered differences between the generalist and clinical views of social work. These differences, not surprisingly, affect the way each group views state social work title and practice regulation. In my experience, generalist social workers have most commonly made title protection of the term social worker a national priority. Clinical social workers have made practice protection their primary goal.

Two other factors to consider in understanding these differences are the impact of the widespread exemption from regulation of state 'social workers' and the drastic cutbacks in clinical coursework in schools of social work. Finally, there is the question of what the difference in scope of practice should be for baccalaureate-level social workers (BSWs) and

master's-level social workers (MSWs) in generalist and clinical social work practice.

Paradoxically, as schools of social work have, for the most part, dropped the clinical courses which were common in the '60s and '70s, clinical social workers have become a major part of the mental health treatment system. In various polls, 40 percent to 60 percent of practicing social workers see themselves as doing clinical social work. But many states are seeing legislative disagreements regarding what generalist and clinical social workers do. And why does a field that prizes diversity in all forms have difficulty accepting the diverse ways social work is practiced?

Common Ground or Different Strokes?

What makes social work unique are the principles that underlie any practice of social work— respect for the humanity in everyone, respect for the

diverse forms our humanity takes, respect for self, and the ethical underpinnings on which social work is based. This is not a model for practicing generalist or clinical social work: it is a value system.

Unfortunately, these principles have become grounds for denying that there are differences in education, training, background, and experience among social workers, which are real and must be understood and accepted. The practices of what have become generalist and clinical social work are based on different interpretations of basic social work values and how to apply them.

The split between Jane Addams, with her view of social workers as "friendly visitors," and Mary Richmond, with her view of social workers as "social caseworkers," during the early years of the profession has never really healed, for good reasons.

(Continued on page 2)

Inside this issue:

Life Coaching	3
Garage sale fundraiser	3
Peer supervision group forming	3
Clinical documentation	4
New members	6

Can Generalist and Clinical Social Workers Get Along?

(Continued from page 1)

The kind of social work Addams espoused was a direct service model, which was based on protecting and providing basic services for those who could not protect or provide for themselves. An additional goal was to advocate for better living conditions through social policy/legislative changes. The inner lives of clients were not addressed directly. Richmond, on the other hand, tried to understand the emotional worlds of her clients, sometimes minimizing what they needed in terms of external support.

It may be that Addams and Richmond were looking at different clients with different needs. Clients who are literally unsafe, whose lives are unpredictable, and who are unstable internally and externally are different from clients who feel unsafe, insecure, and unstable, but have an income, food, and shelter. Both groups are in need of service and should be respected by generalist and clinical social workers. This may mean both groups need to expand their view of what social work practice means—a difficult task.

Generalist Social Work Identity

Most who consider themselves generalist social workers have a strong commitment to social advocacy, justice, and policy but do not include clinical skills as a major part of their identity. Most generalist social work is done in private or state agencies, including most case management and casework. There is resentment in generalist social work regarding the amount of paperwork required to coordinate and document services, which is obviously not the reason most people follow this path.

The public perception of generalist social work is often negative, leading to further frustration. The fact is that generalist social work is often being done by people who have no social work training. The divorcing of social work education, generalist titles, and generalist practice is a hill that is hard for generalists with a social work degree to climb.

Clinical Social Work Identity

Clinical social workers are committed to providing mental health services to their clients through various treatment modalities and theoretical orientations. They see themselves as one of the six major mental health specialists, in addition to marriage and family therapists, mental health counselors, advanced registered nurse practitioners, psychologists, and psychiatrists. Most work in private practice or supervisory positions.

While most clinical social workers have a basic commitment to social advocacy, justice, and policy, their primary interest is in providing mental health treatment as clinicians. The acknowledgement of generalist social work practice by clinical social workers has been largely reactive—i.e., when generalists seek to legislatively define social work in ways that impact clinical practice negatively, they respond to protect their scope of practice. Otherwise, there is not much discussion in clinical social work regarding the way generalist and clinical social work share common ground or

work together.

Clinical social workers have worked diligently to become independently licensed over the past 40 years and have established scopes of practice, educational, experiential, and supervisory standards in all 50 states and Washington, DC, as of 2005. Identifying the clinical elements of casework and case management has not been a priority for clinical social workers.

The practice of clinical social work may include private practice and the provision of clinical supervision. As in generalist social work, there is resentment in clinical social work about the paperwork required, often for reimbursement, and most do not see triaging, finding services to meet daily needs, or coordination of services as part of their work.

Clinicians often feel alienated from generalists because clinical skills are not included and/or valued as part of generalists' skill set. Many clinical social workers also have a commitment to main-

taining the "frame" (as defined by Robert Langs) in treatment, which means avoiding doing things directly for the client and focusing on the client's inner world and the therapeutic relationship itself. This approach to social work is difficult to maintain in casework and case management—i.e., child protective services, foster care services, etc. However, other applications of clinical social work in these areas could be better defined and developed.



Clinicians often feel alienated from generalists because clinical skills are not included and/or valued as part of generalist social workers' skill set

(Continued on page 6)

Continuing Ed summary: Life Coaching

By Linda Pevnick, LCSW

MSCSW member, Nicki McClusky, treated us to a taste of Life Coaching at her presentation for our Education Program on Saturday, April 14. Nicki gave an extremely well organized presentation, giving us an overview of what Life Coaching is and isn't and how it differs from Psychotherapy.

She explained that Life Coaching is about helping clients achieve an even more fulfilling and balanced life

while Psychotherapy works on reducing the symptoms and conflicts inherent in a mental illness. Nicki has taken extensive training in order to be a Life Coach and says she very much enjoys it. She calls her practice Life Coaching from the Bridge, which participants found very creative.

Nicki led us through two exercises that were designed to give us a feel for what it is like to be a client in life coaching. In both exercises, we identified what we want in life and we

explored the strengths we could use to go after what we want. Personally, I really enjoyed the exercises and found I gained insight and encouragement from both in a very short time.

Nicki's program was well attended and there was a lot of enthusiasm for the topic. Nicki volunteered to present a continuation workshop for us in the Fall. Participants expressed their desire for her to do so. I recommend attending it. Thank you, Nicki.

Life Coaching is about helping clients achieve an even more fulfilling and balanced life while Psychotherapy works on reducing the symptoms and conflicts inherent in a mental illness

Peer supervision group forming

After nearly 20 years in private practice, MSCSW member Zenobia Edwards knows the isolation many clinical social workers feel on a daily basis. So Edwards wants to do something about it.

She is organizing a peer consultation group for psychodynamically oriented therapists and several members have expressed interest.

Hoping to kick off the group this fall, Edwards is seeking input on the frequency, time and place of meetings as well as how to incorporate any case presentations, discussions about various topics, books, articles and theories. All ideas are welcome.

"The main thing I am looking for is an opportunity to support and learn from others," Edwards said.

A Washington University MSW graduate, Edwards is currently completing her Ph.D. at the Institute for Clinical Social Workers in Chicago.

She specializes in family therapy.

To learn more, contact Zenobia Edwards at 314-997-4700 or e-mail zenoedwards@sbc.net

Members pitch in for garage sale fundraiser

It was a lot of work and not without casualties, but the Missouri Society's garage sale on April 28 raised a few dollars and even resulted in a new member.

Board member Tina Dale graciously offered her garage in Richmond Heights as the site and the weather cooperated.

Many members donated clothing, books, dishes, toys, knick-knacks and furniture. Board member Susan Toelle gets credit for donating the item that

brought the single highest sale price—a grandfather clock that sold first thing for \$125.

Members Angela Cook and Joy Allen joined board members Linda Pevnick, Al Barton, Susan Frager, along with Dale and Toelle in setting up and working the sale. Member Teri Powers stopped by to offer moral support and made a cash donation.

Several students stopped by and found fantastic bargains on an excellent selection of professional texts.

Washington University student Michelle Rubenstein even was compelled to join the Society while shopping!

Board member Nicki McClusky, who did much of the preliminary work, suffered the sale's lone casualty—two broken arms, a sprained ankle and bumps and bruises from a fall while dropping off items.

We wish Nicki a speedy recovery!

Practice Management

Accountability...

By Susan Frager, LCSW

Over the last 18 months, major managed behavioral care organizations have moved in the direction of either eliminating or reducing the burden of Outpatient Treatment Reports (OTRs). This is a good thing... isn't it?

Of course it is! Those reports, especially when they consisted of essays, were burdensome.

Every insurance patient, every four to 10 visits. What a pain. I remember having to review those essays, when employed by the corporate ancestor of Magellan Behavioral Health. Ninety-nine percent of them were appropriate to the patient's presenting condition, and of acceptable duration of care, given the symptoms. What a waste of everyone's time and money.

Insurance companies finally accepted what we clinicians knew all along, namely, that paying care management staff to review these essays was cost-prohibitive. And where some companies responded by doing away with OTRs altogether (Cigna, Aetna, many of the Blues), others (United, Magellan, ValueOptions) moved to checklist-style forms that could be scored by a computer programmed with pre-determined algorithms according to diagnosis and symptoms.

So does this mean we can all go back to the old way of treating clients without expecting any interference from managed care?

NO!!!! Make no mistake. There is still accountability in the post-OTR

world.

Any time an insurer is involved, they have the right to demand substantiation of "medical necessity," either before or after paying the claim. That's why clients sign a release of medical records, denoted by the "signature on file" or live signature in box 12 of the claim form, which reads "*I authorize the release of any medical or other information necessary to process this claim.*"

So how does accountability work now that OTRs are gone? Cases are identified either by claims audits (typically number of visits per diagnosis much greater than average), or by the screening algorithms for those companies that utilize checklist-style reports.

Audits and requests for additional information should be taken seriously; If an insurer determines that there was not sufficient "medical necessity" for treatment, they can and do take back the money they have paid. In the case of Medicare, they even extrapolate.

Here's how extrapolation works: Medicare audits a sample percentage of all the claims paid during the audit period and then generalizes about the whole number. So if the audit period is 2004 and you had 100 claims, Medicare audits 5 percent, or five claims. If 40 percent of the 5 percent (i.e. two visits out of five) is then found to have been not medically necessary, Medicare will conclude that 40 percent of ALL 100 claims in 2004 were not medically necessary. They will then demand back 40 per-

cent of the 100 claims paid during 2004, not just the two visits of the audit sample. It could add up to quite a lot of money.

So it's often a shock when that letter or phone call arrives, telling you that in general, you are averaging a greater number of visits per diagnosis than your colleagues, or that a specific client has been seen *x* number of times and they want to know what's up. How should we as clinicians respond?

The first and most important rule is: DON'T PANIC. Take a deep breath. Or several. After that, try to remind yourself that there is nothing whatever personal about this request for more information. It is truly no reflection on your skills as a clinician. Because therapy is so personal, this is, I know, harder than it sounds.

The next step will be to respond according to what is requested. If there is a specific case identified, you may wish to consult with a supervisor or colleague, for objective feedback. Ultimately, however, everything will hinge on how thorough your clinical documentation was. It really is a case of "*if it isn't documented, it didn't happen.*"

What should good clinical documentation consist of? From an insurer's point of view, the most critical thing is evidence that you are treating the diagnosis that is reported on the claim form. That means you must document the presenting symptoms which support the DSM-IV (ICD-9) diagnosis. These should be listed, for each visit.

Make no mistake. There is still accountability in the post-OTR world.

...in the Post-OTR World

It is perfectly all right to buy a symptom checklist, or make one up yourself, to make note-taking faster. Along with symptoms, each session note should consist of the following: the remainder of the diagnosis (Axis 2-5), a description of the patient's mental status, presenting problems, psychosocial stressors, treatment goals, progress towards goals (or lack thereof), medications, and interventions. Note that the intervention should correspond to the CPT code billed. For example, insurance companies will consider it to be misrepresentation, if not outright fraud, to see that "marital counseling" was an intervention on a visit that was billed as 90806 (individual therapy).

Most major insurances have websites where treatment record review checklists and tools can be downloaded. The forms are very similar to each other; Pick one and evaluate your treatment record format against it. When you make improvements, the requirements of one insurance company will most likely match or come close to the requirements of all of them.

It's not even just insurance company audits that are of concern. This is an increasingly litigious society. If by some chance a patient files a malpractice suit, or makes a licensing board complaint, your documentation will also be scrutinized. Lawyers and courts will compare your clinical practices (and treatment records) to what appears to be the generally accepted standard among the majority of your professional peers. Because insurance is so prevalent, your treat-

ment record documentation and even clinical practices could conceivably be held to the standards set by insurers – regardless of whether you have filed a claim.

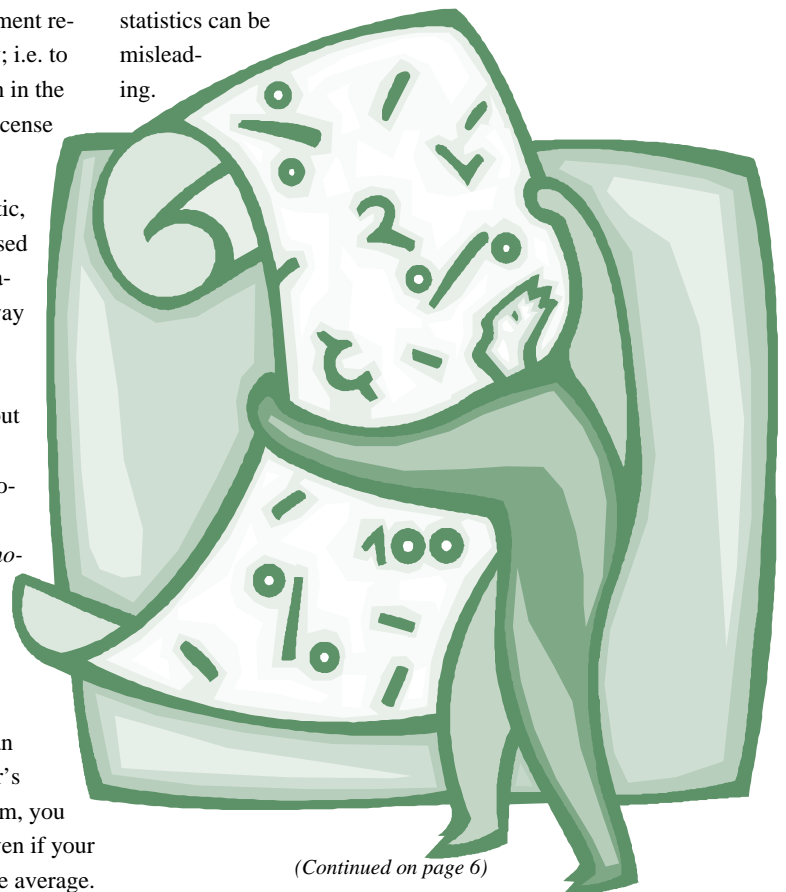
I am often asked, "*I practice psychodynamically, do I really have to do keep this kind of record?*" Unfortunately, yes, if you submit insurance claims - and remember, even if you don't, your patients might be submitting claims themselves. Audits look for the presence or absence of the above documentation to determine whether treatment was "medically necessary." I am of the belief that while specific interventions can be psychodynamic in nature, it is still possible to structure a treatment record to practice defensively; i.e. to ensure maximum protection in the event of audit, lawsuit, or license board complaint.

If clients are asymptomatic, or if treatment is wholly based on a V-code, then it's probably best practice to find a way of paying for services that does not include insurance. The client may not like it, but the language of insurance policies which cover psychotherapy typically specify "*medically necessary psychotherapy*," which refers back to the medical model of DSM diagnosis, symptoms, etc.

If your documentation can stand up against any insurer's treatment record review form, you should be in good shape, even if your number of visits exceeds the average.

If the insurance company does not ask you to justify a specific case, but you get a general letter about your utilization, you might consider calling Provider Relations or Medical Management and asking who there has a clinical background, someone with whom you can talk about your specialties and why it might be that you use a greater number of visits than average.

Perhaps you treat borderline patients, for instance, or dissociative disorders. Or perhaps it is simply a circumstance where you have a low sample size, and one particular client with a severe mental illness is skewing the statistics. As we all know, statistics can be misleading.



(Continued on page 6)

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

Vince Marino, Secretary; (314) 644-5055 vmarino@familysupportnet.org

Tina Dale, (314) 477-8751, tinamdale@sbcglobal.net

Susan Frager (636) 464-8422 susan@psychadminpartners.com

Mary Lutz (314) 725-6552

Nicki McClusky (314) 432-2549 findyourvoice@earthlink.net

Linda Pevnick, (314) 567-5360 pevnick@sbcglobal.net

Susan Toelle, (314) 567-5360

Executive Director: Stacy Ross

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

2806 S. Brentwood, St. Louis, Missouri 63144

or visit us online at www.mcschw.com

Accountability *(Continued from page 5)*

Referrals and continued network participation are determined, in part, on the basis of average number of visits, and also on compliance with clinical "medical necessity" audits, treatment record documentation, and/or outcomes measurements. For example, United announced in a memo dated May 9, 2007, that they are using their "Wellness Assessments" beginning July 1, 2007, as part of a tool to measure outcomes. They state, "Clinician participation rates in administering the Wellness Assessment are included in reviews of clinician performance." OTRs may be a thing of the past, but accountability is here to stay.

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. © Susan Frager 2007.

Welcome New Members!

Michelle Rubinstein

Ann Moran Linda Horrell

Getting along *(Continued from page 2)*

With a few exceptions, clinical social work as part of training at the BSW or MSW level, has diminished widely over the past 20 to 30 years. Currently, the 142 schools of social work, with oversight by the Council of Social Work Education, have a much greater interest in promoting the advocacy and social justice, or generalist, side of social work education at both the BSW and MSW levels. The disconnect between clinical social work as the primary type of work social workers wind up doing and the lack of clinical training in social work education is beyond the scope of this paper, but it is a factor in the communication problems faced by generalists and clinicians.

To resolve the disagreements that exist between generalist and clinical social workers, many issues must be considered, including overlapping scopes of practice, state exemptions of social work education and training for social work positions, differences in scope of practice at the BSW and MSW level for generalist social workers, and regulatory ambiguity regarding definitions of generalist and clinical

social work practice. I propose some questions whose answers may help us find ways to resolve the existing communication problems.

1. *Do clinicians and generalists have areas of commonality in scope of practice?*

The question of whether generalist and clinical social work overlap is an important and disputed one. Florida, for example, has social work licensure laws which put clinical and generalist social work under two different statutes. While these laws avoid the attribution of advanced clinical skills to BSWs, they also create an artificial division between casework and clinical social work. An acknowledgment of the clinical elements in casework and case management and the need for clinical supervision when casework is being performed by BSWs should be considered.

2. *Do BSWs who practice casework or case management need clinical social work skills?*

There is disagreement about whether the scope of practice for BSWs, in case management and casework, should include clinical social work components. An additional issue is

whether or when BSWs are qualified to practice independently.

3. *Are clinical and generalist social work both part of the social work field, or are they separate professions?*

The differences between generalist and clinical social work are significant. The 'field' of social work may in fact be a set of values that does not have specific forms of practice. The poorly defined regulations covering social work practice may reflect the fundamental lack of a workable base for social work practice.

I hope raising these questions will help both generalist and clinical social workers in finding common ground and ways to respect and accept each other's point of view.

Laura W. Groshong, LICSW, has been in private practice in Seattle, WA, for 30 years; a registered lobbyist representing seven WA mental health groups for 10 years; and director of government relations for the Clinical Social Work Association, formerly the Clinical Social Work Federation, for six years.