

Psychotherapy Finances

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FEE, PRACTICE AND MANAGED CARE SURVEY

New data show that most clinicians are falling further behind

For the last decade and more, therapists have been fighting a losing battle against managed care. Since we published our last Survey in 2000, inflation has continued at a relatively low but steady rate—see the red line on the charts below. At the same time, managed care fees remain flat, and professional incomes are failing to keep pace.

In general, psychologists have done better than the master’s-level professions—the trajectories of their managed care fees and overall professional income have moved in a better direction in the last five years than in the years before that.

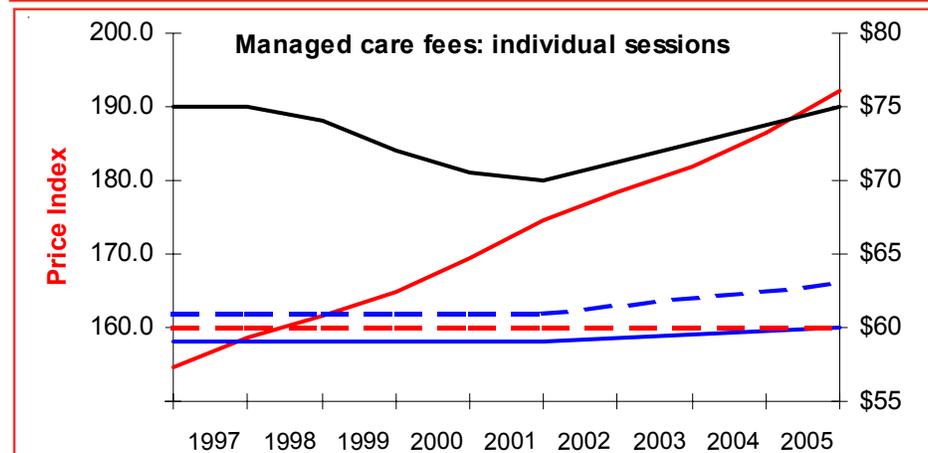
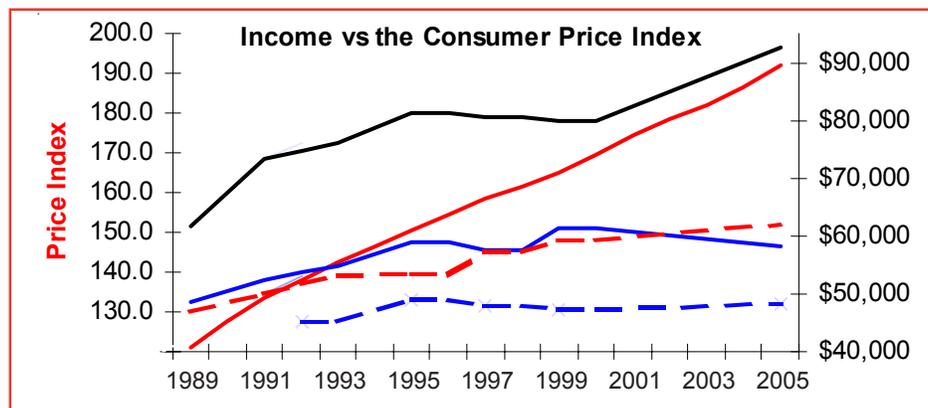
But even psychologists haven’t been able to keep up with the cost of living. Psychology incomes are up almost 16% since 2000, but inflation has been about 17% over that period.

Meanwhile, MFTs have posted a modest 4.5% uptick in income, LPCs are flat, and CSWs actually report *lower* professional incomes, even before taking inflation into account.

In the past, the obvious way to hold the line against inflation has been to increase out-of-pocket income; in effect, using self-pay clients to subsidize low-ball managed care fees. Unfortunately, we now find that the self-pay market is eroding.

Since 1979, *Psychotherapy Finances* has conducted periodic nationwide surveys of private practice mental health clinicians. This is the 12th survey in the series, and more than 1,000 professionals took part. These include psychologists, clinical social workers, marriage and family therapists, and licensed professional counselors. (A small number of psychiatrists and advanced practice nurses also took part, though not enough for statistical break-outs—see page 5 for an explanation of survey demographics.)

Part 1 of our Survey Report appears here, on pages 1-5. Part 2, in the February issue of *Psychotherapy Finances*, will look at *(continues on page 2)*



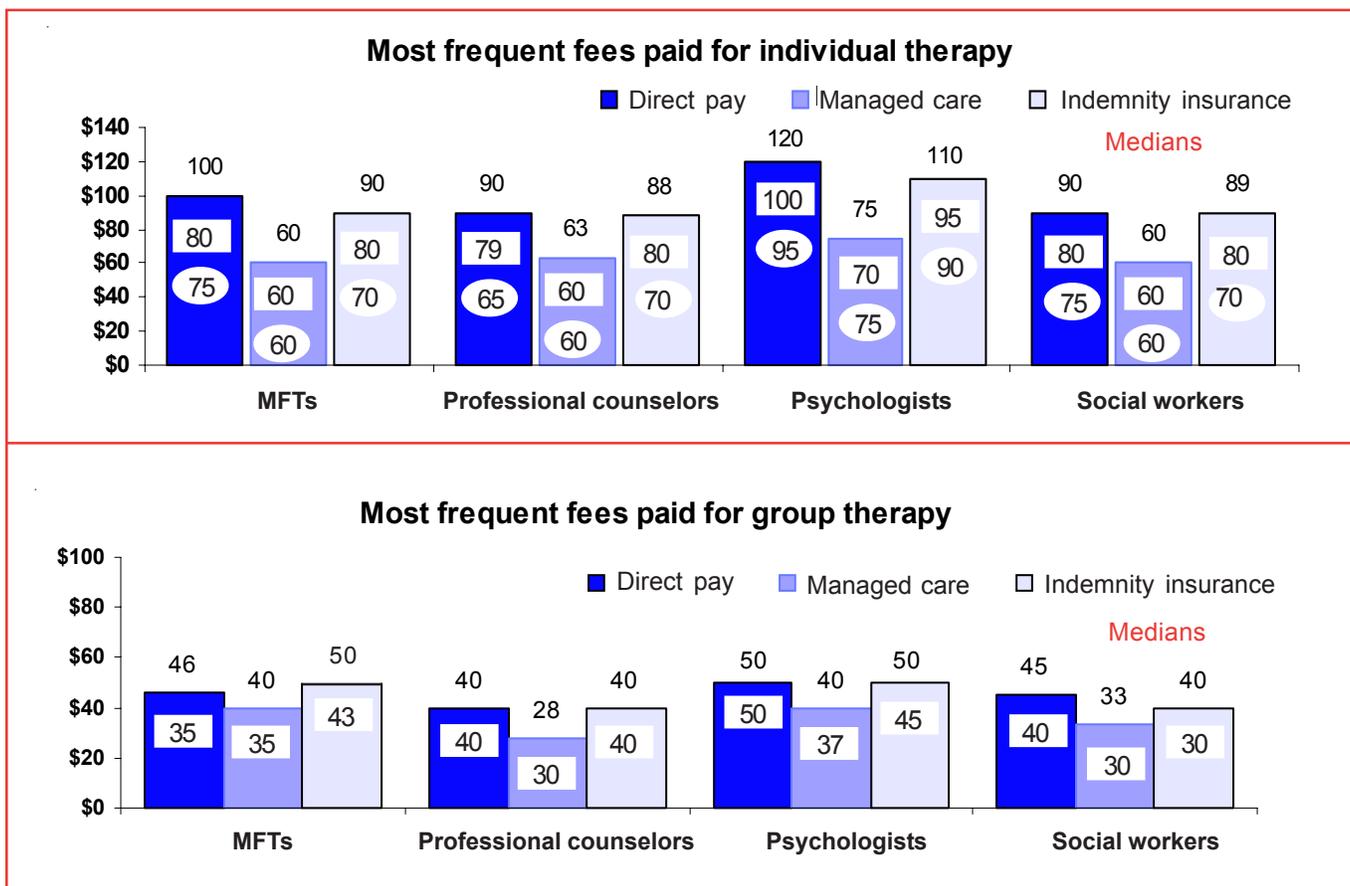
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fees paid by individual managed care companies, at psych testing, and at the range of niches and specialties clinicians are pursuing. Part 3, in our March issue, will cover practice expenses, and other details of how private practices function in today's difficult environment.

Fees are flat

The charts above show what clinicians report their "most frequently paid" fees are for individual and group therapy. Below the current figures, we've listed the numbers from the 2000 and 1997 surveys. (Rectangles for 2000; ovals for '97.)

The first thing you'll notice is that in the individual fee category, managed care fees have hardly budged. Psychologists show a modest gain between 2000 and 2006, from \$70 to \$75. But even that gain is illusory since their number actually dropped between 1997 and 2000.

Overall, managed care fees for individual therapy are about the same today that they were in 1997—nine years ago.

The picture is also bad, though not quite so dire, when it comes to managed care fees for group therapy. The figures have crept up slightly for most professionals (except LPCs), though not enough to offset the effects of inflation.

Psychiatrists, by all indications, are not experiencing the same predations. We have insufficient data from them this time around

to reach definite conclusions. But anecdotally, it seems that by virtue of their scarcity, psychiatrists are still able to command periodic increases from their MCO payers. (For more on that, see the "Look Ahead" beginning on page 6.)

That's the managed care story. In the indemnity insurance category (that is, traditional non-managed care insurance), modest gains are shown across the board. Since 2000, individual fees are up 12.5% for MFTs; 10% for counselors; 15.7% for psychologists; and a bit over 11% for CSWs. Group therapy fees are also generally up in the indemnity insurance area.

Then there's the self-pay market. This is a good news/bad news story. Across the board, everyone is asking for and receiving higher payments from their self-pay clientele. MFTs have scored a 25% increase since 2000; counselors 14%; psychologists 20%; and CSWs about 16.6%.

The downside is that most clinicians don't have as many self-pay clients as they did in 2000. Back then, the average private practitioner reported that managed care accounted for just over 30% of his or her income, and that private pay made up 44%.

Now, the managed care number has risen to 43%, while self-pay accounts for just 26% of practitioners' income. (See the charts on page 5 for a profession-by-profession breakdown of

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"Usual and customary" fees				
Type of service	Marriage & family therapists	Professional counselors	Psychologists	Social workers
Initial evaluation	\$120	\$110	\$150	\$110
Individual session (20-30 minutes)	60	50	65	50
Individual session (45-50 minutes)	100	95	125	100
Family/marital session (50 minutes)	160	95	125	100
Group therapy	43	45	50	40

income sources.)

That, in a nutshell, is the problem clinicians face. Managed care fees are static, and they make up an increasingly large part of the total behavioral health care market.

Usual and customary

Over the years, we've been surprised at the disparity between what clinicians say their "usual" fee is, and how little they'll actually accept from many of their private pay clients. But that disparity is disappearing. When you compare the "usual and customary" fee for a 45-50 minute individual session, listed above, with the most frequently paid self-pay fees on page 2, you see that they are pretty close.

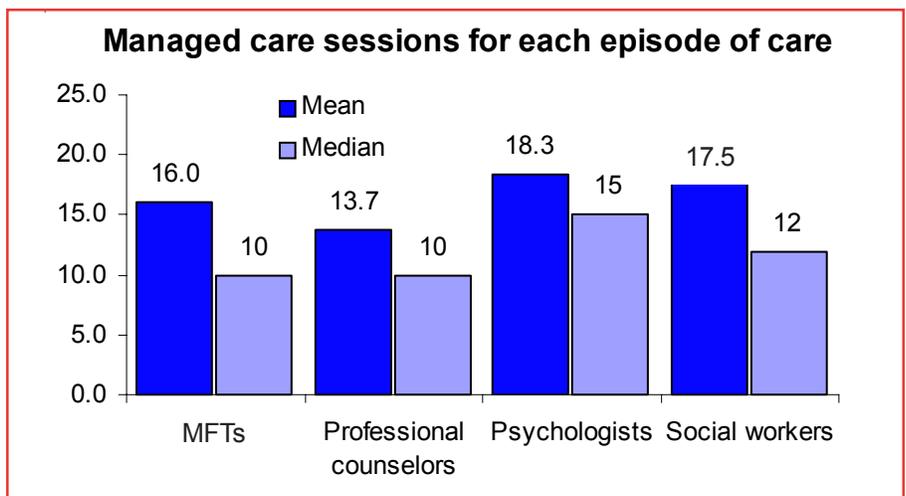
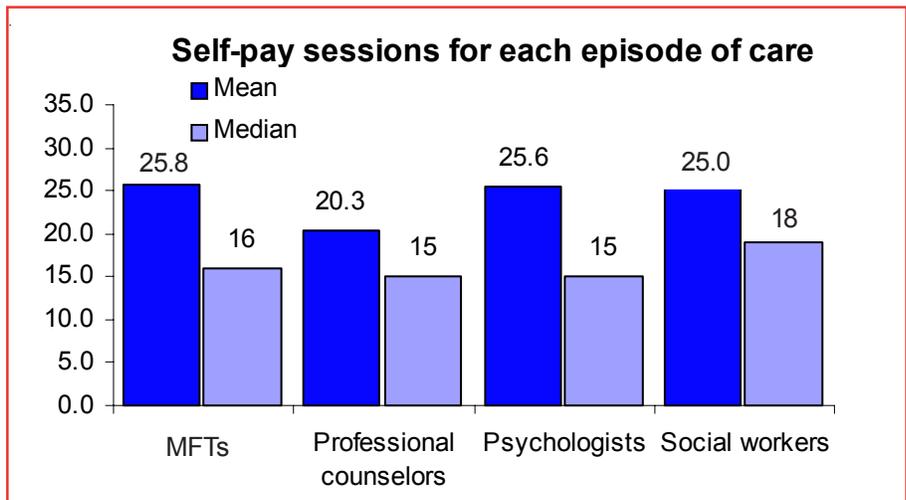
So it may be that clinicians, under increasing pressure from both managed care and inflation, are not discounting as often or as deeply as they did in the past. Sliding scales are a luxury fewer clinicians can afford.

Length of treatment

This hasn't changed in any significant way since 2000, either for self-pay or managed care. MCOs have been telling us that they're not emphasizing tighter case management, and the numbers provided by clinicians seem to confirm it. The fees MCOs are paying are low enough that they don't need to reduce access to care any more than they already have.

Income picture

As with managed care fees, our professional income figures are discouraging—particularly for LPCs and clinical social workers. (See the tables on page 4.) Even before inflation is taken into account, social workers responding to our Survey report a decline in income since 2000. And remember that the consumer price index shows inflation of about 17% over that period.



MFTs fared a little better, showing a slight uptick, though not enough to keep up with inflation.

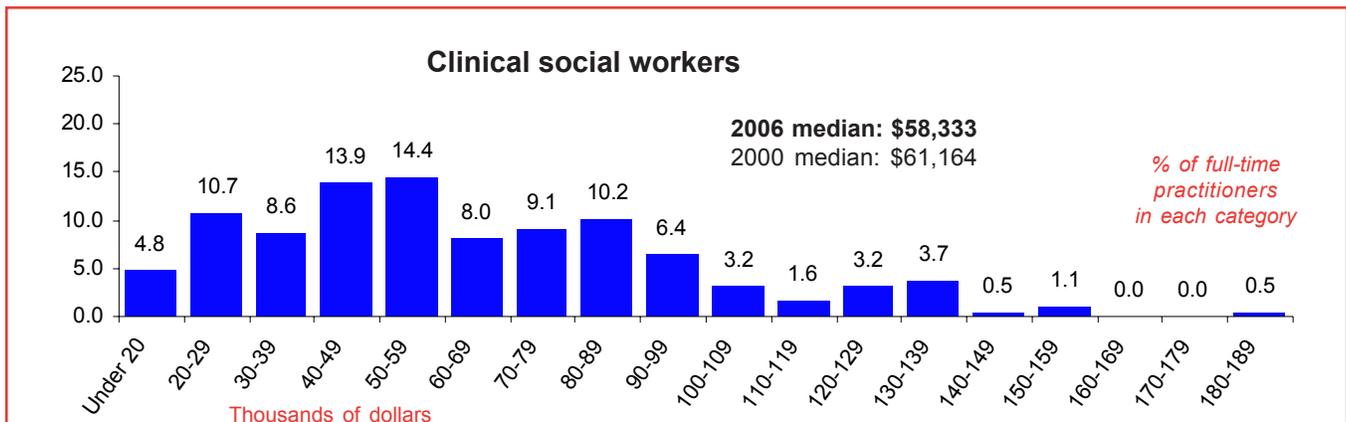
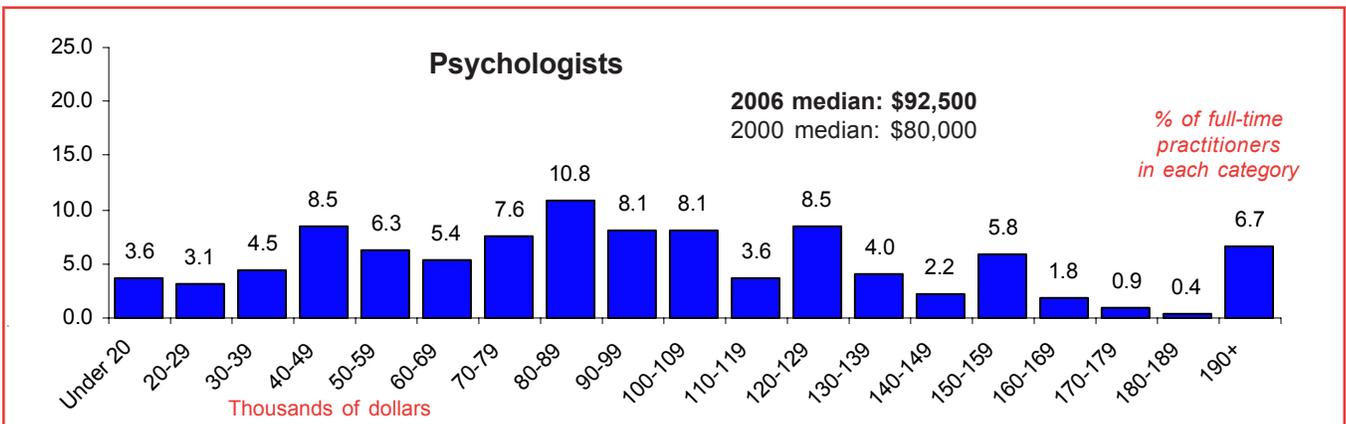
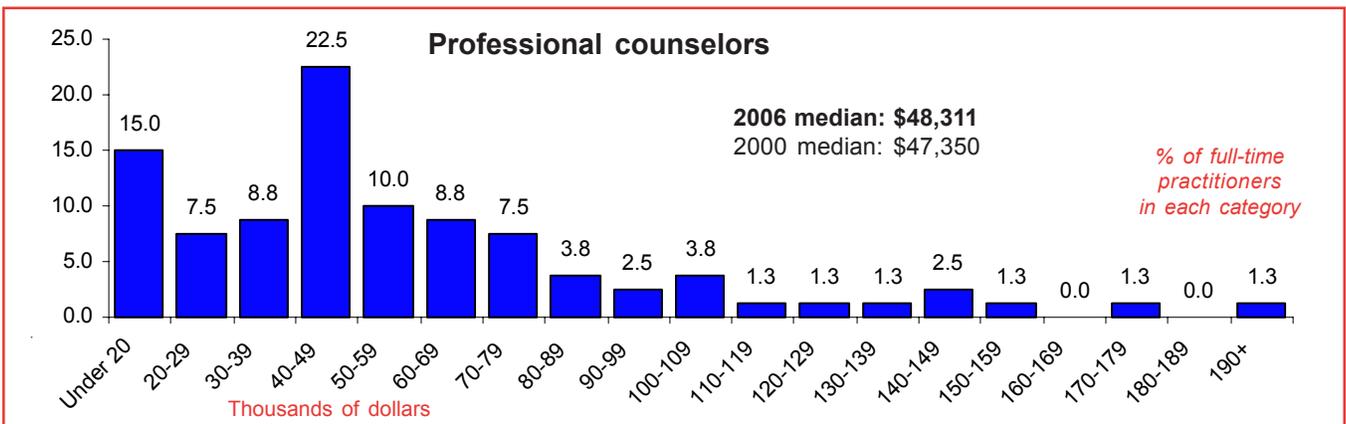
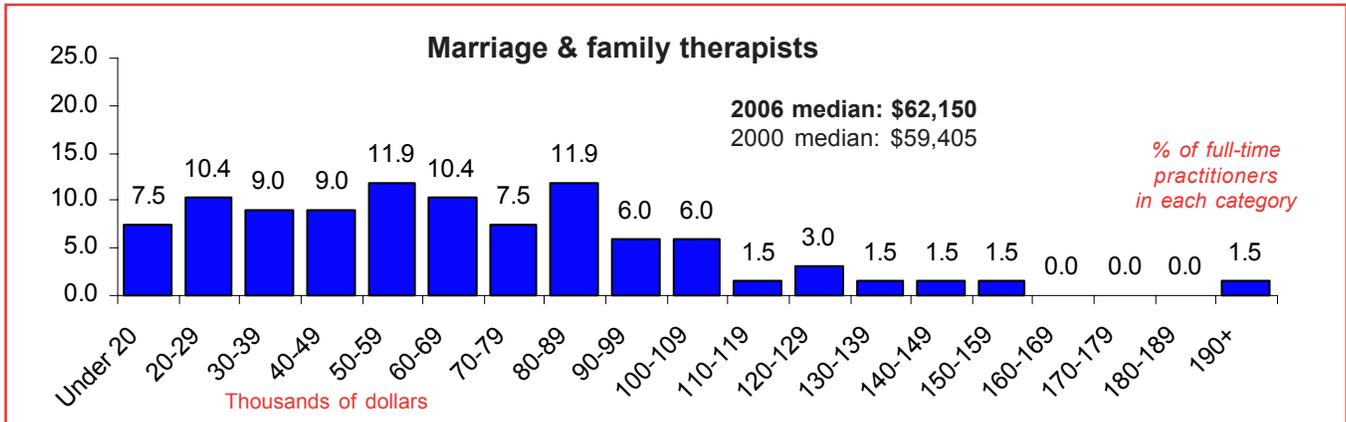
Even psychologists are falling behind—though not as badly as the others, scoring a 15.6% increase in income over the last six years.

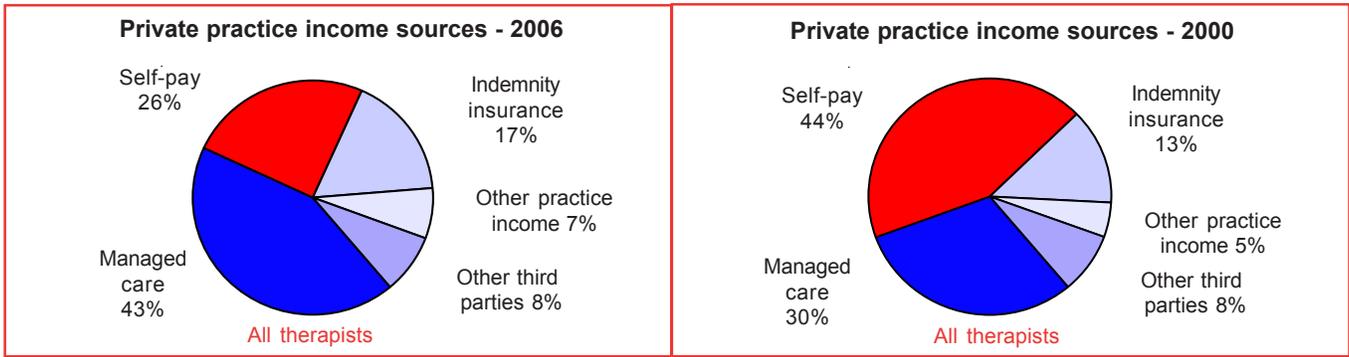
But a question arises: Since their managed care fees are flat, just like those for MFTs, LPCs, and CSWs, how are psychologists keeping their incomes up?

The obvious answer would be that they're seeing more self-

(continues on page 5)

Total Professional Income





pay clients than they were before—but that’s not the case.

The charts above show that practitioners across the board are seeing *fewer* self-pay clients than they were in 2000. Looking at the profession-by-profession break-down, right, we see that psychologists currently outpace social workers and counselors in self-pay income—but just a little. And they’re actually behind the MFTs.

When it comes to managed care clients, psychologists are less dependent than LPCs or CSWs, but come out about even with MFTs.

So what is their advantage? It appears to be two-fold: First, their fees both for managed care and self-pay remain higher than the others. (A lot of industry experts were predicting psychologists would lose this advantage, but there’s little sign of that now.)

Second, they’re better at exploiting income sources outside of the managed care and self-pay markets. Psychologists draw a higher percentage of income from old-style indemnity insurance than MFTs, CSWs, or LPCs.

They also show higher numbers in the last two categories: “Other third parties” and “Other practice income.” Combined, those two categories make up 19% of psychologists’ incomes; 16% for LPCs; and just 13% for MFTs and CSWs.

(The “Other practice income” category includes any professional activity outside the therapy room.)

	Marriage & family therapists	Professional counselors	Psychologists	Social workers
Self-pay	44%	26%	27%	22%
Managed care	34	43	36	52
Indemnity insurance	9	15	18	13
Other third parties	9	13	9	9
Other practice income	4	3	9	4

Bottom line

It simply can’t be overstated: You must increase the non-managed care part of your professional income. That can mean more private pay clients—assuming you can find them; contract work with schools or private companies; teaching; writing; coaching; consulting.

There is absolutely no indication that managed care fees will increase within the foreseeable future. So if you stand pat—if you don’t reduce your dependence on managed care payers—then you will be poorer next year than you are this year...and poorer still the year after that.

Questionnaires returned	Profession	No.	Age		In private practice		Professional degree		Region	
			Years	%	Years	%	%	%	%	%
	MFTs	121	30-39	4.3	0-4	12.3	Doctorate	45.2	Northeast	35.1
	Professional counselors	141	40-49	20.4	5-9	13.1	Masters	53.1	South	16.6
			50-59	43.8	10-14	15.9	Other	1.8	Midwest	19.6
	Psychologists	394	60+	30.8	15-19	16.1	State license	%	West	13.0
	Social workers	333	Gender		20-24	20.4			Yes	99.5
	Others	12	Female	63.4	25-29	12.6	No	.5		
	Total	1,011	Male	36.6	30+	9.6				

SPECIAL REPORT

Look Ahead: Trends in managed care and EAP for 2006 and beyond

In the past, our annual preview of the managed care field has painted a gloomy picture for practitioners who are heavily dependent on third party reimbursement. This year is no exception—as a glance at the fee and income data at the front of this newsletter makes clear.

On the other hand, on paper at least the slide in mental health expenditures has been arrested. We hear from Joan Pearson, a health care benefits specialist with the consulting firm Towers Perrin, that mental health expenditures as a proportion of overall health care expenses leveled off in 2004—the last year for which numbers are available—at 1.5%.

That's the same as 2003, hinting at the possible bottom of a trend that began in the early 1990s, when mental health expenditures were a solid 9% of the health care dollar.

But that news isn't quite as upbeat as it sounds, according to Pearson. She says mental health expenditures have been getting a boost from psychiatrist reimbursement fees, because psychiatrists—at least those willing to play ball with managed care—are scarce on the ground.

“One of the things that's happening, because there's so much treatment being delivered through medication, is there's a growing demand for psychiatrists,” Pearson explains. “Even patients in treatment with [another] therapist for talk therapy are also seeing a psychiatrist for medications.

“On top of that, there's been a dropping supply of psychiatrists, while demand has been increasing. Hourly rates and fee schedules have been climbing. So if you're wondering why there's been any increase in mental health treatment costs, I think the reason is that psychiatrists are in short supply.”

The problem for MCOs is that about half of all psychiatrists don't participate in any network, Pearson says. To entice them, companies are dropping pre-authorization and taking a more hands-off approach:

“Sometimes there's very little review that's done on treatment by psychiatrists, unless it's in a hospital setting,”

she adds.

Here are some other managed care trends that are developing in 2006, as identified by the group of managed behavioral health insiders we spoke with for this report:

- **Carve-outs on the endangered list?** We've heard this prediction on and off for at least 10 years now, but there is a renewed belief that carve-outs—companies that specialize in behavioral health—are on the way out.

Magellan Health Services, arguably the most successful behavioral health carve-out, took a hit January 1 when Aetna pulled its book of business, covering 11 million lives, in-house. This is not an isolated event. Most of the big players in the field—ValueOptions, UBH, PacifiCare Behavioral Health, and so on—are owned and operated by larger health care companies. (See the box below for more.)

“The individual behavioral health organizations are going to be especially challenged to hang on to their business and grow it,” Pearson predicts. “That's because [medical] integration is an important part of the future, and it's going to be more difficult to do that if you're an independent.

“I've gone through this process with a couple of clients this year—trying to integrate the HIPAA issues, the data transfer issues, and so on. If you're doing that under one roof—CIGNA pharmacy, CIGNA behavioral, CIGNA health care—it is infinitely easier than it is to try and build across independent organizations.”

- **Integration of medical and behavioral health seems to be accelerating.** “I'm starting to see closer ties between medical care management and behavioral health,” Joan Pearson says. “Some of our cutting edge clients are moving in that direction.”

Experts have been predicting this for years, but there are real signs now. More insurers are looking for members who may be at risk for depression and other mental health problems. And they are turning to mental health professionals to help people with physical ailments—

Managed care buyouts likely to continue

The consolidation of managed behavioral health care companies is an old story. All by themselves, the top-5 companies in the field (Magellan, ValueOptions, UBH, APS Healthcare, and ComPsych) manage benefits for well over 100 million lives.

And a move toward medical-behavioral integration may drive the trend further. That was a big factor in Aetna taking its behavioral health business back from Magellan.

“The integration of care is something we believe in,” says Antonio Rocchino, Aetna's provider relations chief.

Another indicator: Late last year, Magellan purchased National Imaging Associates (NIA), a company that

manages radiology services for 17 million members.

And PacifiCare snapped up American Medical Security Group (AMS), a small health insurance provider—as well as another insurance company, Pacific Life. PacifiCare Behavioral Health now provides behavioral health care services to both of those insurers.

When it comes to dedicated behavioral health companies, PacifiCare's Jerry Vaccaro says that some have figured out how to offer stand-alone service, “while others haven't...So the big health plans look at that and figure, ‘What's the value then?’ You're going to continue seeing the larger plans bringing behavioral health back in.”

Without their own identity, will EAP services be at risk?

Practitioners can make themselves more attractive to EAPs by treating the work as a specialty—not another version of managed care. But John Maynard, CEO of the Employee Assistance Professionals Association (EAPA), says clinicians have made little progress toward that goal in the last few years.

Part of the reason, he adds, is that many of the mega-companies that offer both EAP and managed care services aren't differentiating the products themselves. And he warns that the EAP field itself may not survive unless it breaks out as a more defined specialty.

"The way EAP and managed care has been sold has driven both products in the direction of being commodities," Maynard says. Some insurers are even offering EAP services as a loss-leader to attract clients to their other products.

"One of the consequences is that reimbursement rates have been pushed down, because [the insurers] aren't getting paid that much for the services in the first place. If we're ever going to break out of that cycle, we're going to have to begin demonstrating quality.

"I actually think that managed care as a vehicle for managing health care costs has run its course as a product. And if EAP continues to be overly-identified and linked with managed care, then EAP will also have run its course.

"What we're encouraging employee assistance

professionals to focus on is how they can apply their knowledge of behavioral health in a way that's more valuable to employers."

For example, clinicians need to realize that although under a managed care contract the goal may be to alleviate a client's illness, with EAP work the goal is simply to get the client back to work. That often requires knowledge of work-life products so that a client can be directed to the most efficient services.

Why does Maynard think managed care may be endangered? Because of the trend toward high deductible health plans, which require patients to pay out of pocket for much of their mental health treatment. But Maynard sees this as an opening for EAP, since federal legislation allows "first dollar coverage" for EAP when health savings accounts and high deductible plans are available.

These consumer-driven health plans will "make EAPs even more valuable," Maynard predicts, partly because it's a service for which they won't have to pay out of pocket. Clinicians, meanwhile, will have to demonstrate their effectiveness.

"If practitioners want to position themselves to be of more value to EAPs, they've got to think of the bigger picture: What are the behavioral issues that workplaces and employers are facing, and how can we be part of the solution to that?"

diabetes, for example—get a handle on their disease in order to prevent hospitalizations and other expensive consequences.

This fuels a need for medical psychologists: "They're going through graduate programs that train them, not only in behavioral health expertise, but also in the medical conditions where behavioral health issues are more likely to occur," says Pearson. "They're more knowledgeable about health and more familiar with medication and the comorbidities associated with various diseases."

● ***Depression disease management "is the next wave" in managed care***, according to Denise Podeschi, a principal with Mercer Human Resources Consulting. "Usually it's a product offered by a disease management firm or a behavioral managed health firm. They're identifying members who are at risk for depression, and they may or may not be in treatment. If you look at the literature, less than half of the people who need treatment get it. What these programs do is identify members at risk."

● ***Outcomes data is back in fashion***. Like medical-behavioral integration, the desire for outcomes data has been a theoretical priority for years. But again, there seems to be real action now. Following PacifiCare into the arena last year, United Behavioral Health is pushing network providers to gather baseline data when a patient enters treatment. Surveys taken months after treatment ends will attempt to measure efficacy of the care received.

"I'd like to see PacifiCare's outcomes driven treatment

algorithms implemented more broadly across the whole book of business," Podeschi says. "I've heard that other managed care companies are heading in that direction..."

"I'm told that providers like the PacifiCare Alert system. They don't think it's administratively burdensome—it's actually helpful to them in their practice. Providers will need to be aware of what kind of outcomes they're getting or not getting and adjust their interventions accordingly."

Positive outcomes data benefits therapists as well as managed care companies and employers, Podeschi feels. "Whoever can demonstrate outcomes will get more business."

PacifiCare has been offering a rewards program that includes financial incentives to practitioners who produce the best outcomes data. Jerry Vaccaro, former CEO of

Our panel

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One example of a managed care medical integration program

What does medical integration really look like? As an example, take a look at the new Aetna depression screening program. Now in pilot form, Aetna physicians are screening patients at high risk for depression in New Jersey, Pennsylvania, Maryland, Virginia, Texas, and Oklahoma, as well as the District of Columbia.

Aetna is reimbursing primary care physicians who use the Patient Health Questionnaire to screen patients with chronic medical conditions such as diabetes and heart disease. The program is expected to expand nationwide.

“We want to integrate behavioral health care with the rest of medical care,” Hyong Un, national medical director for behavioral health at Aetna, tells *Psychiatric News*.

“If you want to do that, you can’t talk about two different data systems and two different care processes. You

have to look at it holistically.”

About two-thirds of all prescriptions for depression are written by primary care physicians—so Aetna officials feel this is the right place to focus the pilot program. But referrals are to be made for more severe cases.

“This program is focused on collaboration with specialists,” Un says. “It is not meant to divert patients away from [mental health professionals]. Based on our data, most of our patients are getting treated by primary care physicians, but we want to get those patients who need to see a psychiatrist an appropriate referral.”

A lengthy interview with Un was published in the January 20 issue of *Psychiatric News*, and is available online at <http://pn.psychiatryonline.org/>. Aetna has more on the program at www.aetna.com/news/2005/pr_20051102.htm.

PacifiCare Behavioral—now CEO of Behavioral Solutions Group following the PacifiCare merger with UnitedHealth Group—says clinicians who take outcomes seriously will have a leg-up at both PBH and UBH.

“We like to see a commitment to outcomes, as opposed to saying, ‘I can’t measure outcomes, it’s not legitimate.’ Someone like that I would debate vigorously. We want people who will accept accountability.”

● **Phone and Internet work is on the rise.** Vaccaro says the science is finally proving the benefits of high-tech contact, and he predicts that will continue.

“At PBH and UBH, we’ve mounted tele-Web and telephonic coaching programs and interventions that are successful,” he says. “Consumers are looking for more of these things, so I see the trend picking up steam.”

Will that translate into more companies reimbursing for phone sessions? “I’m not sure where that goes,” Vaccaro says. “It’s a complicated legal and regulatory issue. But for me, this is a mega-trend. The whole world is moving toward it.”

● **Don’t look for rate increases.** The tale told by the tables at the front of this issue won’t change. “There are

still a lot more of them (clinicians) than there are patients,” says Joan Pearson. “And it looks like the trend will continue for a good period of time. There are more non-psychiatrist therapists available than there is demand.”

The only managed care company we’ve spoken to recently that anticipates a formal review of reimbursement is Aetna Behavioral Health, which launched January 1 after the network was pulled over from Magellan.

“Going into 2006, it’s going to be pretty flat for providers,” says Antonio Rocchino, who heads the company’s provider network. “But we are linking into the overall process within Aetna, and we’ll be looking at those reimbursement levels on an annual basis. We don’t expect them to be static over a period of years.

“We don’t want to have to say, ‘Oh my God we have to update reimbursement 20 percent.’ We want to stay in front of that curve.” (Some clinicians are complaining that the company’s rates are actually dropping. See the article starting on page 10.)

But don’t expect increases from United Behavioral Health or PacifiCare, says Jerry Vaccaro. “We’re looking to understand the world a little better before we make any guesstimates on that,” he says.

FEEDBACK: Answers to your questions about family therapy, ethical obligations

QUESTION: “I appreciated the lead article in the November issue, about billing insurance and MCOs for marital therapy. I almost never see anyone who doesn't qualify for at least an adjustment disorder diagnosis. But I have a question about the procedure code. 90806 specifically means individual psychotherapy. I've assumed that if I bill for 90847--conjoint family psychotherapy--most insurance companies will reject it whatever the diagnosis is. But I've also assumed that billing for 90806 is fraud if in fact I'm seeing the couple. Could you address this?”

ANSWER: Managed care companies do reimburse for 90847 as long as the diagnosis is in the DSM IV and is covered under the client’s insurance plan. That’s what we hear from two industry experts: Susan Frager, a mental health care

biller and managed care consultant; and Deb Adler, vice-president of network operations for ValueOptions.

Here's a typical scenario: Let's say you're treating a woman for an adjustment disorder and billing under 90806. You decide it would be beneficial to bring her spouse in and see them together. You can bill that as a 90847 and most managed care companies will pay for it, Frager says.

This question often comes up when a patient has a diagnosis that stems from a marriage or relationship problem. Therapists can legitimately bill this as individual therapy for an adjustment disorder, then bring in the spouse and bill under family therapy for the adjustment disorder diagnosis.

"Think of it this way," Frager says. "The name that goes on the claim form has to have a diagnosis attached to it. The code for marital problems, is V61.1. A V-code is defined as an 'other focus of treatment.' Insurance companies say, 'That's not really a diagnosis--we won't pay for V-codes.'

"So what you end up having to do is give the person whose name is on the claim form a diagnosis. And most commonly it's some form of an adjustment disorder. In the eyes of the insurance company, you are treating the adjustment disorder." (Frager adds that EAPs often *do* pay for V-codes.)

"You don't have to limit yourself to one code or the other throughout the case," Frager adds. "You can see the individual for mostly 90806. Then let's say the husband comes in once or twice, those two sessions can be billed 90847. And then go back to 90806."

Adler confirms that there's nothing standing in the way of reimbursement for a 90847. "It's valid code when billed with a DSM IV diagnosis." Because employer contracts vary, she recommends contacting the managed care company to verify eligibility and benefit limitations.

QUESTION: "Can I legally withhold writing letters for clients until their account is paid up? I'm sometimes asked to write letters for disability claims, or letters to employers about treatment progress. I may be asked to write a letter stating that someone has successfully finished treatment. In my intake form I have the following statement: 'I will not write any letters on your behalf until all outstanding fees have been paid, including insurance reimbursements.'"

ANSWER: This approach can be dicey, as it raises both ethical and legal questions. For starters, both experts we consulted on this topic--a risk management attorney and an ethics official with the American Psychological Association--say that you can't under any circumstances withhold medical records for non-payment in a situation that could be construed as an emergency. And remember that association ethics codes are often written into state licensing board language.

The key question is, what is the potential harm that could be caused by not providing a patient record? Withholding a custody evaluation, for example, could harm children involved because they would continue in an unsettled state, and not have access to the best parenting.

Stephen Behnke, director of the APA's ethics office doesn't rule out withholding a letter if in the therapist's opinion no harm is caused. But

from a risk management perspective, attorney Bryant Welch says it's best not to do it at all.

"I would strongly encourage the therapist to release the records and collect the money by other, more traditional means," says Welch, who writes a risk management column for the American Professional Agency, a packager of malpractice insurance products. In the child custody case described earlier, the judge would certainly demand the records, he says. And in any case, "it looks unreasonable on the part of the therapist to avoid (sending) the simple summary statement."

Welch concludes, "I generally urge therapists to keep collections and clinical records or duties separate. Even if the therapist is correct, making the patient resentful can only put the therapist at risk from some unrelated contrivance created by the annoyed patient."

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MANAGED CARE: Some Aetna providers are complaining about rate reductions

Did Aetna Behavioral change reimbursement rates after the first of the year? The company says absolutely not, but two professional billers we spoke with tell us that some providers they submit claims for have ended up on the short end of the stick.

Aetna took its behavioral health business back from Magellan on January 1, and now handles the behavioral health care for some 11 million members in-house. "Things have been a little tough getting started," says Jean Thoensen, who runs PsychBiller in Centreville, VA. "I've had four claims so far that were supposed to be paid at a non-HMO rate, but all of a sudden in January they were paid at the HMO rate."

Susan Frager, of Psych Administrative Partners, a biller in St. Louis, has had two claims paid at a lower rate since January 1. "Arbitrarily," she adds, "without any written notification."

Frager says one of her therapists was told at the end of 2005 that her reimbursement rate would be bumped up to \$60 from \$55. "Instead, she's getting \$50," she tells us.

Jackie, an Aetna Behavioral provider in the Northeast, tells us she was supposed to be getting an \$80 PPO rate, \$60 for an HMO rate. Instead, she's getting \$50 per session across the board--including client co-pay. "I am incensed," she says.

"It's chaotic," says Russ Holstein, an Aetna provider in New Jersey who adds that

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Managed Care Alert: New Opportunities for Providers *

Corporate Counseling Associates EAP (CCA) was listed here in December as strictly a New York company. Subsequently, they updated us, saying they operate throughout the U.S., Puerto Rico, and Canada. “Yes, you can encourage providers to contact us. We’re expanding rapidly in many locations throughout the U.S.” Get an application online at www.corporatecounseling.com. Click the “Our Team” button on the home page, then the “Our Providers” button on the left side of that page.

EAP, Inc., a Mississippi-based company operating in the Southeast, has limited openings. A company rep tells us they prefer that clinicians contact them in writing. To request an application, send credentials and malpractice insurance info to: EAP Inc., Attn. Jackie, 8365 Ridgewood Road, Kiln, MS 39556.

Health Resources, a Massachusetts-based EAP, has openings in that state. The rep we spoke to would not confirm needs in other states but insisted “we are nationwide.” You can request an application online at www.healthresourcescorp.com. Click on “Contact us” and fill out the form there. Make it clear that you are a therapist requesting to become an “affiliate.” The company’s Web site also offers clinicians the opportunity to call, (800)451-1834, ext. 855, but when we called, they seemed to prefer online contact.

Coming in the next PsyFin: The top 25 companies in managed behavioral health and EAP.

* **Using Managed Care Alert:** We generally specify the department within a company that you’ll need to reach. But sometimes it isn’t possible. If you don’t know who you need to contact, try asking for “provider relations.” Some companies use the terms “network development” or “network manager.” **And please note:** Listings in Managed Care Alert are verified by our editors. At times, however, clinician response overwhelms company employees—and they are less than accommodating to you. Our advice is to stick with it. If you’re discouraged from applying, put the info away for a while—and then try again.

he hasn’t received a clear answer on what his rates will be. “I spent two hours on the phone,” he says. “No one could tell me.”

Aetna maintains that the transition has gone relatively smoothly, although officials admit there have been some glitches: “We did not change any of our rates.” spokeswoman Kate Prout says. “But it’s possible that there were some errors in payment as a result of the transition. We are proactively auditing our systems to correct any problems.” Aetna won’t discuss individual provider complaints, she adds.

Contacts: **1)** Susan Frager, St. Louis, (800)841-5565, email: susan@psychadminpartners.com; **2)** Russ Holstein, New Jersey, (732)571-1200; **3)** Kate Prout, Philadelphia, (215)775-6264, email: proutkf@aetna.com; **4)** Jean Thoensen, Centreville, VA, (703)266-8612, email: info@psychbiller.com.

MANAGED CARE NOTES:

MHN has launched a three-pronged EAP smoking cessation program, consisting of phone counseling, coaching, and Web-based support services. Read more at: www.mhn.com/blank/global/content.do?mainResource=newsroom/November29.

UnitedHealth and PacifiCare have officially merged. The action was completed on December 20. The deal allows UnitedHealth to expand its book of business on the West Coast. For now, no changes are expected for providers serving both PacifiCare Behavioral Health and United Behavioral Health. For details on what the impact might be down the road, see our “Look Ahead” on page 6.

ValueOptions has launched a provider-patient information Web site, with 4,000 consumer-oriented articles on 200 topics. Network clinicians are encouraged to use the material with patients--printing it and handing it out, or steering clients to the Web site--www.achievesolutions.net/providers.

PROFESSIONAL NOTES:

There are still no suspects in the Ira Polonsky murder. The 64-year-old psychologist was shot to death in his Vallejo, CA, office on November 1 by a man wearing a ski mask. Police efforts have been complicated by confidentiality issues. A special master was appointed by a judge to decide which patient records would be made available to the police. Authorities aren't commenting on the progress of the investigation. (For more, see the December *PsyFin*.)

Is your Web page a grabber? It better be, because a new Canadian study shows that Web surfers make up their mind about a page in one-twentieth of a second, about the same as a single frame of TV footage. Researchers at Carleton University in Ottawa showed volunteers brief glimpses of Web pages that had previously been rated good or bad based on visual appeal. The images were on-screen for just 50 milliseconds--but the group's assessments were the same as those who had scrutinized the sites over a longer period. The research was written up in the journal *Behaviour and Information Technology*, Volume 25.

Thinking about moving your practice? According to the U.S. Census Bureau, the fastest-growing states from 2004 to 2005 were Arizona and Nevada, each seeing a 3.5% increase. Right behind them were Idaho at 2.4%; Florida at 2.3%; Texas, North Carolina and Georgia at 1.7%; and Colorado at 1.4%. The biggest decliners were the District of Columbia at -.7%; Rhode Island at -.3% and New York and Massachusetts at -.1% each. As a whole, the U.S. grew by .9%.

See a doctor--at the supermarket. CIGNA HealthCare began opening "Minute Clinics" in retail outlets in seven states on February 1. Stores like Target, CVS Pharmacy, and Cub Foods are sites of the initial launch in Georgia, Indiana, Maryland, Minnesota, North Carolina, Tennessee, and Washington. Clinics in other states will be added over the coming year. Staffed by nurse practitioners and physician assistants, the clinics are open seven days a week, including evenings. Prescriptions are written and filled for diagnoses such as strep throat and flu. A visit costs between \$49 and \$59, with discounts for CIGNA members. For more, see www.minuteclinic.com/.

Primary care medicine "is on the verge of collapse," according to a report issued by the American College of Physicians on January 30. The report says that primary care physicians are under such tremendous stress because of rushed office visits and sky-high bills that the number of retirees in the field out-numbers new graduates. The organization is pressing for a law that would place primary care physicians in charge of organizing a case and prioritizing treatment. (Source: *Reuters*, January 30.)

Medicare psychological testing fees are up. As of January 1, the Centers for Medicare and Medicaid Services (CMS) boosted reimbursement for outpatient testing by between 26% and 69%, according to the January *Monitor on Psychology*. An expanded set of CPT codes is required, however. Info about the codes is available online at www.apapractice.org.

Coming soon in Psychotherapy Finances...

- More Fee and Practice Survey data.
- The 25 biggest companies in managed care.
- How to prepare a practice brochure.
- Building a practice around anxiety disorders.
- Top-10 therapist marketing mistakes.
- More Managed Care Alerts.

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