MSCSW Missouri Society for Clinical Social Work

In Touch

Winter 2007

Two members step up to serve on Board

Missouri Society members Tina Dale and Susan Toelle have joined the MSCSW board.

"We're delighted to have Susan and Tina on the board," said Stacy Ross, MSCSW executive director. "It's just so valuable to have their voices and input."

Dale earned her MSW at St. Louis University School of Social Work in 2000 and has completed the Advanced Psychodynamic Psychotherapy Program at St. Louis Psychoanalytic Institute. She works with children starting as young as 2 years. of age using play therapy, and behavioral–cognitive approaches. She uses the psychodynamic approach with adults.

"I accepted the invitation to the board," Dale said, "in support of its efforts on behalf of mental health professionals and the clientele we serve striving to make a difference,"

Toelle works for BJC Behavioral Health and also has a private practice in which she specializes in psychodynamic therapy with individuals and couples. Toelle has been involved with the Society for quite some time, having once worked on the newsletter. She values the Society for its continuing education programs as well as the opportunity to meet other clinical professionals.

"I think it's important to support the Society's efforts," Toelle said.

Society launches mentorship program

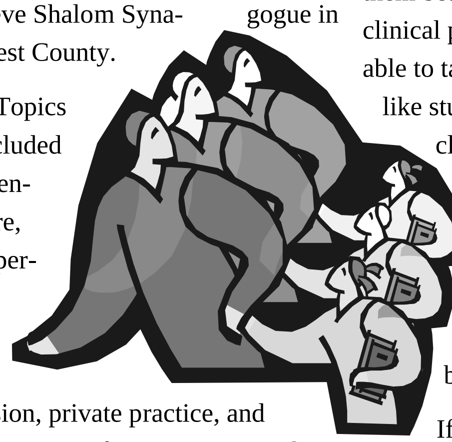
Inside this issue:

The Society has launched a new mentoring program for MSW students at our three schools of Social Work in St. Louis: Washington University, St. Louis University, and UM-St. Louis. Board member, Nicki McClusky has organized this effort.

McClusky is recruiting Society members interested in meeting with interested students one-on-one or in a group. McClusky will match Society members interested in mentoring with a student from one of the three universities.

"This isn't supervision," McClusky explained. "This is an opportunity for students to discuss all aspects of a career in clinical social work with a professional in the field in an informal setting."

She also plans occasional group mentoring sessions. Linda Pevnick was the first mentor at a meeting held in late November and McClusky led a meeting in January. The meetings took place at Neve Shalom Synagogue in West County.



Topics included licensure, supervision, private practice, and counter-tranference, among others. Pevnick said students were also interested to hear about her practice specialties.

It was a lively meeting with no lulls in the conversation, Pevnick said.

"I enjoyed the student's enr ergy," she said. "It was nice to feel I was helping to bridge the gap for them between graduate school and clinical practice. I was glad to be able to talk about topics that I'd like students to know about, including the importance in clinical practice of supervision and one's own psychotherapy. I recommend the experience to other Society members. It was a lot of fun."

If you are interested in participating, review the mentorship program guidelines and download an application from the web site at *www.mscsw.com* or contact McClusky at (314) 432-2549 or *findyourvoice@earthlink.net*

Clinical Topics: Burnout

The high cost of high achievement

By Teri Powers, LCSW

My favorite non-fiction reading is Viktor Frankl's *A Man's Search for Meaning*. What does that have to do with the topic of "burnout?" Stay with me and I'll explain, but first the back story:

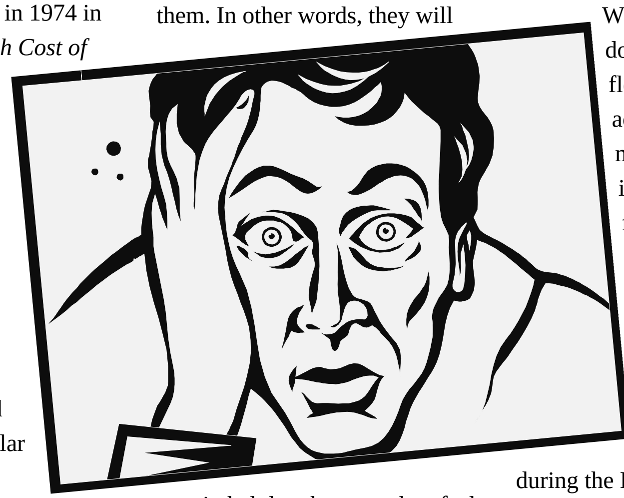
According to Webster's Dictionary, one is "burned-out" as a result of "excessive or improper use." More precisely, Herbert Freudenberger coined the term "burnout" in 1974 in his book *Burnout:The High Cost of High Achievement*. Freudenberger originally defined "burnout" as "the extinction of motivation or incentive, especially where one's devotion to a cause or relationship fails to produce the desired results."

We social workers are notorious for neglecting to find balance between work and play, between being the source of support and having a solid support system.

Depression, anxiety and mood disorders share similar features. Burnout is much more common, yet less severe, more temporary in duration and clearly caused by situational stressors rather than a biological chemical imbalance. Characteristics of burnout include: depleted physical energy, emotional exhaustion, lowered immunity to illness, less investment in interpersonal relationships, increased pessimism, increased absenteeism and inefficiency at work.

The lack of motivation involved in burnout is often the result of lack of rewards for energy expended, feelings of powerlessness, and learned helplessness. When we believe that we do not have the power to influence what happens to us, we feel helpless.

Martin Seligman demonstrated that experiencing uncontrollability tends to undermine motivation to learn in new situations. Individuals struggling with burnout have learned that they can't control their respective worlds so they stop trying to do so, which handicaps their ability to adapt or learn in the future. At this point, burnout becomes chronic. When people stop looking for ways to control their situations, they will stop finding them. In other words, they will remain helpless because they feel helpless.



The antidote to burnout is personal power which is defined as the capacity to influence the world around you in ways you desire. *The Serenity Prayer* and Twelve-Step philosophy teach us we cannot control other people, places, or things. And while we have little control over other people, we do have control over ourselves which is something we tend to forget when we're feeling helpless.

Building personal power comes from developing your capabilities, your powers. And it means learning how to get what you need. In my current work environment, we frequently talk about "triggers" and "warning signs" to our clients and encourage development of coping strategies and healthy self-care. Yet we social workers are notorious for neglecting to find balance between work and play, between being the source of support and having a solid support system. The importance of self-care was something I heard little about in my graduate studies. And self-care is key to avoiding burnout. We all need meaningful down time in which to reflect and acknowledge our actions and accomplishments to maintain our own internal motivation to care for others.

Back to my favorite non-fiction, Viktor Frankl's *A Man's Search for Meaning*: Frankl wrote in describing his experiences in concentration camps during the Holocaust, "And there are always choices to make. Every day, every hour, offered the opportunity to make a decision, a decision which determined whether or not you would or would not submit to those powers which threatened to rob you of your very self, your inner freedom; which determined whether or not you would become the plaything of circumstance, renouncing freedom and dignity to become molded into the form of the typical inmate"

I agree with Rabbi Harold Kushner (another favorite non-fiction author) when he summarizes Frankl's writings as "Forces beyond your control can take away everything you possess

(Continued on page 3)

Society to hold garage sale fundraiser April 28

It's time to clean out closets, your basement, your garage. The MSCSW is seeking donations for a spring garage sale fundraiser, scheduled for Saturday, April 28 in Richmond Heights.

MSCSW Nicki McClusky proposed the idea as an opportunity for members to clean out their closets and de-clutter while helping to raise much needed funds for the Missouri Society. The event was originally conceived as a book sale, but by popular demand was expanded to a full-fledged garage sale.

"As a Society we've always relied on membership dues as our sole source of funding," said Al Barton, MSCSW treasurer. "We thought this was a creative way to increase the Society bank account while giving members the opportunity to clear out unwanted items and even socialize."

The sale also will be an opportunity for members to visit with their fellow members by volunteering to help or just stopping by for coffee that day.

The sale will be advertised as a typical garage sale in the newspaper and open to the public.

We'll be collecting the usual household items including dishes and kitchenware, toys, tools, books, artwork, music CDs, books on tape, DVDs, videos, clothing, holiday decorations, or anything you can imagine being sold at a garage sale.

To donate items, contact us at *mscsw@swbell.net* or (314) 719-2902 to arrange drop off or pick-up.

We'll be collecting the usual household items including dishes and kitchenware, toys, tools, books, artwork, music CDs, books on tape, DVDs, videos, clothing, holiday decorations, or anything you can imagine being sold at a garage sale.

Burn out *(Continued from page 2)*

except one thing, your freedom to choose how you will respond to the situation. You cannot control what happens to you in life, but you can always control what you will feel and do about what happens to you."

I'm not intentionally comparing a stressful work environment to incarceration in a concentration camp; rather attempting to emphasize our personal responsibility to ourselves, our colleagues and our clients to be proactive in maintaining our physical, emotional and spiritual health to avoid burnout. Less you gentle reader, may be finding this entirely too serious, allow me to quote another fine philosopher, Mary Poppins, who sang "In every job to be done, there is an element of fun. Find the fun and snap, the job's a game!"

Teri Powers works full-time at St. Mary's Hospital in the outpatient behavioral department with the chronically mentally ill and has a part-time psychotherapy practice.

Board votes to establish Education Pass for non-LCSWs

The Missouri Society Board has voted to establish a $125 education pass for non-LCSWs interested in attending the Society's Continuing Education programs.

"We have heard from a number of non-LCSW mental health professionals interested in joining the Missouri Society," said Al Barton, MSCSW treasurer.

"We also heard concerns from members about offering membership to non-LCSWs and how that might change the focus of the organization."

The board said they felt the education pass was a good compromise that would allow other mental health professionals to take advantage of the Society's excellent continuing education programs while not conferring full membership.

Members are encouraging to spread the word to their non-LCSW colleagues about the education pass.

Individuals can purchase the education pass by calling Executive Director Stacy Ross at (314) 719-2902 or online at *www.mscsw.com.*

Do you provide supervision? Let us know! The Society would like to develop a roster of available supervisors.

While we miss seeing Don Wesemann's smiling face (while he is doing Hospice Social Work on Saturdays), we are enormously grateful to him for the generous contribution of his office for our monthly educational programs. Thank you very much, Don!

Practice Management

Thinking about waiving a patient's copay?

By Susan Frager, LCSW

Copays are ever-increasing. It's become a matter of routine now that the copay is 50% or more, assuming you are a participating provider. If you are not participating, deductibles in the four figures are common. Sometimes all 20 visits allowed in the calendar year go to the deductible if your patient has no other medical condition.

So…what do you tell the patient who has insurance – and wants to submit – but says s/he can't afford his/her share of the fee? If you haven't run into this problem yet…you're lucky! Most of us run into it often, and will encounter it more frequently as insurance benefits become leaner.

As mental health professionals, we are by inclination and training predisposed to cut the patient a break. We see tragic cases often, and we are helpers. Isn't that why we entered this profession? The tradition in mental health has always been to provide service despite the ability to pay. So we think, "it's my money, I can write it off if I want to." End of story right?

Well, yes, it is your money…but no, writing it off is not necessarily the right thing to do. In the world of insurance reimbursement, routinely waiving copayments, coinsurance (when the patient pays a percent rather than a fixed dollar amount), or deductibles (referred to by me as "patient portion") *is considered an abusive if not outright fraudulent practice*.

Why? Consider what the Medicare provider manual has to say. The online provider manual at the Missouri Medicare site, http://www.momedicare.com/, states:

"The purpose of requiring the patient to pay a part of the cost of medical care is to encourage the patient to cooperate in limiting costs by not incurring unnecessary expenses and to take an interest in the reasonableness and necessity of all services received. The routine and consistent waiving of the collection of coinsurance and/or deductible amounts defeats this purpose."

Commercial insurance companies also view this practice as fraudulent because if the patient portion is waived, then the provider has overstated his/her charge. If you are willing to accept $40 per visit instead of $60 by waiving a $20 copay, then an insurer would want to pay you $20 and expect you to collect $20 from the patient. This isn't just the view of greedy insurance companies. The courts have made it part of case law. In 1991 the U.S. Court of Appeals in *Kennedy v. Connecticut General Life Insurance (CIGNA)* ruled in favor of Cigna when the insurer stopped making payments to a provider who had routinely waived copayments. John Outlaw, Chief Compliance Officer of Pathology Service Associates, LLC, stated *(HBMA listserve email 5/2/06):*

> *If you tell a patient he or she doesn't have to pay, but you tell the insurance company (via a submitted claim form) that it has to pay …that's fraud.*

"CIGNA successfully argued that its agreement to pay for medical expenses incurred by the patient was contingent on the patient having an obligation to pay for the services in the first place, and that to the extent that the patient was released from his obligation to pay the coinsurance, the payor was likewise released from its obligation to make any payment to the provider on the patient's behalf."

In the most basic terms, what this means is that if you tell a patient he or she doesn't have to pay, but you tell the insurance company (via a submitted claim form) that it has to pay… that's fraud.

None of us would knowingly commit fraud…so here are a few options to consider if the patient says s/he cannot afford his/her portion:

- **Accept credit cards**. Taking credit cards is becoming more economical. In the age of the Internet, it is no longer required to lease/purchase an expensive terminal for the purpose of running credit cards. While there may be some treatment considerations against using credit cards for patients with severe debt or certain kinds of addictions, consider also that your services are valuable. <u>If patients are invested in treatment, they will be willing to pay</u>. And if that means there's no cash in the bank available to write a check…you can take plastic. Also, too, many people like the incentive rewards points offered by the credit card companies, making credit cards their preferred method of payment. Younger patients today may be so used to paying everything online or with a credit card that they don't even carry a checkbook. To not take credit cards may mean you lose out on money you have rightfully earned.

- **Draw up a budget**. Following from the premise that if patients are invested in treatment, they will be willing to pay, what can patients temporarily give up or cut back on such that they can afford their portion? Cutting back on expensive addictive habits such as smoking or drinking might not only free up cash but also serve to further treatment goals. How about not buying those expensive tech toys this month? Or going out to eat less? It's all about choices...and our job as therapists is to "market" to our clients the importance of our services such that patients are willing to fork over their discretionary income

Think again.

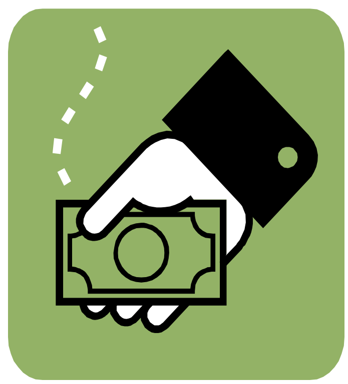
for treatment. Some people who say they "can't afford" their share might, in fact, be able to if they drew up a budget and planned accordingly.

- **Draw up a payment plan (no interest of course).** Assuming your patient is trustworthy and that building up a balance won't increase anxiety to the point where it is counter-therapeutic, this could be a good solution. One therapist I bill for has a long-term patient of several years whose insurance plan has a $500 deductible, then pays 90%. The patient simply pays $20 per visit. Early in the year, her balance builds up while the claims go to the deductible, but then late in the year, when insurance is paying 90%, the patient is overpaying. It all evens out to zero by the end of the year, and this patient then continues to pay $20 per visit to be credited against the next year's deductible. A note of caution: if you do draw up a payment plan, be sure to enforce it and communicate about it. I recommend even putting the agreement to writing, having the patient sign it, and place a copy in the chart. Don't let the balance become the white elephant in the therapy room that no one ever talks about. <u>If you act as if the patient's balance is not important, that's a signal to the patient that it's ok not to pay</u>.

- **Consider not using insurance at all and sliding the fee to a level that is affordable.** Many patients believe that *"I pay enough for my insurance, I might as well get something out of it."* And when you participate with the patient's health plan, that's true. But in an out-of-network situation, remember that the patient not only has to pay what the insurance says is their coinsurance and deductible, the patient has to also pay whatever portion of your fee is over and above "usual & customary."

Some math might illustrate:

Say your total charge is $125, and the patient can afford to pay $60 per visit. You are out of network. The patient has a $1000 deductible and then the plan pays 50% of "usual & customary." After submitting claims, you discover that the insurer only allows $100 as "usual & customary." While meeting the deductible, the patient must pay you the full $125. That's what you've stated is your fee on the claim form…a legal document. After meeting the deductible, the insurance will pay $50 (50% of the "usual & customary" $100.) But because your fee is $125, the patient owes not only the other $50, s/he also owes the $25 over and above "usual & customary," making the patient's portion $75.



Might it perhaps not be better to simply take $60 per visit cash and avoid insurance altogether? In addition to everything else, the client gets the benefit of fully confidential treatment, and you don't have to worry about the hassle of submitting and following up on claims.

But be careful not to slide TOO low… Medicare and Medicaid expect (if you participate) that they be the lowest of any fee customarily offered.

If the patient still cannot give up the idea of submitting to insurance, you can certainly lower the fee…provided you lower the fee to the insurance company as well as to the patient.

- **Don't waive the patient portion entirely. Waive only some of it.** Surely your patient can afford $5?

- **Refer the patient to community mental health or United Way agency.** Obviously, therapeutic considerations are primary, and you can't abandon the patient. The community/agency system is overloaded, and there might be a long waiting list.

So because you can't abandon the patient, what do you do if you've considered all the above, and there's no possibility the patient can pay, and a referral either doesn't exist or you're at a point in treatment where to refer might be construed as "abandonment?"

The key words in all of this are ROUTINE, CONSISTENT and CUSTOMARY. From the Missour Medicare online manual:

Note: This policy is not designed to prevent the waiving of collection of coinsurance and/or deductible amounts in a situation where a particular patient's financial condition prevents payment. Rather, the policy is designed to cover those situations where a provider routinely and consistently waives this collection on assigned claims.

In other words, says Medicare, act on a case-by-case basis. But to protect yourself, you should apply a consistent method of determining financial need. The best way to do that is to draw up for yourself a financial hardship form for your practice, to be applied whenever a patient claims financial need as a basis for waiving their portion. It is something on the order of what a United Way or community agency does in every case when setting fees, only it doesn't have to be nearly as detailed. The hardship form should consider sources of income, amount of debt, monthly obligations,

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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.

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or visit us online at *www.mscsw.com*

You've Gotta Eat!

Plan to join us for an opportunity to **socialize** with your clinical colleagues and check out an area restaurant at our new **"Sample St. Louis"** program immediately following the next continuing education program on **Saturday, February 10.**

Welcome New Members!

Sheri Angelides
Courtney Everson
Melissa Ferrar
Jennifer Gates
Suzanne Greenwald
Nan D. Karl
Marcia Long
Candice Nenninger
Heather Teague

Copay (*Continued from page 5*)

number of family members, special circumstances (e.g. just lost job, paying child support, etc.). Once the patient signs it, a copy should be retained in the chart.

While it may seem very legalistic and "agency-like" to have such a form, having a consistent basis for determining whether a copayment/coinsurance/deductible should be waived is a way to protect yourself against allegations of misconduct. It's also a way to fairly determine financial need, because all patients claiming need are then treated the same.

Furthermore, because the standards state that routine waiver of patient portion is what is problematic, you should be careful not to waive the patient portion too often. For example, if you absolutely have to waive a patient portion, better to waive Mr. Smith's $50 copayment for January 16, 2007 (one time only), than to do it at every visit. Or, better to waive a portion of his $50 every time than to waive it all. The problem is, neither Medicare or commercial insurance is very clear on what "routine" is. To be safe, I would say 10% of the time or less is a patient portion waived. And ALWAYS, even if you don't use a financial hardship form, document in the chart the specific reason the copayment/coinsurance/deductible has been waived.

At this juncture I am usually asked *"well, what if the patient just doesn't pay? I can't keep billing someone forever."* No, of course not. Some patients simply don't make good on their obligations. No one can fault you for fraud or abuse if you've tried to collect. In other words, you can't tell the patient with a wink, *"well, I have to send you two statements, but you can just ignore them."* Talk about modeling unethical behavior to clients – but I've seen it done, and by clinicians I otherwise respected. The Medicare manual has this to say:

Prior advertisement of an intention to waive collection of Medicare coinsurance amounts, or other evidence that such waiver is an established business policy, or failure generally to make reasonable collection efforts (similar to those customarily made to collect comparable amounts from non-Medicare patients), constitutes prima facie evidence that the provider has reduced his actual charges.

When all else fails, a final option: **See the patient "pro bono."** In our business, some "pro bono" work is expected. Only you can determine how much "pro bono" work you are able or willing to undertake, and who is the neediest and most deserving of free care. But if the patient is that truly needy, and you can't refer, and you are willing to work for free, then expecting an insurance company to pay when the patient can't is a potential road to professional disaster. Is it really worth your license and professional good name (not to mention fines and possible jail time) to risk it?

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.