In Touch

The newsletter of

Summer 2006

The Missouri Society for Clinical Social Work

Federation Becomes Association

After more than 30 years as a federation of state clinical social work societies, the Clinical Social Work Federation transformed itself into an individual membership association and adopted the name the Clinical Social Work Association at its meeting of the Board of Directors on Friday, May 19.

Following a full day's discussion of the committee report covering everything from the name, mission, governance structure, dues levels, services and benefits of membership, and more, the Federation's Board, consisting of representatives of the state societies, adopted the report by a unanimous vote and completed the work of transformation that began more than eight months ago.

For more than a decade the Federation has struggled with declining membership, dropping from a peak of about 12,000 in the early 1990s to 3,500 today. Efforts to stem the loss of membership by the Board over the years involved a number of changes including many addressing its original structure. In the last four years it became increasing clear that if the Federation was to continue to serve the clinical social work profession in the future a complete change of its governance structure was required.

"We actually started looking at alternatives to the Federation in the early 1990s," Abbie Grant, Federation President, said. "We've had several restructurings over the past decade, but nothing has proven successful. The new association will be a traditional membership organization, receiving dues from individual clinic

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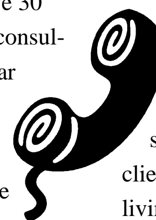
New Member Benefit: Billing Hotline

The Missouri Society for Clinical Social Workers is pleased to announce an exciting new member benefit.

Society member and LCSW Susan Frager has generously offered to provide an insurance/billing hotline for members.

Susan has operated Psych Administrative Partners for eight years, a nationwide service specializing in billing and filing insurance claims for all types of mental health providers. She has taught graduate courses on managed care issues and presented at professional conferences.

Effective immediately, Missouri Society Members will receive 30 minutes worth of telephone consultation with Susan per calendar year. Susan's normal fee for this service is $75 an hour.



The free 30 minutes can be used all at once or in two 15-minute consultations. For consultations beyond the 30-minute member benefit, Susan is offering a discounted Missouri Society member rate of $60 per hour. She also can provide you with a customized contract rate for ongoing service.

"I'm passionate about the fact that the business of private practice is something we don't learn about in graduate school," Susan said. "Staying with only self-pay clients is great if you can make a living doing it, but a lot of clients can only afford mental health care if covered in part by their insurance."

Members can contact Susan to set up a consultation at (636) 464-8422.▪

Don't Forget!

- We want to use your membership dues wisely. Help us save money and trees and make sure we have your e-mail address. Send us your address at mscsw@swbell.net. In addition, let us know if you're willing to receive MSCSW communication by e-mail only.

Federation Transformation

Society's Representative Provides Perspective

By Linda Pevnick

The Federation of Clinical Social Work has changed as of July 1 to the Clinical Social Work Association. This newsletter contains a press release from the Federation/Association about that change *(page1)*. Both versions of the organization serve an important function as our clinical social work professional association, serving solely clinical social workers, protecting and promoting our profession and the people we serve.

We now have the opportunity to join both our national organization and our local organization. This is the way many professional groups are organized. Psychologists, for example have a national APA and also a state APA. In Missouri, we continue to have MSCSW representing us on the state level and now the CSWA representing us on the national level. I encourage all clinical social workers to join both. MSCSW will continue all activities as before with the addition of a number of new offerings.

Please read about that in this newsletter, also. It is my belief that joining both MSCSW and CSWA is the best way to be represented professionally in clinical social work.

It is my belief that joining both MSCSW and CSWA is the best way to be represented professionally in clinical social work.

For a number of years now, it has been my privilege to serve as Missouri State Representative to the Clinical Social Work Federation. Sometimes once a year, but usually twice a year, I attended a three- or four-day board meeting with representatives of some 32 state societies. I found this to be an incredible group of people, including many dynamic clinical social workers involved in all kinds of activities: brain research, teaching, administration, private practice, agency work, publishing, family therapy, psychoanalysis, graduate school curriculum planning, legislative consultants, and more.

I was excited each time to be in the company of so many interesting clinical social workers. Every year CSWF organized a plan for each of us to lobby our state's U.S. Representatives on issues of concern to us as professionals and our clients, when we met in Washington DC. We learned about, voted on, and helped with initiatives to improve our profession, protect our right to practice, protect our patients legally, improve our methods, protect and promote clinical education in graduate schools of social work, promote ethics, promote licensure in all 50 states, and much more.

It was inspiring to see what our profession is doing in so many areas. As a board, it was an always interesting and amazing process. Working things out in a group of therapists was compelling and challenging, frequently filled with many therapeutic interpretations of the group process.

It has been gratifying to have served on the Board of CSWF on behalf of MSCSW. I have appreciated and enjoyed the opportunity. Thank you all for allowing me to represent you. I am looking forward to continuing on the MSCSW Board and to also being a member of CSWA. If you have any questions about this transition, feel free to give me a call at my office, 314-567-5360.

Member organizing peer consult group

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.

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

Liability Insurance 101

Claims-Made vs. Occurrence Coverage

In response to frequent questions regarding the difference between claims-made insurance and occurrence coverage (the type provided through the Association), CSWA Executive Director Richard Yates has provided the following explanation:

A claims-made policy covers claims that happened and are reported during a covered period of time. With a claims-made policy you must have the policy in effect during the time period when the event occurred and at the time the claim is made, even if the two are separated by many years.

An occurrence policy covers those claims that arise from an event during the time the policy was in-force, regardless of how long a period separates the event from the claim.

Is there an advantage of having an occurrence policy versus a claims-made policy?

The advantage lies in the fact that claims are rarely made in the same year in which the service was provided; in fact many years can go by before the claim is filed. So long as the occurrence policy was in-force during the time the practitioner provided the service, the practitioner is covered. This means that years after a practitioner has stopped carrying this kind of insurance they are still covered for events that took place when they had the insurance, no matter when the claim is filed.

What happens to my coverage when I switch from a claims-made policy to an occurrence policy?

Any claims that arise out of events during the time of the claims-made policy will not be covered by the occurrence policy. Most practitioners will want to consider purchasing what is called Extended Reporting Period (ERP), more frequently (and mistakenly) called "tail coverage". ERP, like an insurance policy, covers the practitioner into the future for that time period when the claims-made policy was in-force but is no longer. Remember, when a claims-made policy ends so does the coverage, so a claim made later arising from an event during the time a claims-made policy was in-force is not covered.

Practitioners have the option of purchasing ERP from 1 year to an unlimited time period into the future at different rates.

How long a period should my ERP cover?

Each practitioner's situation is different so it is impossible to provide a single answer for all.

Generally, claims are reported:

- 40% in the first year following the event;
- An additional 30% in the second year;
- An additional 15% in the third year;
- An additional 10% in the fourth year; and,
- The final 5% in the fifth year.

Other factors the practitioner may want to consider as they assess their risk are:

- Type of practice and the level of risk associated with it;
- Degree of difficulty of individual clients;
- Various statutes of limitations in their state; and,
- Any history of prior claims or state licensing board actions.

Also, additional factors may have an impact depending on the practitioner's particular circumstances.

For additional information, a free quote, or answers to questions contact CPH and Associates at 800-875-1911 or visit their web site at www.cphins.com.▪

*A **claims-made** policy covers claims that happened and are reported during a covered period of time.*

*An **occurrence** policy covers those claims that arise from an event during the time the policy was in-force, regardless of how long a period separates the event from the claim.*

Meet New Board Member Susan Frager

Your MSCSW board is pleased to announce Susan Frager as our newest member.

Susan graduated with her MSW from Washington University in 1991 and has been licensed since 1993. She worked in several positions for an employee assistance program before starting Psych Administrative Partners, a nationwide billing and insurance claims service for mental health providers. She is generously providing a new billing hotline for MSCSW members. (*see article on page 1.*) Susan lives in Arnold.

Susan joins Treasurer Al Barton, Secretary Vince Marino, Federation Representative Linda Pevnick and members Mary Lutz, Carolyn Manning and Nicki McClusky on the board.

National Provider Identifier Explained

By Susan Frager

By now you've probably received something in the mail from the Centers for Medicare & Medicaid Services (CMS), or a private insurer telling you to apply for the NPI. What is this, and why do you need to do it?

The NPI stands for "National Provider Identifier" and, if things go according to plan, after May 23, 2007, it will be the one and only number that identifies you as a health care provider, replacing all other numbers. Right now you probably have a Medicare number, Medicaid number, Blue Cross/Blue Shield number, Tricare number, and those are just the government payers! Then there's Aetna, Cigna, United, Magellan, and all of the rest.

Why is the NPI necessary? Well, in short, because it's the law. Remember HIPAA? The website for the NPI gives the clearest definition:

"The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers…The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information."

Okay, so now it's ten years after HIPAA was enacted, and we're just getting started!

Well, it's the law, but other than the fact that it's the law, why is the NPI *really* necessary? People ask me that all the time, and to understand the answer, you need to understand a bit about how electronic claims work.

As a biller for mental health services who sends claims electronically on a daily basis, I can attest to the fact that the numerous provider numbers, a different one for each payer, makes transmitting claims electronically much more difficult. Right now, each payer wants their unique provider number of varying lengths in a different spot on the claim form. *And if you don't do it THEIR way, you don't get paid!!*

When a claim is transmitted electronically via a clearinghouse, the clearinghouse must take the data from the biller/provider/hospital and convert it into a HIPAA-compliant electronic format. Unique provider numbers of varying alpha or numeric characters, of different lengths, and in different places, makes programming more intricate and challenging, thus delaying the transmission – and thereby delaying payment.

So, then I am usually asked, *"Why do electronic transmissions have to go through a clearinghouse – why can't you just use the Internet to submit claims to each insurance company's website?"*

There are lots of reasons. For one, not all payers have websites that allow submissions. For another, there are literally hundreds if not thousands of payers out there. If you're curious as to how many, here's a link to a clearinghouse payer list: http://www.medavanthealth.com/payerlist/default_db.asp. While most mental health providers only submit claims to a small fraction of these payers, remember that there are hospitals, labs, clinics, and so forth that must submit to many more payers than we do. Ultimately, the clearinghouse serves as a central mechanism that allows whoever is doing the billing to communicate with all payers through one portal. The clearinghouse also serves other useful functions. For example, payers then send back reports to the clearinghouse that claims are accepted. This is proof of "timely filing" – no more *"we didn't receive your claim!"* Payers can report when a claim is denied because the patient no longer has insurance – typically within three days. Imagine how much easier it is to collect from patients when you can get this information in three days instead of the four to six weeks' response time for paper claims.

Back to the National Provider Identifier. At this point I am always asked, *"I don't submit electronically, so I don't need to get one, right?"*

Sorry, wrong. Unfortunately, HIPAA has mandated that ALL claims, even paper claims, be submitted with the NPI as of May 23, 2007. In fact, CMS has changed the 1500 claim form. All claims – paper or electronic- submitted after May 23, 2007 must be on the new form with your NPI. Unfortunately, the new claim form has not yet been approved by the OMB, so you cannot order them yet or begin using them. If you would like to see the draft copy, email me at susan@psychadminpartners.com and I will send you a sample.

There's one more area of resistance I frequently encounter. *"What if I don't participate with any insurance companies but submit only so that my patients can get reimbursed?"*

Well, if you are submitting via a claim form, you will need an NPI and the new form come May 23, 2007. Your participating-provider status and whether or not you are accepting assignment is irrelevant. If you are handing your client a superbill, you might be able to get away without an NPI for awhile after next May, but at some point down the line you can

THE MISSOURI SOCIETY WANTS YOU!R OPINION!

Please complete the enclosed survey and tell us what you think about the Missouri Society and how to make it work for you!

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St. Louis, MO 63144
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Continuing Education Schedule taking shape

Our 2006-2007 continuing education schedule is shaping up to be better than ever.

We have Anne Desmond scheduled to present on supervision while Dorothy Becvar will talk on "Families that flourish: Facilitating resilience in clinical practice." Other tentatively scheduled speakers and their topics include Vince Marino on temperament and clinical practice and a case presentation by Dr. Robin Turner .

Also in the works are two panel discussions. One will focus on secondary trauma. We'll have MSCSW members who were involved in working with Hurricane Katrina survivors as well as other disasters. In addition, Al Barton is organizing a panel discussion on the ins and outs of private practice.

Additional topics under consideration include psychopharmacology and life coaching.

Watch your mail box (or your inbox) for the 2006-2007 schedule.

Please keep in mind, speakers and topics may change once the schedule is finalized.

The programs will generally take place on the second Saturday of the month from 3-5 p.m. at 225 S. Meramec Ave. in Clayton. However, don't forget to return the survey included with the newsletter to let us know what additional days, times and locations you would like to have continuing education program presented.

Watch your mailbox (or your inbox) for the 2006-2007 Continuing Education Schedule. Please let us know if there is a particular topic or speaker you'd like to hear. Contact us as ***mscsw@swbell.net*** *or* ***(314) 719-2902****.*

NPI *(Continued from page 4)*

expect that your clients will encounter difficulties getting reimbursed unless you can provide the insurance company with your NPI.

Applying is really not that difficult. If you've ever filled out a Medicare provider enrollment form, this is nothing. All you need is your license number and provider IDs for other insurance companies so that they can build a database of "legacy" provider IDs. This will make it easier to identify providers during the transition period from unique IDs to the NPI. The easiest way to apply is online at: https://nppes.cms.hhs.gov/NPPES/Welcome.do. Send questions via e-mail to: customerservice@npienumerator.com.

If you do not have the ability to apply online, call the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203 to order an application form. Their address is: NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059.

Of course, you DO have till May 23, 2007 to apply. But, think about this: Every single provider, regardless of specialty or type of practice, needs an NPI. The NPPES does check by social security number to validate providers' information. This is a monumental task. Already, the time to get an NPI has jumped in the last two months from five to 15 days for online submissions. Medicare now requires that if you make any changes to your provider enrollment, you must furnish the NPI.

Over the next year, the challenges for the industry are enormous and managing cash flow will be critical. No one will do it for us – we each have to ensure the financial wellbeing of our own practice.

I strongly encourage everyone to plan ahead. If you wait till next spring like the majority of others, the NPPES will be so overwhelmed that it might take literally months after May 23, 2007 to get your NPI. If that happens, your cash flow will dwindle to ZERO unless you have a 100% self-pay practice where everyone pays at the time of service.

Without an NPI, you will be forced to hold all your claims for months while you wait for the NPPES to issue your NPI. And remember, "timely filing" will still apply!

As a matter of fact, I'm something of a pessimist. Realize that every major insurance company out there must revamp its computer systems to accept the new claim form – even claims submitted on paper. I strongly suspect that come next summer, there will be a huge claims backlog while systems problems get sorted out. In fact, I am encouraging everyone I work with to put aside money now to cover the cash-flow crunch that I believe will inevitably happen during the transition period.

In the long run, say by 2016, my opinion is that the NPI will have achieved its stated goal and as a result clinicians will see faster payment. But over the next year, the challenges for the industry are enormous and managing cash flow will be critical. No one will do it for us – we each have to ensure the financial wellbeing of our own practice.

Welcome New Members!

Kathryn Ellis, LCSW, BCD
Zenobia Edwards, MSW, LCSW
Francesca Ferrentelli, Ph.D., LPC
Peggy Keilholz, MSW, LCSW
Paul Lehmann, MSW, LCSW
Christine McNaughton, LCSW
Lawrence Nickels, MSW, LCSW
Diane Wesemann, Student

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; Vincent Marino, Secretary; Linda Pevnick, Representative to Federation; Carolyn Manning, Education Committee Chair; Susan Frager; Mary Lutz ;and Nicki McClusky

Executive Director: Stacy Ross
Contact us at: (314) 719-2902 or mscsw@swbell.net
2806 S. Brentwood, St. Louis, Missouri 63144

Society members recruit GWB students

Missouri Society member Ed Koslin, left, and board members Mary Lutz and Al Barton talk with Nicole Brueggman, MSW of MERS Goodwill at the Washington University George Warren Brown School of Social Work Job and Practicum Fair on March 3. The Society used the opportunity to raise awareness of our organization and recruit students. Thanks to Ed, Mary and Al for representing us. Let us know if you can help us staff the table at the next ob fair on August 24 from 5-6 p.m. in Goldfarb Hall..

Federation *(Continued from page 1)*

social workers and will have the ability to communicate directly with its members, something that hasn't been true for the Federation.

As a federation of state societies the organization was dependent on the societies for its dues, membership recruitment, and communication to the members. In a facilitated session last year, the Federation Board members recognized that the increased demands of their profession and the societies they led made it increasingly difficult to attend to the business of the Federation.

"We are very excited by this change and confident that it is the right move at the right time," stated Kevin Host, the recently elected President of the new association. "This structural change will allow us to provide better, more effective services, communicate more efficiently with our members, and directly develop membership in the organization. We couldn't be happier or more optimistic."

Host added that all existing services and benefits which its members are now receiving will continue without interruption. Products such as the malpractice insurance program, subscriptions to the CSW Journal, the "800" hotline telephone number, and more, will seamlessly continue as part of the new association.

Host also remarked that the new association will be able to build on the rich and successful 30 year history of the Federation. He pointed out that it was the leadership of the Federation that: brought licensing for clinical social workers to all 50 states; that led to the development of the national credentialing organization, ABE, a collaborative effort led by the Federation working with NASW (National Association of Social Workers); and spun-off of a national psychoanalytic organization, NMCOP (National Membership Committee on Psychoanalysis), which began life as a Federation committee, as a few examples of that history.

In addition, the Federation has developed standards of practice in a variety of areas, provided national training on federal regulations affecting clinical social workers, and developed a code of ethics regularly cited as the standard throughout the profession. Through its newsletter, *access*, the Federation distributed clinical articles, provided financial advice directly related to clinical social workers, and connected clinicians to the trends and developments in mental health service. Most recently the Federation developed national guidelines for child custody evaluations which was published in the CSW Journal last September and the soon to be published paper on social work education and clinical learning.

The new association will also continue to provide its members with national advocacy in the Congress and the Administration, provide state-level licensing and regulatory advocacy, distribute the latest in studies from government organizations such as the NIMH (National Institute of Mental Health), and SAMHSA (Substance Abuse Mental Health Services Administration), as well as the research conducted by universities, private foundations, and national mental health organizations.