

PRACTICE MANAGEMENT FOR EARLY CAREER PSYCHIATRISTS

A REFERENCE GUIDE

American Psychiatric Association
Office of Healthcare Systems and Financing



©2003

First Printing, April 1999

Second Printing, April 2000

Third Printing, April 2002

Fourth Printing, October 2002

Fifth Printing, September 2003

Sixth Printing, October 2006

American Psychiatric Association
Office of Healthcare Systems and Financing
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209

Editor: Ellen Jaffe

Production: Kristen Moeller

*Staff Contributors: Sam Muszynski, Sandra Hass-Yamhure, Mary Ward, Becky Kilmer
Yowell, Karen Sanders, Sam Hawkins*

All rights reserved. No part of this work may be reproduced or utilized in any form by any means, electronic or mechanical, including photocopying, microfilm, and recording or by any other information storage and retrieval system, without written permission from the American Psychiatric Association, Office of Healthcare Systems and Financing.

INTRODUCTION TO THE 2006 PRINTING

This is an updated version of *Practice Management for Early Career Psychiatrists*. Since the 2003 printing many of the chapters and appendices have been updated.

We continue to date all the materials in the book so you will be able to tell how recently what you're reading was revised. The text is continually updated as necessary, and any post-printing material can be found by viewing the book on the APA website at <https://www.psych.org/members/ecp/index.cfm> and checking the dates at the bottom of the pages. By clicking on the entries in the Table of Contents you can download specific chapters or appendixes.

If there are topics we have failed to cover that you would like to see, please let us know, and we may be able to include them as we continue to improve upon this reference guide. If you'd like to tell us what you think of the book, we'd like to know that as well. We'd like *Practice Management for Early Career Psychiatrists* to continue to be a living document that grows to serve its users. You can e-mail us at hsf@psych.org or give us a call at 703-907-8591.

Irvin L. "Sam" Muszynski, Director
Office of Healthcare Systems and Financing
October 16, 2006

INTRODUCTION

This reference guide has been created by the American Psychiatric Association's Office of Healthcare Systems and Financing as a handbook to provide you with an overview of many of the things you need to be aware of as a psychiatrist practicing now and on into the 21st century. It has been specifically designed to meet the needs of residents and early career psychiatrists (ECPs), but the information it contains may also be of value to those who have been in practice for years.

We have covered many issues, some of which you may find you'd like to learn more about. In 1997 the APA published a series of monographs that explore specific practice issues with a practical, rather than theoretical, perspective. We'd like to recommend these books as a first line of research. They are *The Psychiatrist's Guide to Practice Management*, *The Psychiatrist's Managed Care Primer*, *The Psychiatrist's Guide to Capitation and Risk-Based Contracting*, and *Public Mental Health: A Changing System in an Era of Managed Care*.

We have provided a bibliography in the back of the handbook of the books we've referred to, as well as twenty-six practical appendices, which we direct you to throughout the text. Of particular interest may be Appendix D, Utilizing the APA and Its Resources, which provides a compendium of the services the APA offers along with phone numbers to access them. We also recommend that you visit the APA website, www.psych.org, for the latest information on the association and its activities.

The guide is in a loose-leaf binder because we plan to update and expand it in the future. The practice of medicine is going through a period of great turmoil and may be changing in ways we are unable to foresee at the present. We anticipate providing APA members who are ECPs and fourth-year residents with annual updates and/or new material that will keep them apprised of changes as they occur.

The binder is divided into seven parts, or general topics, with each one containing chapters dealing with specific issues:

- I. **Starting Out**, which provides information on how to find a position or decide where to go into private practice and how to obtain the necessary licensing and certification.

- II. **Establishing Your Own Practice**, which deals with many of the practical issues involved in establishing a private practice.
- III. **Maintaining Your Practice**, which deals with the ongoing issues encountered in private practice.
- IV. **Patient Care Issues**, which deals with issues specifically related to your contacts with patients, including confidentiality, duty to warn, informed consent, civil commitment and medical records (in fact, almost all of the issues in practicing psychiatry relate to patient issues).
- V. **Managed Care Issues**, which provides a framework for psychiatrists who want to work in managed care networks. The material is neither intended to encourage nor to discourage psychiatrists about participation in managed care. Instead, it summarizes those topics most often addressed by the Office of Healthcare Systems and Financing on behalf of the mentally ill and those issues most often cited by APA members calling the Managed Care Help Line. We begin with a definition of managed care and then proceed from signing a contract with an MCO on to appealing denials and getting help.
- VI. **Professional Issues**, which deals with the ethical issues encountered in the practice of psychiatry, as well as managing relationships with patients, reducing malpractice risk, and practice guidelines.
- VII. **Legal Issues**, which deals specifically with a number of key legal issues encountered by psychiatrists, including information about Medicare and Medicaid, definitions of what constitutes fraud and abuse, a brief discussion of ERISA, antitrust issues, and an introduction to the National Practitioner Data Bank.

We have divided the material into these seven sections in the hope that the divisions will make it easier for you to locate the information you need. However, all of the elements that comprise a psychiatric practice are interrelated, and some topics would seem to belong under more than one heading. We hope that the cross-referencing throughout the book will enable you to find topics even when there may be some ambiguity about where they belong.

This project was begun when the Office of Healthcare Systems and Financing was still the Office of Economic Affairs and Practice Management, and we'd like

to thank all of the people in that office who worked on it as well as all those APA members who reviewed the project when it was in its earlier incarnation.

Just a word about pronouns: To avoid the awkwardness of continually using the phrases *she or he* and *his or hers* or *she/he* and *hers/his* (although we do this in some places) we have chosen instead to use one gender or the other throughout the text on a relatively arbitrary basis—though we admit to making an attempt to use both equally.

If there are any issues we haven't touched on in the notebook that you feel need to be covered, or if you have any other comments, please contact us at the APA's Office of Healthcare Systems and Financing. You can reach us by phone at (202) 682-6230, by fax at (202) 682-6352, and by e-mail at imus@psych.org. It's only with the help of psychiatrists working in the field that we can provide the information that is really valuable to our members.

Irvin L. "Sam" Muszynski, Director
Office of Healthcare Systems and Financing

SELECTING COMPUTER APPLICATIONS AND SOFTWARE

Using computers intelligently should allow you to simplify many aspects of your medical practice. This includes billing; scheduling; maintaining patient records; and submitting insurance claims; which can all be done electronically.

It is widely believed that electronic health records (EHRs) can improve the quality of healthcare, improve communication and care coordination, and prevent medical errors. There are many national initiatives underway to expand and facilitate the adoption of EHRs, covering aspects of health information technology (HIT) such as uniform technical standards, software certification, and privacy/security standards. Check the EHR page of the APA website (<http://www.psych.org/members/ehr>) for background on national initiatives, software reviews, and links to outside resources and tutorials.

Before investing in new software, it is necessary to define your particular practice needs and then identify the resources necessary to implement new technology. The following are essential questions that should be answered before you buy software for your practice:

1. **What are the costs?** This includes upfront costs such as installation, necessary hardware upgrades, licensing, training; and ongoing expenses such as support and maintenance fees.
2. **What features does the program include? Do these meet the needs of your practice?** Possibilities include scheduling, charting, billing, electronic prescribing, e-communication with patients and/or providers, clinical decision support, and remote access.
3. **How much training will be required?**
4. **Would a support services contract be better than paying each time a problem arises?** The answer will depend on the complexity of the system and your comfort level.
5. **How frequently can you expect the program to be upgraded?** This can be discovered by reviewing the program's history. If an upgraded version with new functions will be out soon, it may make sense to wait for its release.
6. **Is the software compatible with your hardware and other programs that you use?**
7. **Can the program be customized to meet your practice's special needs?**
8. **Can you unbundle the product** (i.e., buy only some of the functions)?
9. **Does the program have the capacity for multiple users?**

-
10. **What do the vendor's references have to say about their experience with the product?**
 11. **Has there been anything published about the vendor or its products?**
 12. **Is a trial period an option?**
 13. **Is the software certified or is the vendor planning to seek certification?**
Currently the Certification Commission for Health Information Technology (CCHIT, <http://www.cchit.org>) is certifying general ambulatory software and could expand to behavioral health software certification as early as 2008.

Purchasing computer hardware and software can be confusing and expensive. A single-user computer with software can cost several thousand dollars and a good multiuser system will easily run into five figures. Make sure that you are well informed before committing to a product. You should ask for a demonstration and visit offices that already have the system in place. You may also want to have an independent consultant help you in your decision. Check the APA EHR website (<http://www.psych.org/members/ehr>) for more information and resources.

Marketing Your Practice Effectively

Although the term *marketing* may have negative connotations for many physicians, conjuring up images of tacky Yellow Pages advertisements, marketing is not just advertising or self-promotion. Marketing is the whole process of distinguishing yourself, and your practice, in the marketplace.

Whether you are just starting out in practice or seeking to expand your practice, a comprehensive marketing plan can help you stay on track and reach your goals. A successful marketing plan should include the following elements.

OBJECTIVES AND GOALS

The key to successful marketing is determining what your goals are for your practice and developing a comprehensive plan to meet those goals. The first step is to decide where you want your practice to go and how you are going to get there. This part of the plan is extremely personal. One objective of more and more psychiatrists is to establish a niche in the market. There are a number of clinical specialty areas within psychiatry that can allow you to create a marketing niche, including:

- Geriatric psychiatry(substance abuse, medication management, depression)
- Child and adolescent psychiatry
- Workplace/occupational psychiatry (drug testing, employee assistance programs)
- Clozaril management
- Grief/bereavement counseling
- Consultation/liaison psychiatry
- Crisis intervention (disaster relief)
- Substance abuse/dual diagnosis
- Post-traumatic stress
- Pain management
- Family issues (step-parenting, parent coaching, divorce recovery)
- Forensic psychiatry
- Neuropsychiatry

Some psychiatrists develop a niche by marketing general psychiatry services to special populations. This would include treating non-English-speaking patients, patients who are blind or hearing impaired, patients with medical rehabilitation needs, and patients with severe and/or persistent mental health problems.

Expanding your practice into new sites of service is another way to develop a niche. You may want to consider obtaining admitting privileges at key institutions, as well as providing services to patients in their homes, at worksites, in prisons, and in schools.

Once you decide the objectives for your practice, the next step is to define your goals. They should quantify your objectives so they are measurable, and have a timeframe for achievement. Simply saying that you want to increase the number of private-pay patients in your practice is probably not enough. It is better to say that you want to increase the number of private-pay patients in your practice by 25 percent over the next twelve months.

Another important consideration in setting goals is to make sure they are realistic. For most psychiatrists starting out, maintaining a practice that is 100 percent private pay may be impossible. Setting this as a goal is likely to guarantee failure for your marketing plan.

STRATEGY STATEMENT

It's valuable to develop a strategy statement that broadly describes how you are going to meet your goals. You should address the following questions in your strategy statement:

- **What is your target market?** Remember that you may need to market yourself not only to potential patients and referral sources, but also to managed care companies (see Chapter 27), insurance companies, and large employers. Each of these groups will have different needs and expectations. Although targeting these external customers is important for maintaining and expanding your practice, you must not forget your internal customers—your current patients. General business analyses have shown that it is much less expensive to keep the customers you have than to recruit new ones. Of course, you should not try to keep patients in your practice who no longer need your services, but it is important to ensure that they are aware of all the services and benefits your practice offers. This will reduce the likelihood that a patient will leave the practice before treatment is complete. In addition, current patients are an excellent source for referrals. If your patients are familiar with the full range of services your practice provides and are satisfied with the treatment they receive, they are more likely to refer other patients to you.
- **What message do you want to send about yourself?** What is it about your practice that distinguishes it from others? Do you offer any special services or have subspecialty training? Do you have experience with specific types of

patients, such as senior citizens, children, adolescents, or non-English speakers?

- **Are there any strategic alliances you need to form?** These can be alliances with other psychiatrists, physicians, nonphysician clinicians, employer groups, community service organizations, and universities in your area. Becoming more visible in the community is a good way to increase awareness of your practice and of your specific areas of expertise. Have you developed collaborative relationships with referring physicians and nonphysician providers? Such relationships can be an excellent source of referrals when other clinicians learn that you are willing to work with them to meet the needs of patients.

ASSESS THE CURRENT PRACTICE ENVIRONMENT

In analyzing the current environment, it is helpful to consider social, economic, legal, technological, and competitive issues. Who's out there? Who has the managed care contracts? The following questions will help you begin to formulate your assessment:

- Are there underserved client groups in your local area? Who are they?
- Do you (or would you) enjoy working with any of these groups?
- Do you have unique skills that could be marketed to any of these groups?
- Would targeting any of these groups complement your practice's financial goals and operational structure?
- How prevalent is managed care in your locale?
- Are independent provider networks developing or already in place?

STRENGTHS AND WEAKNESSES, OPPORTUNITIES AND THREATS

The next step is to look more closely at your practice and yourself. Your goal is to identify strengths, weaknesses, opportunities, and possible threats to provide a starting point for developing an action plan that will work for your practice. It is important to remember that one practice's strength can be another's weakness, depending on their external environment and practice goals. The following questions will help you begin to identify your practice's strengths and weaknesses:

- Are you board certified?
- Do you have subspecialty training?
- Do you offer any services that are unique?
- Do you speak any foreign languages or know sign language?
- How involved are you with the local psychiatric community? Are you active in your APA District Branch?

-
- How involved are you with the local medical community? Do you belong to your local medical society?
 - How do you feel about managed care? Do you want to be more or less involved?
 - In what treatment settings do you practice?
 - How convenient is your office in terms of parking, access to public transportation, and operating hours?

The following questions will help you start the process of identifying your opportunities and any possible threats:

- How prevalent is managed care in your area (private and public sector)?
- What are the demographics of your current patient base? How do they compare to the demographics of the population in your area?
- What types and levels of psychiatric services are available in your area? Are there “new” services that need to be introduced?
- What types of allied mental health professionals practice in your area? Are they competitors or potential allies?

ACTION PLAN

Using your strategy statement as a guide, your next step is to develop an action plan. This should include the specific activities you are going to undertake to meet your goals and a timeline for meeting them. Although your action plan will vary according to your specific goals and strategies, becoming an active part of the surrounding community is vital if you want your practice to grow. The following are sources of referrals to be aware of. You'll note that almost all of them have to do with involving yourself in the life of the community.

- **Current Patients and Referral Sources.** As stated before, in business it is easier to keep old customers than to attract new ones, and this is true for medical practices as well. When your current patients are happy with the service they receive from you and your staff, they are more likely to continue to seek treatment at your practice and more likely to refer people to you. To keep your current patients happy, maintain a comfortable office area, schedule appointments to minimize unnecessary waiting-room time, and treat all patients as appreciated customers. Physicians, other clinicians, and others who refer patients to you should be treated with the same courtesy. When another clinician asks you to see a patient, follow up with a thank you letter (see Appendix M) and a summary of your evaluation and treatment plan. Keeping the lines of communication open with referral sources not only makes them more likely to refer to you again, it also makes good clinical sense.

- **Community Mental Health Organizations.** Contact the community organizations that support mental health awareness programs. The members of these groups are usually laypeople and clinical professionals; you can offer to provide them with a psychiatrist's perspective on mental health issues.
- **Free Clinics.** Do volunteer work at emergency shelters, halfway houses, and the like. You'll not only be helping people who need help and might not get it otherwise, you'll gain experience working with different patient populations and make yourself known to the larger community of caregivers.
- **Telephone Hotlines and Emergency Services.** As with volunteering at free clinics, when you help out with hotlines, either by training counselors or assisting callers, you not only help the community, you become a trusted part of it.
- **Speaking Engagements.** Offer yourself as a speaker on mental health issues to local organizations (e.g., garden clubs, civic organizations, Rotary Clubs) and to libraries that sponsor educational lectures.
- **The Religious Community.** Offer mental health services to help local clergy deal with the emotional needs of their congregants. You can offer to speak on issues that may be of interest to the congregation, or you can provide workshops for either the clergy or the congregation. You can also offer to see indigent patients referred by the clergy.
- **Teachers and Parent Teacher Associations.** Contact the school principal or a teacher you know and offer to give classroom lectures or workshops on specific health education issues.
- **Communications Materials.** Another way to promote your practice is with brochures or other written materials. Brochures not only allow you to describe your services but can help establish a recognizable image for the practice. Your practice brochure should include office hours, billing policies, insurance coverage accepted, services offered, profiles of clinical staff, and a list of any hospital affiliations. These booklets can be displayed in your office, distributed as part of a direct mail campaign, or provided to local community groups for distribution to members. When you do an outreach activity like the ones listed above, it's especially good for you to have materials to hand out when someone expresses an interest in your practice.
- **Local Organizations.** Join local groups like the Chamber of Commerce and the Rotary Club.
- **Public Relations.** Public relations involves working with members of the news media to address mental health issues surrounding current events. For

this to be successful, you must be willing to approach reporters and other members of the media and offer your insights as a psychiatric expert. In many cases this amounts to free advertising for the practice, since you obtain access to the media at no monetary cost to you.

- **Paid Advertising.** This includes everything from placing a listing in the local Yellow Pages to buying television air time. This is one of the most expensive marketing actions you can undertake, and you need to be careful to ensure that your message is appropriate and getting to your target group. All advertising outlets track demographic information on their audiences, and you should request this information prior to buying any advertising. Also, before you purchase any advertising other than a Yellow Pages listing, try to get a read on the community's attitude toward physician advertising.
- **Internet.** Establishing a web page is an inexpensive way to reach potential patients. These days many people depend on the internet for all of their research. You can use your personal web page to describe your background and training; explain any special services you offer; provide your office address, phone number, and hours; list which insurance you accept (essentially all the information you'd have in your office brochure); and you can also post articles that you've published as well as information from other sources about mental illnesses and their treatment.

REVIEWS AND REVISIONS

The final element of your marketing plan involves monitoring your progress in terms of meeting your goals and staying within your marketing budget. Periodically, at least once per quarter, you should review your goals, marketing budget, and the success of action plan items to assess the effectiveness of your marketing plan. This review allows you to identify problem areas as well as areas that are succeeding at a better than anticipated rate. The marketing plan is intended to be a living plan that works for you. If something is not working, revise it or get rid of it altogether. One easy way to monitor the success of your marketing plan is to maintain a patient referral log. When a new patient calls to schedule an appointment, ask how he heard about the practice. By keeping track of this information, you'll be able to determine which of your marketing efforts are generating the most referrals and which are not working as well. Change is inevitable. As the public and private sectors continue to focus on reducing the costs and improving the quality of psychiatric care, you must be prepared to face changes and make the most of them.

PUTTING YOUR PRACTICE ON A BUDGET

With all the decisions and compromises that are made when forming or joining a practice, getting all parties (or just yourself, in solo practice) to agree to adhere to a budget can be the most difficult step. The following are basic guidelines to assist in this process, keeping in mind that a budget needs to be customized to your practice.

Basic Budgeting Guidelines

- Depending on the size of the practice, overhead costs should be between 10 and 25 percent of the total budget (due to economies of scale, larger practices should have lower overhead). If overhead is too high, it may be an indicator that patient volume is too low, staffing is too high, or office management is inefficient. If overhead costs are too low, it may indicate that fees are too high, salaries are too low, or the quality of services needs further attention.
- Rent, if applicable, should be less than 10 percent of expenses.
- Salaries for clinicians and administrative staff should range from 65 to 80 percent of the budget, depending on the size and specializations of the practice.
- Telephone services should be 3 percent or lower.
- There should be a reserve account, which includes funds for infrequent expenses, such as computers and upgrades, furniture, copier, repair services, etc. There should be a petty cash fund, and a system for tracking how these dollars are spent.

TIPS FOR SURVIVING BUDGET MANAGEMENT

- Involve everybody who works in the practice in the development of the budget to ensure their “buy-in.”
- Start by examining past financial statements for up to three years, if available. Note any service and lease contracts, fee schedule information, and plans for

any major expenditures (new equipment, additional staff and/or pay increases, information system updates, etc.).

- It may be helpful to think in terms of fixed versus variable expenses (e.g., costs that are predictable and consistent, such as rent, as opposed to costs that may fluctuate with patient volume, such as office supplies). Where possible, calculate average annual changes in expenditures to identify trends (e.g., the accountant's bill may be increasing steadily at a 4 percent annual rate), which can then be applied to predict future expenditures.
- You may have more precise information and tracking if you operate individual accounts for distinct functions (e.g., petty cash, payroll, office operations).
- Review the budget each month to determine if your initial estimates were in the ballpark.
- For group practices, ongoing budget reviews should include the full staff, and someone should be designated to be in charge of the process, with the responsibility for producing budget reports.
- In particular, review variable budget items regularly, including costs for telephone service, postage, and any frequently utilized external services, such as consultants, lawyers, printers, and suppliers.
- Buy in bulk and obtain volume discounts whenever possible (purchasing a given set of services through a single contractor may also help you negotiate good deals). Use an order list for supplies that requires approval, rather than allowing random ordering.
- For practices with a variable patient volume, consider paying employees by the hour rather than on salary.
- Consider using bulk mailing services when possible. A postage meter can also reduce costs.
- Consider using voice mail rather than having staff take messages.
- If your practice is sufficiently large, have contests to identify effective cost-cutting strategies (a portion of the savings and public acknowledgment are well worth the investment).
- Consider implementing a policy about missed appointments, and keep the collections process as efficient and timely as possible to maintain cash flow (see Appendix O).
- If your practice is sufficiently large, consider subcontracting the following functions:
 - accounting;
 - administrative services;
 - claims processing;
 - information management;
 - managed care contracting;
 - marketing;

-
- quality assurance/improvement; and
 - utilization management.
 - Consider buying budget software.

If you need additional information, the APA's Office of Healthcare Systems and Financing can provide you with information on these and related budgetary issues.

MANAGING RELATIONSHIPS WITH OTHER CLINICIANS

Whatever the size or nature of your practice, at some point in time you will be required to work with another clinician in caring for a patient. These interactions can take a variety of forms.

CLINICIAN REFERRALS

One source of patients sometimes overlooked by psychiatrists is referrals from other clinicians. Generalists, such as internists and family practitioners, as well as other specialists, frequently come in contact with patients in need of a psychiatric evaluation and possibly treatment. In addition, allied mental health professionals may refer patients to psychiatrists when they want confirmation of a diagnosis or assistance in evaluating the need for medication. Developing and maintaining a positive relationship with these referral sources can help your practice in a number of ways.

Benefits of Working With Referring Clinicians

- Open communication between treating clinicians is better for the patient;
- Ongoing referrals can help maintain a stable patient base; and
- Such relationships can help establish a niche for your practice.

One of the key benefits of developing ongoing, collaborative relationships with referring clinicians is that they help you provide better care to your patients. When another clinician refers a patient to you, you can obtain information from her about the patient's current medical conditions and medications, past treatment, and whether there are any other physicians currently involved. Obtaining this information at the beginning of your contact with the patient can help you design a treatment plan that takes into account all of his needs, even if he is unable or unwilling to communicate these needs to you.

From a financial standpoint, developing relationships with referring clinicians can help you maintain a steady flow of new patients. Once a referring clinician has had a good experience working with you, he is much more likely to refer additional patients to you. In addition, establishing relationships with multiple clinicians can help you establish a market niche for your practice and may provide you with enough new patients to opt out of managed care.

Many psychiatrists understand the importance of working with referring clinicians, but few know how to do it well. The key is to keep in touch. Remember, be sure to get the patient's written consent before discussing his or her case with anyone else (see the sample release of information form provided in Appendix N).

The following steps will help you to establish and maintain good working relationships with your referral sources.

1. Call or write the referring clinician as soon as possible after you learn of the referral and/or see the patient. This not only lets the clinician know that the patient followed through on the referral, it also lets you, as the specialist, find out what the referring clinician is expecting from you; whether it's just confirmation of a diagnosis or a complete takeover of the patient's care. This is also an excellent time to obtain information on the patient's medical history.
2. If the referring clinician is not the patient's primary care physician, you should also call the primary physician to let him know that you are involved in the patient's care and to get any additional medical information that's appropriate.
3. Send a written thank you letter to the referring clinician within a week of the patient's visit. A sample thank you letter is provided in Appendix M.
4. Let the referring clinician know if you think a consultation with another specialist is necessary.
5. Provide timely follow-up information to keep the referring clinician informed of the patient's treatment. This can be a simple letter letting her know: a) that you are beginning therapy with the patient; b) the expected length of therapy; and c) that you would be happy to discuss the treatment plan if the clinician has any questions.
6. Inform the referring clinician in writing when the patient has completed treatment with you.
7. Return the favor. If your patients need referrals to generalists or physical specialists, remember your referral sources as potential clinicians to whom to refer them.
8. If a referring clinician ignores your recommendations, advise him to seek another consultant and sign off on the case in writing. Keep a copy of this

letter in your files as protection against a malpractice suit if anything should go wrong with the patient's care.

The key to successful relationships with referring clinicians is to remember to communicate openly and regularly and to treat their patients the way you would want your patients to be treated.

SUPERVISION OF OTHER CLINICIANS

In working with treatment teams, the psychiatrist often has more education and training than the other members of the team. Despite this inherent status, it is important to remember that the other clinicians on the treatment team are trained professionals who have something to contribute to the delivery of care.

In most circumstances, the psychiatrist bears the responsibility for the patient's care and can be held liable in a malpractice suit. It is extremely important that you take an active role in overseeing the work performed by other clinicians under your direction, rather than simply signing off on treatment forms.

The APA's "Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists" provides the following guidance for psychiatrists who supervise other clinicians:

In a supervisory relationship, the psychiatrist retains direct responsibility for patient care and gives professional direction and active guidance to the therapist. In this relationship the nonmedical therapist may be an employee of an organized healthcare setting or of the psychiatrist. The psychiatrist is clinically responsible for the initial workup, diagnosis, and prescription of a treatment plan, as well as for assuring that adequate and timely attention is paid to the patient's physical status and that such information is integrated into the overall evaluation, diagnosis, and planning. The psychiatrist remains ethically and medically responsible for the patient's care as long as the treatment continues under his or her supervision. The patient should be fully informed of the existence and nature of, and any changes in, the supervisory relationship.

COLLABORATION WITH OTHER CLINICIANS

Managed care has created more situations where psychiatrists are required to work directly with other mental health professionals in the treatment of patients. In many cases, this results in the patient seeing the psychiatrist for medication and the allied professional for psychotherapy. While the clinical- and cost-effectiveness of "splitting treatment" continues to be debated, it is essential to good patient care that psychiatrists work collaboratively with these clinicians when they accept patients under these terms.

Sometimes, and ideally, the other clinician involved will be someone on your staff or someone with whom you have worked before. In these cases, both you and the other caregiver will have already established a professional relationship and level of comfort in working with each other. In other cases, the allied mental health professional providing therapy may be a stranger to you. When this happens, and you have agreed to treat the patient under these terms, you should schedule some time to meet with the clinician to introduce yourself, discuss areas of specialization, and set up ground rules for exchanging status reports and other relevant information about the patient. It is important to remember that, should problems arise in terms of malpractice, the psychiatrist will retain the greatest responsibility, even if only tangentially involved in the provision of service.

The APA's "Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists" also addresses this situation:

This relationship is based on mutually shared responsibility for the patient's care, in accordance with each clinician's discipline and activities. The patient should be educated on the respective responsibilities of each clinician, emphasizing that neither clinician's responsibilities diminish those of the other. Both the psychiatrist and the allied mental health professional are responsible for the periodic evaluation of the patient's status to ascertain that collaboration continues to be appropriate. Both clinicians must inform the patient, either jointly or separately, if they decide to terminate their collaborative relationship.

MANAGING APPOINTMENT SCHEDULING

All scheduled appointments should be well documented, and a card with the date and time of the next appointment should be given to the patient whenever possible. An automated system can improve the efficiency of the scheduling process (see Chapter 9 for information on selecting a system to meet your practice's needs).

Managing missed appointments can be difficult. In addition to causing financial distress to a practice, repeatedly missed appointments can be detrimental to patients. For both these reasons, it is important to provide a financial incentive for attendance, while remaining sensitive to the fact that patients occasionally need to miss or reschedule appointments due to situations beyond their control. The most important thing is for you to have the patient's commitment to honoring scheduled appointments. We recommend developing a contract that clearly delineates your practice's appointment policies and having your patients read and sign it prior to beginning treatment. It is important to inform patients that their insurance is unlikely to cover missed-appointment fees.

Many psychiatric practices allow their patients to cancel appointments without penalty as long as the practice is given either twenty-four or forty-eight hours notice. Select a length of time that meets your practice's needs in terms of being able to reschedule the time slot. If an appointment is canceled at the last minute, it is common to require either full or partial payment (for both individual and group sessions, although you may want to utilize different policies for each scenario). It may be helpful to impose financial penalties in increments (e.g., excuse the first cancellation, charge half of the fee for the second missed session, and charge the full fee for the third missed appointment and any beyond that). When there are extenuating circumstances, exceptions can always be made at the practice's discretion.

Note: You are not permitted to bill Medicare for missed appointments. However, if it is your office policy to bill all patients a fee for missed appointments, you should have your Medicare patients sign the same contract that your other patients sign, which stipulates they will be personally responsible for paying for missed sessions. Some MCOs also state in their contracts that you may not charge for missed appointments. If this is the case, you will not be able to receive compensation from the MCOs for appointments missed by their patients. However, just as with Medicare, if the patient signs the contract that she understands she will personally responsible for paying for missed appointments, you can bill the patient.

When a patient demonstrates a pattern of canceling appointments, or misses an appointment without calling to cancel, it is appropriate to remind him of the policy. It may be necessary to discuss the advantages and disadvantages of continuing treatment with him at this time. If there is agreement that further treatment would be beneficial, it is appropriate to obtain (or reobtain) the patient's commitment to participating fully in the treatment process, including being present for scheduled sessions.

Some practices set aside an hour or two each week for make-up sessions. While this arrangement gives both the practice and patients some flexibility, it may on occasion leave this time unused (and thus unreimbursed). It also might encourage patients who are aware that a make-up time exists to miss appointments. However, having spare hours can be very helpful for last-minute appointments with patients who are in emotional crisis.

Please see Appendix O for a sample policy on missed appointments.

INSURANCE TERMINOLOGY

It is important to know who is responsible for administering and paying for a patient's health benefits. Understanding the terminology is the first step in ensuring that your patients receive the coverage to which they are entitled, and that you receive fair compensation for your services.

INSURANCE COVERAGE

The vast majority of patients with health insurance are covered under group policies. For benefits purposes, a group is any set of individuals who are treated as a single entity. In most cases, groups consist of the employees of a single company or members of an organization and their dependents. Some self-employed or unemployed individuals purchase health insurance directly under individual policies. However, this type of coverage is not as common.

WAYS OF INSURING

Employers who provide group health benefits for their employees may purchase these benefits in two ways. The most common way, historically, has been for an employer to pay a premium to a managed care plan or insurance company. The insurance company or managed care plan employs underwriters who are responsible for reviewing groups to assess the health risk each group presents and determine appropriate premium levels. The premium payments cover the insurance company's administrative costs, claims costs, and profit.

Larger employers often elect to provide insurance the second way, they self-insure. Under this arrangement, the employer funds health benefits through its own resources without purchasing insurance. The employer can administer the benefits program and process claims itself, or it can hire another organization to provide this function. The term *third-party administrator*, or *TPA*, is used to designate this independent entity that administers group benefits and claims for a self-insured group, TPAs are sometimes referred to just as administrators.

The arrangement between the employer and a TPA to provide these administrative services is called an administrative-services only, or ASO, arrangement. Under an ASO agreement, a third party is contracted to deliver administrative services, such as maintaining a network of providers and processing claims, while the group is at risk for the actual cost of the healthcare services provided. When a TPA receives a claim, it processes the claim and then requests a check from the group to pay the claim amount.

WHO PAYS THE BILLS?

The payer is the entity that is financially responsible for claims payment. In the case of a self-insured company, the company is the payer. In the case of an insurance company or managed care organization (MCO) that underwrites risk and charges premiums, that organization is the payer. If the health benefits have been underwritten by an outside entity, the underwriter may be referred to as a third-party payer. Organizations such as Medicare, Medicaid, Blue Cross and Blue Shield, and commercial insurance companies are considered third-party payers.

In comparison, the term *carrier* refers to an entity that may underwrite or administer a range of health benefit plans. It may refer to an insurance company or MCO, regardless of whether the organization has underwritten the risk or maintains administrative responsibility only. A carrier can be a payer or a TPA.

CARVE-OUT COMPLICATIONS

The distinctions between the involved parties become more complicated when health benefits are *carved out*. In an effort to save money, some payers elect to carve out a portion of the health benefits to allow another entity with expertise in that area to manage it. This is particularly common with psychiatric benefits and pharmacy benefits. In most cases, the carve-out plan acts as a TPA, but it can also be a payer. Depending on the arrangement, the carve-out may provide utilization review services, forward the claims on to a TPA for processing, and have the claims paid by the employer. In other cases, the carve-out will act as a TPA and request claims funds directly from the employer.

PHARMACY BENEFIT MANAGEMENT

Currently most insurers have their pharmacy benefits administered by entities known as PBMs (pharmacy benefit managers, or pharmacy benefit management companies). These companies work with insurers to formulate and administer beneficiaries' prescription drug benefits, and in recent years have become major distributors of prescription drugs. Generally a formulary is established and copays for medications are set based on the medication's status in the formulary. However, copays are also determined by how the drugs are obtained by the patient, either directly from the PBM at a lower copay, or from the neighborhood pharmacy at a higher rate. Pharmacy benefit management is a very complex and constantly evolving issue as insurers employ new methods to attempt to control the cost of providing prescription drugs. For more information on PBMs, call the APA's Managed Care Help Line at 800-343-4671.

VERIFYING BENEFIT COVERAGE ACCURATELY AND EFFICIENTLY

Accurate benefit verification is vital to maintaining the financial stability of your practice. Even if you do not accept assignment on any claims and obtain payment directly from your patients, it is important for you to know the amount and type of insurance benefits your patients have. Failure to understand a patient's benefits can result in claims denials or, in the case of Medicare, charges of abusive or fraudulent billing.

Your first session with a patient is the best time to verify her insurance benefits. At a minimum, you should obtain the following information:

- Patient's name
- Address
- Date of birth
- Social Security number
- Name of insurance plan
- Insured's name (this may be the same as the patient)
- Insured's policy number
- Insured's social security number
- Insured's date of birth
- Employer's name
- Group number

This information should be recorded and kept with the patient's permanent file. A sample benefit verification form is presented in Appendix P.

You should also make a photocopy of the patient's insurance card to keep on file. The insurance card will include a telephone number to call for verifying benefits and any prior authorization or referral requirements. You should contact the insurance company as soon as possible, preferably before the patient's first appointment, to confirm coverage. If you participate with any managed care plans, be sure to follow their procedures for benefits verification of plan beneficiaries. You should obtain the following information from the patient's insurance company:

- Effective date of coverage
- Preexisting condition restrictions (if any)
- Psychiatric benefits
- Yearly benefit maximum
- Yearly deductible
- Copayment

To ensure that you do not spend session time completing insurance paperwork with the patient, you may want to ask him to arrive a few minutes early or send the paperwork to his home for completion prior to the first appointment.

If possible, you should verify benefits at every session with a patient. This is not as time consuming or difficult as it may sound. The patient sign-in sheet can be made to include a place for the patient to indicate if her insurance has changed since the last visit. If the patient has new insurance, you can obtain the new information immediately. Alternatively, if there's a receptionist, he can ask patients about any changes in their insurance coverage when they check in.

If neither of these methods seems feasible for your practice, you can use the following triggers to identify possible changes in your patients' health benefits:

- **Job Change, Retirement, or Lay-Off:** If a patient mentions that she has left her current employer for any reason, you should contact the insurance company to determine how long her coverage will remain in effect. You should also ask the patient about any new coverage she may have through her new employer, spouse, or Medicare.
- **End of the Year:** The end of the year is a popular time for employers to change insurance benefits. This may include adding new options or changing benefits within an existing plan. You can ask patients about any changes to their insurance coverage during their first visit of the new year. Be sure to document any new information in the patient's file. You should also contact the patient's insurance company to confirm any changes.
- **Sixty-Fifth Birthday:** All physicians, even those who bill patients directly for services and do not participate with any insurance programs, are subject to federal rules if they treat even one Medicare patient unless they have specifically opted out of the program (see Chapter 40). Currently almost everyone becomes eligible for Medicare at age sixty-five, and if you treat a Medicare patient, you must abide by all of Medicare's regulations concerning that patient's treatment. This includes a limit on the amount you may legally charge a patient for your services. Medicare actively tracks the fees charged by physicians and will require you to repay any money paid to you by a patient that is more than the Medicare-allowed amount for that service. An annual review of patient charts will help you to identify those patients who will become eligible for Medicare during the year.

Staff in the Office of Healthcare Systems and Financing will assist APA members with any questions they may have verifying benefits for their patients. Just call the Managed Care Help Line at (800) 343-4671.

COORDINATING BENEFITS FOR PATIENTS WITH MORE THAN ONE SOURCE OF INSURANCE COVERAGE

If a patient is covered under his own employer-sponsored health insurance plan and is listed as a beneficiary on his spouse's plan, which plan do you bill first? If you are treating a child whose parents are divorced, which parent's plan do you bill? Coordination of benefits (COB) provides guidelines to help you answer these and other questions that arise when a patient is covered by more than one health plan. The primary goal of COB is to determine the order in which insurance plans pay and to ensure that the total payment does not exceed 100 percent of the billed expenses. COB also ensures that the primary plan pays as if it were the only plan. The secondary plan and any subsequent plans pay the difference between the billed amount and the payment made by the primary plan.

In 1970, the National Association of Insurance Commissioners (NAIC) developed model legislation for COB. These guidelines form the basis for the majority of state laws on COB, providing some degree of consistency. The federal government, however, complicates the issue. ERISA (Employee Retirement Income Security Act, see Chapter 42), the federal legislation that covers employee benefit plans sponsored by self-insured employers, exempts such employers from state COB laws, allowing the plans to develop their own policies for COB. In addition, COB rules for Medicare and Medicaid that also preempt state laws are maintained by the Centers for Medicare and Medicaid Services (CMS). For the most part, health plans maintain detailed processes to ensure that COB occurs and is carried out correctly for patients who are covered under multiple plans.

As a physician, it is important for you to understand the general principles of COB and know how to identify potential COB issues to ensure that you and your patients receive prompt and accurate reimbursement.

GENERAL PRINCIPLES OF COB

As stated above, the main purpose of COB is to determine the order of payments when a patient is covered by more than one insurance plan. The first step in this process is to determine which plan is the primary payer, which is secondary, and so on. In general, the following guidelines are used to determine primacy:

- **Type of Plan:** If a patient is receiving treatment as a result of an accident, the insurance policy that covers the accident (workers' compensation,

automobile, homeowner's) is generally the primary plan.

- **Family Member Coverage:** The subscriber's plan is primary for the subscriber. It will be secondary for any dependents of the subscriber who are subscribers themselves on other policies.
- **Plan Provisions:** Some plans specify their order of payment. For example, Medicaid is always considered the payer of last resort. Also, if the service provided is not considered a covered service by a plan, COB is not an issue. The plan that covers the service should be billed as the primary plan.
- **State of Residence:** Applicable state laws may offer some guidance in determining COB.
- **Employment Status:** For active employees, the employer-sponsored health plan is generally primary. Other plans, such as Medicare, may be primary for disabled or retired employees.
- **Legal Decrees:** Child custody agreements may specify which parent's plan is primary for the child. Such legal decrees take precedence over other methods of determining the primary plan.

IDENTIFYING POTENTIAL COB SITUATIONS

There are a number of triggers that should indicate to you that a patient may have more than one health plan and will require COB. These include:

- Patient is sixty-five or over (this may indicate Medicare coverage)
- Patient is under sixty-five but has end-stage renal disease or a disability (this may also indicate Medicare coverage)
- Patient and patient's spouse are both employed
- Patient is a child whose last name is different from the parent/subscriber
- Patient is being seen for an injury or condition related to employment
- Patient is being seen for an injury or condition resulting from an accident

If any of these apply, verify all insurance coverage with the patient and contact the insurers directly to confirm which is primary before submitting any claims. This will reduce the chance of delays and errors in claims processing.

RULES OF THUMB

Despite the complexity of COB legislation and regulations, there are a few rules of thumb that will help you facilitate processing and payment of claims in COB situations.

- **Subscriber:** The plan for which the patient is the subscriber, member, or active employee is almost always primary.
- **Spouse:** If the patient is a subscriber on one plan and a dependent on the spouse's plan, the spouse's plan is secondary. If the patient is only covered as a dependent on the spouse's plan, that plan is primary.
- **Dependent Children:** If the parents are married, unmarried and living together, or share joint custody, the primary plan is the one carried by the parent whose birthday falls earlier in the calendar year. If both parents have the same birthday, the primary plan is the one that has been in place longer. If the parents are divorced and a court decree specifies who is responsible for the child's healthcare coverage, this decree takes precedence over the "birthday rule."
- **Managed Care:** If the primary plan is managed, that plan is permitted to reduce the allowed payment amount if cost-containment policies are not followed (e.g., preauthorization). In general, if the secondary plan is managed, it cannot reduce the allowed amount for not following cost-containment policies unless the primary plan makes a reduction as a result of similar plan provisions. This means that if the patient's primary plan does not require preauthorization for services and the secondary plan does, the secondary plan cannot penalize you for not obtaining preauthorization.
Note: Many managed care plans are changing this rule by including language in their benefit plans requiring preauthorization, even if the plan is a secondary payer.
- **Medicaid:** Medicaid is considered the payer of last resort and is never the primary plan unless it is the only coverage a patient has.
- **Medicare:** Medicare is generally secondary to workers' compensation plans and employer-sponsored plans, if the patient is still an active employee. If a patient is no longer considered an active employee due to retirement or disability, Medicare is generally primary. **Note:** If a physician has opted out of Medicare (see Chapter 40) so that Medicare cannot be billed for her services, the patient's Medigap policy will not reimburse for the treatment either, although other Medicare supplementary policies may.
- **TRICARE:** TRICARE, the health plan for U.S. military personnel and their families (formerly known as CHAMPUS) is always a secondary payer, except

when Medicaid is involved.

For additional information on COB for a specific patient, the patient's health plans are the best source of information, particularly the one you believe to be primary. The APA's Office of Healthcare Systems and Financing also has staff available to assist APA members in obtaining more information about COB.

IMPLEMENTING ELECTRONIC BILLING CAPABILITIES

To reduce the insurance workload in your office and speed up claims processing, you might consider implementing some form of an electronic claims submission procedure. This can be done by contracting with a billing service or by purchasing electronic claims software. Either way, you can increase the efficiency of your office with electronic claims because they allow you to:

- Catch errors before they get to the insurance carrier (decreasing billing problems that can slow down payments);
- Send claims more promptly so that they are received and handled by the insurance carrier more quickly;
- Easily monitor and track unpaid claims; and
- Focus on other work.

Note: Please be aware that if you currently do not do any electronic transactions you are not covered by the federal Health Insurance Portability and Accessibility Act (HIPAA). However, if you start billing electronically, your office will have to become compliant with HIPAA's Privacy and Transactions Acts and any other regulations that follow in the years to come (see Chapter 41A for information about HIPAA).

BILLING SERVICES

While using a billing service can be more expensive than purchasing software to submit claims yourself, the service can provide additional expertise and features to improve the overall billing process. You simply send your claims to the service once or twice a week. They will enter all the information for the electronic submission and send it to a clearinghouse, which in turn sends it to the insurance carrier. The service will check for errors before submission and will do any follow-up for claims that have coding problems or other errors. Billing services can also electronically submit old claims that were never paid, with significant success rates.

You can have a billing services do your noninsurance billing as well, which would include collecting copayments and billing private-pay patients. Most billing services charge between \$2 and \$5 per claim, depending on the amount of service provided.

BILLING SOFTWARE

Many psychiatrists who already use practice management software and/or electronic health records prefer to purchase electronic billing software and submit claims themselves. This can be less expensive than hiring a service and, although your office will have to enter and submit claims, it will still provide you with the benefits of:

- Less paperwork;
- Faster claims submission;
- The ability to automatically check for errors; and
- Status reports on submitted claims.

Depending on the software package you purchase, you may be able to file some of your claims directly to the insurance carrier, avoiding fees that apply to claims first sent to a clearinghouse. Prices for electronic billing packages can vary, with start-up fees beginning at \$200 to \$300 for single users. Once the software is in place, charges may include monthly fees, and/or fees per claim (typically \$0.35 to \$0.50 per claim).

INCREASING THE SUCCESS RATE OF COLLECTIONS EFFORTS

Ensuring timely, patient-friendly collections can be difficult. Disagreement over a bill can be very disruptive to the physician-patient relationship, and arguing with a payer over reimbursement can cause stress for both the psychiatrist and the patient.

To avoid unnecessary pitfalls, you must first and foremost develop a clear understanding of the patient's insurance, including what it does and does not cover and any restrictions against billing the patient. As noted in Chapter 15, this information should be requested from the patient during or before the first visit and confirmed with the insurer for accuracy as soon as possible. Remember, you cannot rely on the patient's understanding of her coverage or on your own knowledge of what the same insurer covered for another patient.

If patients do not have adequate insurance to cover the necessary treatment, inform them immediately and work with them to develop an alternative arrangement that is mutually acceptable. Before you do this, however, you'll need to review any contractual agreement you may have with the insurer to confirm that the arrangement is allowable. Many payers do not allow psychiatrists to balance-bill the patient for services that are not authorized.

Patients must then be made aware of the practice's collections policies in writing and as soon as possible. Describe all of the fiduciary terms in detail, including the practice's policy on charges for missed appointments and copayment collection (see Chapter 13 for advice on managing missed appointments). Whenever possible, copayments should be collected at the time of service delivery, and it may be helpful to post this policy in an obvious place in the office. All financial arrangements should be documented in writing for future reference, and the patient (or his guardian) should sign and receive a copy.

For patients covered by managed care, you must monitor treatment authorizations carefully. If you exceed the authorized number of sessions or bill for services beyond those authorized, your practice will probably have to absorb the costs, since payers are typically inflexible when network providers do not follow their administrative protocols. To improve collections, claims submitted to managed care organizations and other payers must also be "clean" (i.e., must contain sufficient information for expeditious processing). While there is some variability in what is required, most payers look for the diagnosis, procedure, place, date, and type of service. Please see Chapter 30 for additional information on billing issues.

Although most practices bill their patients monthly, we recommend billing every two weeks to keep patients up-to-date with their balances. Practices should also review their collections and deposits at least once a month. An automated system may be helpful (see Chapter 17).

TIPS FOR HANDLING DIFFICULT BILLING SITUATIONS

- When patients claim they have paid, but there is no record of funds having been deposited, ask them to mail or fax a copy of the canceled check. If they say they have paid in cash, ask for a copy of the receipt (be sure to give receipts for all cash payments).
- When patients say they cannot afford the balance due, develop a payment plan with a minimum of \$20 per month or allow them to give you postdated checks.
- If a patient dies owing money, first exhaust all third-party resources. Check your state's laws about further avenues of collection. Depending upon the state, payment may or may not be the responsibility of a spouse, parents, and/or children. If applicable, it may be advisable to submit the bill to the estate attorney or the executor of the will. We recommend that no collection calls be made to the patient's family for at least thirty days.
- If you are planning to charge interest or finance charges, or to allow installments over four or more payments, be aware that federal and/or state truth-in-lending laws may apply to these activities.
- When a patient's check is returned due to insufficient funds, add an insufficient funds charge of \$15 to \$25 to the bill (this policy should be posted prominently in the office and given to the patient in writing at the beginning of treatment). Inform the patient in writing or by telephone that payment is expected within a week or two weeks (at your discretion).
- As an avenue of last resort, warn the patient that if you do not receive payment by a certain date, the account will be forwarded to a collection agency -- and stick to that promise. Be aware that a collection agency will keep or bill you a percentage of the amount collected. Percentages can be extremely variable, and it is wise to comparison shop. We recommend against paying more than one-third of the collected amount and against paying this fee up-front. (**Note:** This option is typically not worth the effort unless the bill is over \$100. Furthermore, be aware that collection efforts sometimes lead to counterclaims of malpractice.)

INCREASING THE SUCCESS RATE OF COLLECTIONS EFFORTS

Ensuring timely, patient-friendly collections can be difficult. Disagreement over a bill can be very disruptive to the physician-patient relationship, and arguing with a payer over reimbursement can cause stress for both the psychiatrist and the patient.

To avoid unnecessary pitfalls, you must first and foremost develop a clear understanding of the patient's insurance, including what it does and does not cover and any restrictions against billing the patient. As noted in Chapter 15, this information should be requested from the patient during or before the first visit and confirmed with the insurer for accuracy as soon as possible. Remember, you cannot rely on the patient's understanding of her coverage or on your own knowledge of what the same insurer covered for another patient.

If patients do not have adequate insurance to cover the necessary treatment, inform them immediately and work with them to develop an alternative arrangement that is mutually acceptable. Before you do this, however, you'll need to review any contractual agreement you may have with the insurer to confirm that the arrangement is allowable. Many payers do not allow psychiatrists to balance-bill the patient for services that are not authorized.

Patients must then be made aware of the practice's collections policies in writing and as soon as possible. Describe all of the fiduciary terms in detail, including the practice's policy on charges for missed appointments and copayment collection (see Chapter 13 for advice on managing missed appointments). Whenever possible, copayments should be collected at the time of service delivery, and it may be helpful to post this policy in an obvious place in the office. All financial arrangements should be documented in writing for future reference, and the patient (or his guardian) should sign and receive a copy.

For patients covered by managed care, you must monitor treatment authorizations carefully. If you exceed the authorized number of sessions or bill for services beyond those authorized, your practice will probably have to absorb the costs, since payers are typically inflexible when network providers do not follow their administrative protocols. To improve collections, claims submitted to managed care organizations and other payers must also be "clean" (i.e., must contain sufficient information for expeditious processing). While there is some variability in what is required, most payers look for the diagnosis, procedure, place, date, and type of service. Please see Chapter 30 for additional information on billing issues.

Although most practices bill their patients monthly, we recommend billing every two weeks to keep patients up-to-date with their balances. Practices should also review their collections and deposits at least once a month. An automated system may be helpful (see Chapter 17).

TIPS FOR HANDLING DIFFICULT BILLING SITUATIONS

- When patients claim they have paid, but there is no record of funds having been deposited, ask them to mail or fax a copy of the canceled check. If they say they have paid in cash, ask for a copy of the receipt (be sure to give receipts for all cash payments).
- When patients say they cannot afford the balance due, develop a payment plan with a minimum of \$20 per month or allow them to give you postdated checks.
- If a patient dies owing money, first exhaust all third-party resources. Check your state's laws about further avenues of collection. Depending upon the state, payment may or may not be the responsibility of a spouse, parents, and/or children. If applicable, it may be advisable to submit the bill to the estate attorney or the executor of the will. We recommend that no collection calls be made to the patient's family for at least thirty days.
- If you are planning to charge interest or finance charges, or to allow installments over four or more payments, be aware that federal and/or state truth-in-lending laws may apply to these activities.
- When a patient's check is returned due to insufficient funds, add an insufficient funds charge of \$15 to \$25 to the bill (this policy should be posted prominently in the office and given to the patient in writing at the beginning of treatment). Inform the patient in writing or by telephone that payment is expected within a week or two weeks (at your discretion).
- As an avenue of last resort, warn the patient that if you do not receive payment by a certain date, the account will be forwarded to a collection agency -- and stick to that promise. Be aware that a collection agency will keep or bill you a percentage of the amount collected. Percentages can be extremely variable, and it is wise to comparison shop. We recommend against paying more than one-third of the collected amount and against paying this fee up-front. (**Note:** This option is typically not worth the effort unless the bill is over \$100. Furthermore, be aware that collection efforts sometimes lead to counterclaims of malpractice.)

CONDUCTING AN EFFECTIVE JOB OR PRACTICE SEARCH

Unless you're planning to set up your own practice, you will need to know how to go about finding a position in an existing practice or with a healthcare organization. Your search for such a position, if done well, can lead you to a practice opportunity that will give you the professional satisfaction, financial rewards, and stability you desire. If done poorly, your search will probably begin again after a short period of time. Communication, planning, and patience will help you avoid making what could be a costly mistake.

TIME LINE

The length of time you search will vary depending on your experience as well as your personal needs and preferences. If you're in a training program, you should plan to start looking for a position twelve to eighteen months prior to the completion of the program. Physicians in two-career families, or those who are looking for a specific kind of position or a specific location, should plan to start early as well. On average it takes from eight to ten months to move through the process. This does not take into account the time it takes to get a state medical license. That varies from state to state and, in some cases, can take as long as a year. Proper planning is key

IDENTIFY AND ASSESS YOUR PERSONAL AND PROFESSIONAL NEEDS

A spouse's unhappiness with the community is one of the reasons most frequently given by physicians for leaving a position after only a short period of time. Assessment of your needs and those of your family is the first step toward identifying a location and practice opportunity that is right for everyone. By taking this step seriously and involving those who will be most affected by your choice, you can reduce your risk of making a costly mistake, both financially and emotionally. This is especially important in two-career families. Identifying the right position requires that you take into account not only the location of the opportunity and the specific responsibilities involved, but also your role within the organization. For example, you need to think about whether you would be happier being an employee or whether you're the kind of person who would prefer to own a practice. This chart provides you with a few things to consider:

Ownership	Employment
<p>Pros:</p> <ul style="list-style-type: none"> • Total control of the decision-making process • Choice of when, where, and how long you work • 100% of any profits • The ability to sell the business 	<p>Pros:</p> <ul style="list-style-type: none"> • Guaranteed income and benefits paid by employer • No responsibility for employee disputes • No decision-making responsibilities for the practice • No direct responsibility for practice losses
<p>Cons:</p> <ul style="list-style-type: none"> • Full responsibility for all business issues (taxes, payroll, employment, legal) • Responsibility for 100% of any losses incurred • Responsibility for negotiating the sale of the practice • Acceptance of the fact that the owner is the last one to be paid 	<p>Cons:</p> <ul style="list-style-type: none"> • Little control over salary and benefits • Limited participation in practice profitability • No inclusion in equity built in the practice when it is sold • Limited control over schedule • Minimal participation in practice decision making

(source: *Unique Opportunities*)

Each opportunity is different and may include aspects listed on both sides of the chart. For example, a partnership option with a small group practice may give you the chance to be involved in the decision-making process while limiting your financial risk. You need to determine what works best for you.

It is essential that you discuss your options with those close to you, both at this point and throughout your search. You can use the Self-Assessment Questionnaire located in Appendix A to help stimulate this process.

CURRICULUM VITAE AND COVER LETTER

Your curriculum vitae (CV) is usually the first impression you make on a prospective employer. The length of your CV will vary, depending on the nature of the position you're applying for and your years of training and experience. In any event, be as concise as possible while not omitting important information.

Be certain to include all of your relevant educational, clinical (including teaching and research experience), and administrative experience. List any presentations and publications as well. If a paper has just been submitted, list it as “in submission”; if it has been accepted for publication but is not yet in print, list it as “in press.”

Your cover letter should be no longer than one page and should serve to highlight your specific skills and expertise as they relate to the particular position you’re applying for (pointing out why this employer would want to hire you). In it you’ll want to include the date you will be available and detailed information on how you can be contacted. This is also the place to include any seemingly extraneous information that may make you more attractive to the employer. For example, it would be helpful for the employer to know that you are looking for a job in their community because it is close to your spouse’s family or near your spouse’s new job. Employers respond more quickly to those applicants who indicate a tie to the community. Use this to your advantage.

There are a number of ways you can format your CV, providing you follow some basic rules:

- Choose a simple typeface, such as Arial or Times New Roman, and stick with it.
- Use bold type or all capital letters to create a separation between areas of information.
- Be consistent in your organization of information.
- Proofread your document and show it to a colleague for feedback.
- Make sure the information on your CV is up-to-date and accurate.
- Use white or off-white paper for easy reading.

The format can vary; content is the key. Over time your CV will grow. You may find it necessary to shorten certain sections (duties and responsibilities of previous positions, the list of your publications and presentations – provide only the most recent information, with a note that you will be glad to send the earlier information on request) in order to present the most current information in a concise, easy to read manner. You want a document that will provide an accurate image of your training and experience without overwhelming the employer.

GATHERING INFORMATION

Now that you have some ideas as to what you want to look for, as well as the tools (CV) with which to respond, you can begin the process of gathering information on available jobs and submitting your CV for consideration.

Sources of Information on Available Opportunities

Information on available jobs can be found in a number of places. The following are the most common:

- **Networking:** This is one of the most effective means of locating a good practice opportunity, especially if you are interested in positions within a specific practice setting such as academia, research, or the pharmaceutical industry; or in providing clinical services to a specific patient population such as prisoners, HIV patients, or patients suffering from sleep disorders. Networking is especially helpful for those of you who want to remain in your current community. Not only do your colleagues often hear of positions before they are advertised, they may be able to provide valuable information on the employer as well. They can also tell you what they like and don't like about their current positions and how they got there. Virtually everyone you come in contact with professionally has information that could prove to be valuable to your search. Talk to them.
- **American Psychiatric Association (www.psych.org):** The APA offers a number of sources of helpful information, including classified ads, the APA Job Bank – an on-line database containing information on available jobs, and networking opportunities at APA sponsored meetings. See Appendices C and D for a complete listing.
- **APA District Branches (DBs):** There are seventy-six DBs located throughout the United States (including Puerto Rico) and Canada, as well as a separate DB for military personnel called the Society of Uniformed Services Psychiatrists. Although the resources that are available vary, many DBs offer information on jobs via a classified ad section in their newsletter. In a few cases, DBs sponsor periodic job fairs. In addition, District Branch staff may be able to link you to other APA members who will have information on specific employers and communities. They may also be able to give you a general sense of the current psychiatric climate in the area. See Appendix E for a listing of the DBs.
- **Advertisements:** In addition to the APA publications *Psychiatric News* and *Psychiatric Services*, you can find information on available jobs in a number of other periodicals directed toward the field of psychiatry (e.g., *Psychiatric Times* and *The New England Journal of Medicine*), as well as in local newspapers.

-
- **Internet:** The web contains hundreds of sites with everything from classified ads and job banks to helpful economic data. Do a search through one of the web browsers like Google or Yahoo. A little time and patience should pay off with some helpful information. APA offers an online job bank—APA Job bank—where you can post your availability or check out current job openings. Go to www.psych.org.
 - **Professional Organizations/Meetings:** In addition to the APA, there are a number of associations for psychiatrists with specific interests or expertise. Organizations like the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists provide information on available jobs at their annual meetings in addition to providing networking opportunities. See Appendix G for an extensive list of related organizations and their contact information. This list can also be found in the back of the American Psychiatric Press (APPI) Appointment Book, which is published yearly. To order a book, call APPI at (800) 368-5777.
 - **Recruitment Agencies:** There are a number of these agencies across the country. Look for one that is a comfortable fit and that has a staff that is responsive to your needs. There should be no cost to you to use the services of a recruitment or search firm. The following list of questions was developed by a psychiatrist for use by those interested in selecting a recruiter:
 - Who do you work for; what is the size of the organization; and how long has it been in existence? Is this an independent firm or are you a hospital-based recruiter?
 - Are you a member of the National Association of Physician Recruiters?
 - How many psychiatrists have you placed? May I contact a few as references?
 - What is the financial arrangement between you and the employer; contingency or retainer? How is the amount you are paid determined; set rate or a percentage of the physician's first year salary? Have you visited the practice and met the employer?
 - How will you determine who receives my CV? Will I be contacted with details on the opportunity prior to your mailing out my CV?
 - **Direct Solicitation:** You have probably been receiving unsolicited letters informing you of available positions since you first entered your psychiatry residency. If an opportunity sounds interesting, contact the sender and request additional details. Even if you are not interested in the position, the information in the letter may give you some insight into the current job

market. In addition to responding to direct solicitations from others, you can do your own direct solicitations; sending a letter of inquiry with your CV directly to employers of interest even though they may not have an advertised opening. This is especially helpful if you are limiting your search to a specific geographic locale or are hoping to work in an area of psychiatry so specialized that there are only a limited number of organizations with whom you would be interested in working. Once you've sent a letter expressing an interest in talking with them about the potential for employment, follow up with a telephone call. Although the general purpose of the call is to ensure they received your information, you should also use this as an opportunity to impress them with your interest and skills.

- **Federal Employment:** A number of federal agencies have online information about employment opportunities. Here are three that we are aware of:
 1. Department of Veterans Affairs, Centralized Recruitment Office, can be accessed at <http://www4.va.gov/jobs/> .
 2. U.S. Department of State, for jobs in the foreign service, go to www.careers.state.gov [the State Department hires psychiatrists to work in American embassies throughout the world]
 3. National Institute of Mental Health (NIMH) has a job vacancies listed at <http://www.nimh.nih.gov/about/selected-job-opportunities-at-nimh.shtml> .

Sources of Information on the Current Marketplace

Information on current trends is useful in helping you to evaluate individual practice opportunities. It can also give you an idea of what you can expect to find when you go into practice in a specific area. We have listed just a few of the many available resources. For a list of additional resources go online to the APA Members Corner at www.psych.org and or go to Appendix C for a list of additional resources.

- **American Psychiatric Association:** Again, the APA is a good place to start when looking for data. You can find us online at www.psych.org.
- **American Medical Association (AMA):** The AMA produces a number of reference books containing data on the practice of medicine. Perhaps the most helpful is *Physician Characteristics and Distribution in the United States*. Updated every two years, this publication contains information on trends, characteristics, and the distribution of physicians across the country. It

includes information on the number of physicians by specialty in every county and major city in the country. To order a copy, call the AMA at (800) 621-8335, or check with your local library, medical school, hospital, or medical society.

- **Medical Group Management Association (MGMA):** MGMA has a wide variety of services that groups of all sizes may find helpful. One product includes an annual salary survey that looks at salaries by specialty from region to region. You can get more information on MGMA and what they offer by visiting their homepage at www.mgma.com.

Sources of Information on the Community

You can get a picture of life within a specific community without leaving your home. The following resources provide you with valuable information that can be compared from community to community.

- Do an online search. Most communities now have webpages that can give you a basic idea of what they're like—or, at least, what they deem is important.
- Chambers of Commerce: A good source of information on an area's local economy, community size, cost of living, and school system. They may also be able to provide you with information on local employers if you are having difficulty locating a professional opportunity for your spouse. Factor this information in with what you learn during your site visit, keeping in mind that the mission of the Chamber of Commerce is to promote the local community. For information about local Chambers of Commerce, you can go to www.acce.org for links to local Chambers of Commerce or call the national office at (202) 659-6000.
- **Places Rated Almanac:** Available online at <http://placesrated.expertchoice.com/> and in most libraries, this book covers everything from the cost of housing to taxes, and includes information on educational systems, recreational activities, and safety in communities across the nation.

FOLLOW-UP/PREINTERVIEW/ INTERVIEW AND SITE VISIT

Follow-Up

By now you should have a long list of possibilities to consider; probably more than you care to spend the time or energy pursuing. It is time to eliminate those

of least interest. Here is where time you spent on self-assessment and reflection will pay off.

Employers who have received your CV will call to provide you with additional details on the position, as well as to learn more about you. Use this contact with them to develop your “short list,” identifying those positions that most closely meet your needs. Listen closely to the information they provide and then focus your questions around any issues of importance to you that were not covered. For example, “You mentioned the possibility of doing some consultation work with other physicians. That’s a big area of interest for me. How much of my time can be spent in that area?” or “My spouse is a radiologist. Do you know of any current openings in your community?” This is not the time or place to get into a detailed discussion of the compensation package. That can be a turnoff to an employer. You can, however, ask about the salary range so that you have a feel for your potential income.

Professionalism is very important during this process. A telephone call not returned, poor communication skills, or a less than professional attitude will not go unnoticed. It is likely that the employer has a number of candidates from whom to choose. Don’t let easily avoidable errors make the decision for you. Even if you decide you are not interested enough in the position to accept an invitation to interview, politely let the employer know that and thank them for their interest. If you handle this professionally, you will leave the employer with a good impression, which can be very important in a tight-knit professional community. If no interview is proposed, but you’re interested in pursuing the position, communicate your interest to the employer by following up with a note. Thank them for their call and let them know of your continued interest and availability. It will be up to the employer to respond.

Since you will be gathering a large amount of information throughout this process, you’ll find that a computer file, notebook, or index cards can be useful to record key pieces of information and help you organize your search. Things to note include:

- Name and address of the employer;
- Name, title, and telephone number of the contact person;
- How you learned of the opening;
- Date(s) of contact;
- Position title;
- Notes on specific items of interest, such as size of the group, responsibilities, call schedule, community size, salary range, etc.;
- Interview specifics (if appropriate);
- Your general feeling at the end of the conversation;

-
- How it rates with other positions; and
 - Is follow-up necessary?

Pre-Interview

There are a few things to consider before showing up for the interview:

- **Expenses:** Before going on the interview be sure to clarify what expenses, if any, the employer will cover and who will be making the arrangements (you or them). Will the employer pay for the expenses up front or will you pay and submit receipts for reimbursement? Will they pay to include your spouse? Your spouse should be included in at least one interviewing trip prior to your accepting a position. What will not be covered by the employer? Get this in writing if at all possible. The process will differ from employer to employer, so be sure to get a clear picture of what is expected. In some cases the employer will reimburse you for very little and you will need to determine how much the opportunity is worth to you. In getting this information up front you are protecting both yourself and the employer by reducing the risk of a miscommunication that could jeopardize any further discussions.
- **Preparation:** Prepare and rehearse your questions to ensure that you get the information that is important to you. This list of questions will be longer than that used in your initial discussions over the telephone and will look at specific aspects of the position, the organization, and the community. You'll also want to consider the questions you may be asked and your answers to them. This relieves a bit of the stress and demonstrates to the employer that you are prepared and knowledgeable. This task will be easier once you've gone through one interview. Here are a few potential questions to answer before you go into the interview:
 - What attracted you to this particular position?
 - What skills do you bring to the organization?
 - What do you see yourself doing in five years?
 - How will your family feel about our community?

Interview and Site Visit

Whether this is your first or second interview with an employer, use your time wisely. Be sure that the interview schedule includes time to meet as many people as possible, yet leaves you enough time to evaluate the community. Here are some tips:

1. Be well rested, on time, and prepared for the interview.
2. Dress professionally (business attire); first impressions are the strongest.
3. Don't be afraid to ask questions.

-
4. Given the current marketplace, ask for information relating to managed care and its influence on the group. For example: the number of panels in which the practice participates; the length of time they have been participants in the panels; the number of competing practitioners/groups in the area; payer mix (x% managed care, x% private pay, x% Medicare/Medicaid); qualifications needed to be included in the provider panel (board certification, etc.); and future plans of the organization relating to managed care;
 5. Whenever possible, speak with the physician who is currently in the position you are interviewing for or who held the position previously.
 6. Information on the compensation package should be provided during the first interview. It should not, however, be the focus of the interview. Let the discussion move in that direction naturally.
 7. Keep in mind that the employer is evaluating you throughout the course of the interview. This includes any interactions you have with staff, directly and indirectly, including those during a group lunch or dinner.
 8. Be open about past or current professional problems. It is best that the employer hears of any problems directly from you rather than from one of your references. However, give yourself a chance; let the employer get to know you before sharing what could be perceived as negative information. Take time at the end of the day/interview to fill them in.
 9. Always investigate the position and geographic location on your own. Do not rely solely on information provided by the recruiter and/or employer. This includes contacting physicians and nonphysicians in the area to inquire about the community (economic base, level of managed care saturation, medical services, climate, school systems, etc.) and the practice. Keep in mind that there may be hidden agendas, and that in small communities it may be difficult to do this research discreetly.
 10. Do not accept an offer on the spot. By the end of most interviews your mind is full of new information. Take time to consider carefully if the position is what you want.
 11. Once you are home, take a moment to write a thank you note. In the note you can indicate your continued interest or your decision not to pursue the position further.
 12. Review and revise your needs and priorities as necessary throughout the process, evaluating each opportunity against them, as well as against each other opportunity.
 13. Investigate the state licensure requirements on your own. See the list of State Boards of Medical Licensure in Appendix I.

FINALIZING THE DEAL

After you've completed the interview (and second and third interviews), your family has seen the community, and an employer with an attractive position has made you an offer, there are still a number of things to consider. Before saying yes, ask yourself the following questions:

- Does this position meet my needs?
- Do I see myself staying with the organization for at least five years?
- Do I like the people I will be working with?
- Am I comfortable with their treatment philosophy?
- Do we have a similar work ethic?
- Am I happy with the compensation package?
- Does the community offer what we (the family) want?
- Is my family excited by the possibility of moving there?

Remember, “trust your gut.” If it doesn't feel right, it probably isn't

20

CONFIDENTIALITY

The concept of confidentiality is essential for all medical treatment. This is stated clearly in both the Hippocratic Oath and in the American Medical Association's (AMA's) *Principles of Medical Ethics*. Confidentiality is perhaps even more vital to the practice of psychiatry, as is evidenced by reading the APA's *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (see Chapter 35). Patients cannot be expected to reveal their innermost selves, their fears and passions and obsessions, unless they are certain that what they say will be held in the strictest confidence.

Within the context of the physician-patient relationship, you have a duty not to disclose information you've learned from the patient. A breach of confidentiality not only has the potential to harm your patient, it can put you at risk for a malpractice suit as well.

Most states have statutes that define the privileged nature of the physician-patient relationship, and many have enacted other statutes that more specifically confer privilege on the psychotherapist-patient relationship. This concept of privilege generally allows the patient to prevent a physician or therapist from disclosing any confidential material learned in the course of treatment in any judicial proceeding. The federal Health Insurance Portability and Accountability Act (HIPAA) is very clear about the confidentiality protections required for patients' identifiable health information (see Chapter 41A).

It is important that all staff people working in a psychiatric office understand the importance of strict confidentiality and that safeguards be in place to protect the privacy of patient records. A physician will be held responsible for any breach of confidentiality committed by a member of his or her staff.

EXCEPTIONS TO STRICT CONFIDENTIALITY

On occasion a psychiatrist will have reason to breach the concept of strict confidentiality and disclose information a patient has relayed during the course of therapy. This can only be done with the express authorization of the patient or under legal compulsion.

Consent

If a patient has given informed consent for information to be released, the psychiatrist is permitted to reveal information learned in the course of therapy.

It should be noted that to be *informed* the consent must be voluntary and intentional (see Chapter 22).

Overriding Interest of the Public

Most courts have found that a physician has a duty to warn (see Chapter 21) when a patient poses a threat to a third party. In fact, the physician can be held liable for any harm that occurs if a warning has not been given. Many states also have specific waivers allowing psychiatrists to reveal confidential information in the context of civil commitment proceedings (see Chapter 23).

Patient's Interests

Disclosures can sometimes be justified on the grounds that they are necessary to protect the patient. For instance, it is generally acceptable for a psychiatrist to warn a patient's family or roommate when the patient is very depressed and has voiced suicidal thoughts.

Reporting Statutes

Almost all states have statutes requiring that certain conditions—infectious diseases, incidents of child abuse, diseases characterized by loss of consciousness, et al—be reported to government authorities. These statutes differ tremendously from state to state as to what conditions must be reported and what events trigger the duty to report. You'll need to familiarize yourself with your state laws.

MENTAL HEALTH CONFIDENTIALITY STATUTES

Over the past ten years an increasing number of state and federal laws have been enacted that address specific confidentiality concerns. Some of these deal with disclosing HIV/AIDS information while others deal with the release of substance abuse information. A number of states have enacted mental health confidentiality statutes that attempt to deal comprehensively with the issue of confidentiality and spell out what a psychiatrist can and cannot safely disclose. Some of these laws establish a general rule of confidentiality and then enumerate the exceptions to that rule. If you are working in a jurisdiction that has one of these laws, you should become familiar with the relevant provisions. A call to the state agency that oversees mental health licensure should let you know if your state has a specific mental health confidentiality statute.

CONFIDENTIALITY AND MINOR PATIENTS

When your patients are minors rather than adults, the rules of confidentiality become much less clear. Parents may argue that since they are financially

responsible for the care their child receives, they have the right to make all confidentiality decisions involved in that care. However, while it is clear that a psychiatrist has a duty to let parents know if there is a risk that a child may commit suicide, it is not necessarily the case that parents should be informed of everything a child says in therapy.

Although there is no clear line as to who is a “young minor,” when treating children under twelve, you are probably safe to rely on a parent’s consent for the release of confidential information. It is important to remember that you must be careful not to disclose information to parents that would exacerbate problems in the parent-child relationship or undermine your doctor-patient relationship.

If there is any possibility of child abuse, the parent loses the right to make decisions about disclosure of information. Most states require a report to the responsible government agency and immunize the doctor making the report against charges that confidentiality has been breached.

When dealing with adolescents, the rules relating to confidentiality become even more complex. It is safe to operate under the premise that minors possess the independent right to privacy when they are legally able to consent independently to medical care (see Chapter 22).

PRACTICAL POINTERS FOR AVOIDING CONFIDENTIALTY PROBLEMS

- Follow the general principle to honor a patient’s confidences unless a legal exception applies.
- Instruct staff not to release any patient information without your advance approval.
- Have a written “Authorization for Release of Medical/Mental Health Information” form that can be tailored to specific situations. (See Appendix N).
- If you have any doubt about the validity of consent-to-release information, call the patient to discuss the information and verify consent.
- Be aware of the possible breach of confidentiality when communicating by cell phone, e-mail, fax, or voice mail. Be sure nothing is communicated that is of a confidential nature unless you can be certain of who will be reading or hearing it.
- When leaving messages for a patient with family or on a machine, leave only your name and phone number and the times you can be reached. Be sure to instruct staff to do this as well.

-
- When doing an evaluation (e.g., for worker's compensation), clarify the limits of confidentiality at the outset, explaining who will and will not receive a copy of the evaluation.
 - Obtain legal advice before releasing any information after a patient's death.
 - Inform group therapy participants about the parameters of confidentiality.
 - If you're subpoenaed to testify or release records, seek advice from the APA's Legal Consultation Plan or a local attorney.
 - Do not automatically assume that an MCO has the patient's consent to have information released to them. Try to discuss such an authorization with the patient at the beginning of treatment. Always get written consent.
 - If you need to use a collection agency or small claims court to collect on an unpaid bill, be sure to send the patient appropriate advance notice in writing and reveal the least amount of information necessary.

21

DUTY TO WARN

Duty to warn is a concept of importance to any psychiatrist who treats a patient capable of committing an act of violence against another person. In 1976 the decision handed down in the landmark case *Tarasoff v. Regents of the University of California* changed the traditional rule that psychiatrists were not to be held responsible for the violent acts of their patients. In the *Tarasoff* case a psychologist at UC-Berkeley became convinced that his patient, Prosenjit Poddar, might try to kill Tatiana Tarasoff. He had the campus police detain Poddar so he could begin the process of civil commitment. The police, however, felt Poddar was rational and released him. Later, the psychiatrist who supervised the psychologist also decided there was no basis for commitment. Poddar terminated his treatment and two months later murdered Tatiana Tarasoff. Tarasoff's parents sued the psychologist, the psychiatrist, and the university, saying they had a responsibility to have done more, including warning Tatiana directly that she was in danger. The court found in their favor, concluding that a psychiatrist has a duty to warn identifiable victims, although not necessarily a duty to restrain, or commit, a patient who might pose a threat to identifiable or nonidentifiable victims.

Since *Tarasoff* there have been many court cases that have upheld its precedent, while others have gone even further, concluding that a therapist of a potentially violent patient is liable for harm done even to victims who might not have been identifiable in advance. Still other courts have refused to follow *Tarasoff*, as in *Hopewell v. Adebimpe*, where a psychiatrist was sued for breach of confidentiality for informing a patient's employer that she was feeling harassed at work and might hurt someone seriously if the harassment didn't stop. The court held the psychiatrist had an absolute obligation not to disclose confidential communications without the patient's written consent.

HOW TO MINIMIZE YOUR LIABILITY FOR A PATIENT'S VIOLENT ACTS

Because of the apparent lack of clarity about how the courts will rule in cases of duty to warn, psychiatrists should take a number of steps to minimize the risk that they'll be held liable for their patients' violent acts:

- **Obtain prior treatment records.** You'll have more information to work with and be better able to assess the seriousness of a patient's threat of violence. In fact, the 1983 court case *Jablonski by Pahls v. United States*, determined

that a mental health professional's duty to predict dangerousness includes consulting a patient's prior records.

- **Document your decision-making process.** Having a record can help establish that you consulted all the relevant sources of information and considered all the relevant factors when deciding if the patient posed a threat that people needed to be warned about or protected from. Even if your decision turned out to be wrong, this documentation will show that your decision was a reasonable one.
- **When in doubt as to whether to issue a warning or take other steps to prevent harm, arrange a consult with another clinician or an attorney (and document the consult).** Since your liability will be determined in reference to the standards of your profession, consulting another psychiatrist will provide extra protection. The fact that you consulted an attorney will show that due care was taken in your decision making.
- **If it is determined there is a threat of violence to an identifiable person, all appropriate warnings should be made, even if you believe the potential victim is already aware of the danger.** It is also important to determine if others, such as parents and spouses, should be contacted as well.
- **Upon discharging a patient who is known to have a potential for violence, you must be certain that any treatment plan developed is actually followed, and if not, decide whether the patient must be restrained again.** You must make some effort to follow up on this type of patient, even if it just means asking the outpatient therapist or community mental health center to contact you if the patient stops coming to appointments.

22

INFORMED CONSENT

All physicians are required to obtain a patient's informed consent before initiating medical treatment. This means that before a patient agrees to treatment she must be given a fair and reasonable explanation of what the treatment will entail. It must be clear that the patient (or the patient's representative) understands what risks the treatment involves or the consent granted will not be effective (i.e., will not shield the doctor from charges of battery or negligence).

While the traditional standard for legally sufficient disclosure is based on a professional standard, either the customary disclosure practices of physicians or what a reasonable physician would disclose under similar circumstances; many courts are now using a more patient-oriented standard. Instead of the focus being on what a reasonable *physician* thinks the patient *should know*, the focus is now on what "material" information about risks a reasonable *person* in the patient's situation *must know to make an intelligent decision*. Several factors are relevant to determining whether a risk is considered material:

- the severity of the risk;
- the likelihood of injurious side-effects or death;
- the need for treatment;
- the likelihood of success of the treatment;
- and the availability of comparable and less dangerous alternatives.

Hence, if a particular treatment is obviously necessary and the risks are minimal, less than complete disclosure may be permissible. However, where a treatment is particularly intrusive or dangerous, disclosure requirements may be much more demanding.

In an informed consent case, the plaintiff must establish that the alleged negligence of the physician to adequately inform the patient about risk was, in fact, the cause of harm. Courts generally require that the plaintiff prove that a reasonable person in his position would not have agreed to the treatment if he had been given the omitted information. In more patient-oriented courts, however, the patient may only have to prove that *he* would not have consented if he'd had the information the doctor failed to disclose to him.

EXCEPTIONS TO THE REQUIREMENT OF OBTAINING INFORMED CONSENT

There are certain circumstances under which the requirement to disclose risks to a patient and obtain consent does not hold. You should, however, be very careful about relying on these exceptions since the support for them is sparse and courts

are unlikely to expand exceptions that will effectively undermine the doctrine of informed consent. With that warning, the exceptions are:

- **Emergencies.** The premise is that any rational person facing an acute, life-threatening crisis demanding immediate attention would choose treatment.
- **Therapeutic privilege.** It is sometimes accepted that under certain circumstances physicians have a therapeutic privilege to not provide complete disclosure because such disclosure would have a detrimental effect on the patient's physical or psychological welfare. However, psychiatrists should be very cautious about taking advantage of therapeutic privilege. Even if you are convinced that full disclosure would have harmed your patient and been detrimental to treatment, the court may not consider your concerns valid.
- **Incompetency.** An incompetent patient is, by legal definition, unable to give informed consent. If you are treating such a patient you should obtain the informed consent from a substitute decision maker. If a patient has not legally been declared incompetent, it is risky to use incompetency as a basis for not having obtained informed consent from him.
- **Waiver.** You need not disclose the risks of treatment if a patient has specifically requested that she not be told. Since waivers of legal rights are required to be both "knowing" and "voluntary," it must be documented that the patient realized she had a right to the information and willingly surrendered that right.

METHOD AND FORM OF CONSENT

Although it is generally not required that a written consent form be used, a signed form can be very valuable for two reasons:

1. The formality of the procedure may force the patient to focus on what he is consenting to and make it less likely that he'll later believe he wasn't adequately informed.
2. The signed form is evidence that the consent process took place and establishes what was disclosed.

Remember, however, that the signed form is not a substitute for a meaningful consent procedure, it is only evidence of consent (see Appendix EE for a sample treatment consent form).

If only oral consent is obtained, you must be sure to make an entry in the record as to what the patient was told, the patient's understanding of the disclosure, and the patient's consent.

DRUG TREATMENT AND INFORMED CONSENT

As with any treatment, when you prescribe medication you must be sure to get the patient's informed consent. This means the patient must be told the diagnosis, the benefits and risks of the drug therapy, what alternative forms of treatment are available, and the likely results of receiving or not receiving treatment (see Appendix R for a model form).

When treating patients with antipsychotic medications, you must be prepared to reveal the existence of the risk of serious side effects inherent in their use.

Since most litigation raising the issue of informed consent for treatment with an antipsychotic medication has involved tardive dyskinesia and related side effects, it is particularly important to disclose these risks whenever they exist. Patients should be advised to inform you whenever they experience any side effects or physical symptoms after beginning drug treatment. This may stop a minor side effect from becoming a serious one and will also allow you to reassess the choice of medication on the basis of the patient's reactions.

CONSENT TO TREATMENT OF MINORS

As a general rule, you should not treat a minor patient without the consent of the custodial parent or another adult specified in a custody decree. However, there are many statutory and judicial exceptions to this rule, and they vary greatly from state to state. The general exceptions are:

- Emergencies;
- Children who have been defined by the courts as emancipated minors;
- Mature minors – legally, minors who are capable of appreciating the nature, extent, and consequences of medical treatment; and
- Specific consent statutes – some states have enacted legislation that grants unemancipated minors of a certain age the right to consent to certain types of treatment.

You'll need to become familiar with the laws of the state where you practice, especially as they pertain to older minors.

23 CIVIL COMMITMENT

As with most issues where psychiatry and the law intersect, the statutes that regulate civil commitment vary substantially from state to state. As a practicing psychiatrist, you'll want to familiarize yourself with your jurisdiction's civil commitment law. Most states should have this information available online, and the Treatment Advocacy Center has information on all the states at its website at <http://www.treatmentadvocacycenter.org/LegalResources/statechart.htm>. There are general issues and potential problems common to most states, and we'll discuss those here.

COMMITMENT PROCEDURES AND TYPES

Emergency Commitment

Most states have provisions for a short-term emergency commitment until a formal determination can be made. The length of the emergency commitment may vary from just seventy-two hours in one state to as many as fifteen days in another. The grounds for emergency holds are generally that the patient is mentally ill and poses a threat to himself or others. Some states require that the threat be "substantial" and "imminent."

The procedures for initiating an emergency commitment also vary greatly. There are no general rules as to who may file the petition, where it should be filed, or how the patient is to be taken into custody. Again, you must consult your state statutes.

State laws also differ as to the requirement for a probable cause hearing and the timing of such a hearing. The purpose of a probable cause hearing is to determine whether there is substantial evidence that the patient meets the criteria for involuntary hospitalization. If she does, the patient can be hospitalized until a more formal determination takes place. In states that have probable cause hearings, there is generally no provision for short-term commitment. Once probable cause has been found, the emergency commitment continues until a formal commitment determination is made.

Short-Term Commitment

A number of states have provisions for short-term as well as emergency commitments. The length of time of these short-term commitments also varies greatly, from fourteen days in California to sixty in New York. A patient held in New York, however, can request a hearing at any time during those sixty days, and if the court fails to find him "in need of retention," he'll be released. Although

these short-term commitment statutes require greater procedural protection than those for emergency commitments, the initial responsibility for the decision is still vested in the hospital rather than the court. The standards for short-term commitments are not as rigorous as those for long-term retention.

Long-Term Commitment

In virtually every state, a patient cannot be involuntarily committed on a long-term or indefinite basis unless a court (or, occasionally, an administrative agency) determines that he meets the substantive criteria of the state's law. Although the procedures vary, in most states a patient can't be committed without a hearing. While some states still authorize indefinite long-term commitments, this is now generally out of favor, and is precluded in many states. Instead, a periodic review of the patient's continuing need for commitment is usually required. The frequency of these reviews varies.

Commitment of Minors

Because the laws vary so widely, if you work with children and adolescents you definitely need to familiarize yourself with your state's provisions for the "voluntary" hospitalization of minors. In some states the minor is given a degree of veto power over "voluntary" admissions, in others parents can only commit a child under a certain age voluntarily. In still other states, the minor and the parent must sign the application for commitment. If the child refuses, the parents must initiate involuntary commitment. Check your state law.

SUBSTANTIVE STANDARDS FOR LONG-TERM COMMITMENT

Commitment of the mentally ill has traditionally been justified as the exercise of two of the state's powers: 1.) *parens patriae*, which rests on the state's interest in caring for and protecting those who cannot care for themselves; and 2.) police power, or the state's power to protect its citizens from potential harm or danger from others. At present, civil commitment laws have much more to do with police power than *parens patriae*. The most common standards for civil commitment are:

- **Mental Illness:** All states currently consider mental illness to be a prerequisite of commitment. While some states delineate what specific psychiatric disorders qualify, others are less clear. Most require that the patient's illness "substantially impair" her functioning to the point where protection or care and treatment are required. Again, you need to familiarize yourself with the state statutes.

-
- **Dangerousness:** Dangerousness to oneself or others is currently the most common substantive ground for long-term commitment. Although states vary as to the exact definition, *danger to others* is generally defined as risk of substantial physical harm, or injury, to another person or persons. Some states require that this danger be imminent, or immediate, while others go so far as to demand that there be a judicial finding of an overt act that indicates the danger.

Dangerousness to oneself is accepted in all states as grounds for commitment, but while some may only require that you demonstrate an individual's extreme neglect of his basic needs, others demand evidence that the patient is "gravely disabled." It is relatively safe to say that proof that a patient is unable to provide for his own food, shelter, and clothing would adequately define "dangerousness to self" anywhere in the United States.

- **In Need of Treatment:** The commitment of a person because she is "in need of care and treatment" rather than because of a perceived danger to herself or others falls under the traditional *parens patriae* standard and is now much less common. A number of courts have even questioned whether the involuntary commitment of a nondangerous person is consistent with due process. However, some states still specifically permit involuntary commitment for this cause.
- **Additional Requirements:** Several states apply additional standards for involuntary commitment. Some states:
 1. Require that a patient be advised of, and given the opportunity for, voluntary commitment.
 2. Condition involuntary commitment on a determination that the patient is likely to benefit from the treatment he'll receive as an inpatient, or that his disorder is at least susceptible to treatment.
 3. Require that the person committed lack the capacity to make reasoned treatment decisions for herself.
 4. Require that the commitment in a hospital will be the "least restrictive alternative" or "least restraint" that will meet a patient's needs.

LIABILITY FOR WRONGFUL COMMITMENT

The most important safeguards for you in avoiding liability for a commitment decision are to conscientiously abide by the commitment procedures mandated by your state and to conduct adequate patient examinations. If you reasonably follow the required procedures in good faith, chances diminish that a court will find you liable for wrongful commitment.

A number of courts have held that a psychiatrist participating in commitment proceedings is immune from liability. They reason that the therapist is performing a quasi-judicial function and, like a judge, should be able to make the decision without fear of liability. In some jurisdictions, however, this immunity is granted only if the psychiatrist and patient do not have a doctor-patient relationship.

PRACTICAL POINTERS

- Be sure state commitment laws are known and correctly followed.
- Be familiar with the substantive criteria for commitment in your state, such as the legal definitions of *mentally ill* and *dangerousness*.
- Always document that the patient refused voluntary commitment before involuntary procedures were invoked.
- Be sure the decision to commit is made only after an adequate examination or on the basis of compelling clinical evidence.
- Be especially circumspect in considering requests to commit made by a third party.

24

MEDICAL RECORDS

Keeping proper medical records is vital to the success of your practice and essential if you should ever need to defend yourself against a malpractice suit. In fact, the courts will view a carefully annotated treatment record as your testimony, on your own behalf, that you practiced responsible medicine during the course of the patient's treatment. See Appendix CC for an in-depth discussion of documentation of psychotherapy.

KNOW YOUR STATE LAWS

Retain your records at least as long as you are required to by state law. Since the requirement varies from state to state, you'll have to find this out when you start your practice. It is also good to remember that there is generally no statute of limitations on how much time can pass before a former patient or his family can file a malpractice suit. If you've got a case that strikes you as problematic, it might be good to hold on to your documentation even after you've met the state requirement.

MAKE YOUR RECORD COMPLETE

Note: The Privacy Rule of Health Insurance Portability and Accountability Act (HIPAA) establishes a more stringent level of confidentiality for Psychotherapy Notes, which contain information other than that provided below, which is all considered part of the patient's medical record. Psychotherapy notes, which may deal with specifics of the patient's life revealed in therapy, should be kept on pages separate from the patient record, which the patient has the right to access. See Chapter 41A for more information on HIPAA and the definition of psychotherapy notes.

Although record-keeping procedures will vary in different practice settings, the following should be included in all psychiatric records:

1. Name, address, and telephone number(s) of patient (and designated others if the patient has granted appropriate authorization for you to communicate with others)
2. Any signed informed consents for treatment and authorizations for release of information to others, including managed care companies and third-party payers
3. All pertinent medical history
4. Your initial assessment and subsequent reassessments of the patient's needs
5. The dates of service, as well as length of time and service provided

-
6. Reports from psychological testing, physical examinations, laboratory data, etc.
 7. Prescriptions or medications, adjustments to dosage, complaints about side effects, etc.
 8. Progress notes or other documentation that reflects a patient's reaction to treatment or the need to vary treatment. Any consultations with colleagues about the patient
 9. What actions you took and why, and what actions you considered but rejected and why—especially with regard to serious situations such as suicide, homicide, or transference problems
 10. Copies of correspondence concerning the patient
 11. A discharge summary, if relevant, including the patient's status relative to goal achievement, prognosis, and future treatment considerations
 12. Documentation of the termination process

WHAT NOT TO INCLUDE

Just as it's important to include all the appropriate notations and documents in your patients' medical records, it's equally important to leave out the inappropriate ones. Information about the patient's personal life that you might want to make notes about to aid your memory as treatment continues would be considered "psychotherapy notes" under HIPAA, and, if needed, should be kept separately from the information in the medical record (see box above and Chapter 41A). It's best to avoid personal criticisms of the patient, and to avoid using the names of third parties—for example, the person with whom the patient is having an affair.

DOCUMENT EXCEPTIONAL CIRCUMSTANCES

Be sure to document any circumstances that strike you as out of the norm. For instance, if the patient balks at your treatment plan or if the spouse or parents of a suicidal patient refuse to become involved in the patient's treatment, you must be sure to note these issues and file a detailed account of how you handled them.

KEEP YOUR RECORDS IN A SAFE PLACE

Records should be kept in a secure place, accessible only to those in your office who have reason to need them and have been educated to comply with confidentiality rules.. If you keep your records on a computer, they must be password protected, and, as with paper files, only accessible to staff who are compliant with confidentiality rules. Make sure your staff observes very strict protocols in handling the files. Everyone in your office must understand the necessity of confidentiality concerning patients and their records.

ALTERING DOCUMENTS

In situations where you have a legitimate cause to alter a record—if a mistake was made and needs to be rectified, for example—make sure you carefully date the correction and note that you are correcting an error. Make your correction by drawing a single-line through the wrong information and be sure to date and initial the correction. Altering records to avoid looking bad in court after a case has been brought can be fatal to your case. As we noted earlier, no records should be destroyed before the time established by state law, and it's not a bad idea to keep them beyond that if you think a question may arise sometime in the future.

CONDUCTING A PATIENT SATISFACTION SURVEY

As the healthcare field approaches a threshold for cost savings, there is more of a focus on quality-based competition. Physicians and other providers are increasingly being held accountable via performance assessments, of which patient satisfaction surveys are a part. While many psychiatrists challenge the accuracy of these surveys since they often see acutely ill patients, a portion of whom may 1.) have considerable negative transference; 2.) be in treatment involuntarily; or 3.) be too ill to respond to such surveys; managed care and other healthcare organizations continue to use patient satisfaction surveys as part of their efforts to improve the quality of mental health services.

Large group practices with managed care contracts can benefit from high performance scores on satisfaction surveys. The results of the surveys can be used to market the practice to providers and patients, and to negotiate entry to new provider panels.

Administering your own patient satisfaction surveys (see Appendix S for a sample survey) can also help you attune your practice to the needs and opinions of your patients. The best results on self-administered satisfaction surveys can be obtained by following these recommendations:

1. Use a written, anonymous, one-page survey with graded responses that can be computerized and analyzed quantitatively.
2. Distribute the surveys randomly; for example, at the end of five visits to every third patient. The survey can be mailed to the patient's home with a friendly letter and a self-addressed, prepaid envelope. This would be especially appropriate for patients who are too busy to complete the survey in your office. However, be careful of compromising confidentiality when sending survey information to patients' homes. Also, do not send mail-back surveys with bills. This could confuse your patients' feelings about the practice with their feelings about financial payments. Some psychiatrists solicit feedback from patients on the telephone, but this could take the time away from your practice. If you are going to use more than one survey method, be sure that the different methods are used simultaneously to get a fair representation of your patients. You might also want to send surveys to referring physicians to find out what the patients they referred have to say about your practice.
3. You can include the following elements in your patient satisfaction survey to help your patients rate you, your practice, and your staff:
 - Physician's professional manner
 - Physician's knowledge
 - Physician's ability to explain and communicate

- Physician's understanding of the patient's problems and feelings
 - Perceived benefit from treatment
 - Staff courteousness, friendliness, helpfulness, and efficiency
 - Practice hours
 - Accuracy of billing and payment
 - Convenience of payment policy
 - Comfort and cleanliness of office
 - Adequacy of parking
 - Waiting time in the office for an appointment
 - Fees
 - Patient's age
 - Number of times the patient has referred others to the practice
 - Number of months or years the patient has been treated in this practice
 - Likelihood of patient referring others to this practice in the future
4. Have the survey returned to a location other than the office and have someone other than staff analyze the results to ensure objectivity.
 5. Develop an internal report that addresses both positive and negative comments. Focus on the complaints presented by more than one patient and develop a strategy to address them.
 6. Distribute the results of the survey to your patients along with concrete examples of how you plan to address the problems they identified. For example, "Several patients have indicated that they sometimes have difficulty getting through to the office, so we are installing additional telephone lines." By addressing negative responses in this manner you can build confidence in your professionalism and commitment to high-quality service.
 7. Get the most mileage from a positive report. You can send it to third-party payers, MCOs, primary care physicians, and even to your local media. This will lend credibility to your practice and is an excellent marketing tool.
 8. Allocate part of your marketing budget for patient satisfaction surveys and be sure to allocate resources for developing, copying, and distributing the survey, as well as for analyzing the survey's results.

26

DEFINING MANAGED CARE

THE MANAGED CARE ENVIRONMENT

In the traditional fee-for-service world of the past, the psychiatrist assessed a patient's need for psychiatric services, developed a treatment plan, and charged a fee for the services provided to the patient. Insurance companies reimbursed the cost of the treatment as long as the services provided were covered benefits under the patient's health insurance plan and the patient was an eligible beneficiary (i.e., covered under the plan). This world may still exist in some high-end insurance plans.

As healthcare costs rose in the 1980s, however, managed care organizations came into being as a way to control expenses while still providing necessary care. Nowadays the vast majority of people are insured under some kind of managed care plan, administered by a managed care organization (MCO). In the days of fee-for-service medical insurance, the only managed care around took the form of the staff-model health maintenance organization (HMO), but today managed care comes in a variety of forms and combinations of those forms.

Some psychiatric services provided under managed care are covered under mental health carve-outs, administered by separate managed behavioral health organizations (MBHOs). The MBHO may function under an entirely different set of procedures than the MCO that contracts with it has. This has become less prevalent in the past few years, and now many insurers have been moving away from these carve-outs and are administering their mental health benefits in house. This is sometimes referred to as *carving in* the mental health benefit.

It is important to understand that the economic concerns of the purchasers of health insurance, primarily employers, are usually the force that determines how managed care plans are structured. Plans are restricted to fit what employers are willing or able to pay for.

MANAGED CARE MODELS

There are several basic models for managed care, and there are many combinations and variations of these models in effect today. The basic forms of managed care are distinguished primarily by their restrictiveness—both for the patient and for the psychiatrist.

Preferred Provider Organizations

Preferred provider organizations (PPOs) use a restricted network of clinicians who have agreed to provide services at reduced rates, and may require preauthorization for care as well as other utilization management. The rate reductions generally take the form of a predetermined fee schedule or discounts on usual and customary fees. (The discounts average approximately 30 percent of the usual rate.) PPOs provide incentives for beneficiaries to use participating providers. When they see a member of the PPO they generally just have to pay a low co-pay; when they go to a physician outside the PPO, or *out of network*, they are only reimbursed for a percentage of the physician's *undiscounted* fee, and there is usually a deductible that must be reached before this reimbursement kicks in.

Health Maintenance Organizations

Health maintenance organizations (HMOs) are often described as “prepaid health plans.” Historically the most restrictive of managed care models (and also the earliest model), HMOs usually require a referral from a primary care physician for any specialty care and mandate that patients use only a specific network of clinicians. The most common types of HMOs are staff-model HMOs and IPAs (independent physician associations). Physicians in staff-model HMOs are on salary. IPAs are physician-controlled groups that provide services to HMO members. The physicians retain their separate practices, but function as a group for the purpose of providing care to the HMO members. IPA members are paid on a capitated basis. Typically, there is no benefit payment if a patient chooses a non-HMO psychiatrist, except in emergencies. Times are changing, though, and many HMOs are now beginning to offer point-of-service options.

Point-of-Service Plans

Point-of-service (POS) plans are a hybrid of the HMO and PPO models. This is currently becoming the most popular form of coverage. POS plans usually have the core characteristics of HMOs, including utilization management and preauthorization requirements; a restricted network of clinicians; a primary care gatekeeper; and fixed-dollar copayments. However, a POS plan also includes an “out-of-network” benefit that operates like a PPO. A POS plan allows a patient to choose a nonparticipating psychiatrist and provides a reduced level of benefits for such services. Because of the difference in benefit levels and coinsurance requirements, patients have a strong incentive to choose psychiatrists within the network.

Managed Indemnity or Managed Fee-for-Service Programs

The managed indemnity, or managed fee-for-service, program is the least restrictive managed care model, but it generally still requires preauthorization for some or all procedures and treatment settings (e.g., inpatient admission). If not combined with some other kind of managed care program that limits access to certain providers, patients are generally able to choose any psychiatrist as long as the treatment is preauthorized. The amount of services is restricted only by the limits stated in the benefit plan document.

Provider Sponsored Organizations (PSOs)

These provider groups, PSOs, are usually regional associations that include health systems as well as individual physicians and other healthcare providers and provide integrated care. They may be both the insurers and providers of health services, and often use case managers to facilitate care. PSOs often provide healthcare for government-sponsored programs such as Medicaid and Medicare.

These managed care models and all their variations and combinations may be used by commercial healthcare insurance companies and for government sponsored programs such as Medicare, Medicaid, and workers' compensation. They may also be used by disability carriers.

EMERGING MCO STRATEGIES

As managed care evolves, and with the recent move toward healthcare reform and integrated care, many of the plans are implementing, or considering implementing, different strategies. There are currently a number of proposed models of payment reform, some of which are being tested in pilot/demonstration projects being carried out by both commercial and private payers. These include:

- The development of disease management models to assist physicians in organizing their delivery of care to certain disease populations. These may include rating scales, protocols, follow-up plans, and telephonic case consultation.
- Pay for performance—This is still an emerging idea, but MCOs (following the example of Medicare) are studying how to obtain data to reward quality care.
- Blended payment system—this has 3 components: 1.) fee for service based on the Medicare fee system; 2.) a per patient management fee; and 3.) pay for performance.
- Accountable Care Organizations (ACOs) – A group of providers agree to take responsibility for the delivery of comprehensive care to a population of

patients and accept a negotiated global payment in return. This is a new idea, and is currently being tried by Medicare.

- Risk-adjusted comprehensive payment bonus – Under this concept, reimbursement is offered for comprehensive, individualized service, and coordination of care. This is done through a risk adjusted yearly payment per patient per month for all physician and team services. Bonuses are given for positive outcomes.
- Preferred, or select, panels, which may be selected based on performance measures or special expertise (e.g., experience in the treatment of eating disorders).
- Evidence-informed case rate – This model establishes payments for the treatment of specific chronic conditions based on the total cost of services that are needed to treat the conditions using evidence-based practice guidelines. Bonuses are paid for avoiding potential complications and a severity adjustment is included.
- Pay for the episode of care—This is similar to what's done for inpatient care with DRGs (diagnostic related groups). The physician contracts for a flat fee to care for an episode of care such as psychosis.

EVALUATING MCOs and MBHOs

Some mental health services are provided by managed behavioral health organizations (MBHOs) with whom MCOs contract for their members' mental health care. An MBHO is just an MCO that only deals with mental health care—that administers the mental health services that have been “carved out” of the MCOs complete healthcare policy that it sells to purchasers. As a psychiatrist you may be contracting with the MBHO carveout rather than with the MCO.

Clearly, not all managed care organizations are alike. Each establishes its own policies and procedures. Each develops a set of practice guidelines. Each has its own policies regarding appeals. Each has a separate contract with providers, and providers may find that the MCOs also have separate contracts with individual employers, which define patient benefits.

The following questions may help you to evaluate whether or not you wish to join a particular MCO or MBHO network:

1. Is the MCO or MBHO financially solvent? Financial problems within the could mean your bills won't be paid on time—if at all. Ask to see recent reports, budgets, and audited financial statements. Check to see if the company has at least a B+ rating with A.M. Best (www.ambest.com).

2. What is the administrative structure of the MCO or MBHO? Find out who the medical director is, or who is in charge of mental health benefits, and how he or she fits into the chain of command.
3. The MCO or MBHO should have written policies and procedures for grievances, appeals, utilization review, selection and credentialing criteria, claims filing, and payments. These are usually contained in the provider handbook. You should have a copy of this that you've read carefully before you sign any contract.
4. What is the MCO or MBHO's payment structure and what CPT codes does it cover? Be sure you get a copy of the fee schedule and which codes they will pay psychiatrists for. Some MCOs and MBHOs will not pay psychiatrists for evaluation and management codes, even though it is appropriate for psychiatrist to use these codes in noting the care they provided. [Begin here](#)
5. What practice guidelines does the MCO or MBHO use? Any practice guidelines should be compatible with the guidelines developed by the APA (see Chapter 39).
6. Which employers in your locale contract with the MBHO and how many potential patients do they represent?
7. How does the MBHO market itself?
8. With which hospitals does the MBHO contract? Are you required to have admitting privileges at them?
9. What is the annual disenrollment rate of providers? Can the MBHO terminate you without a statement of cause?
10. Is the MBHO accredited by external organizations, such as the National Committee for Quality Assurance (NCQA)?
11. Is the MBHO insured, and what are the limits of the insurance?

Requesting answers to these questions not only allows you to make an informed decision as to whether to join the MBHO's network, it also allows you to establish a relationship with the MBHO's staff to see how you would feel about working with them on a regular basis.

MCO ACCREDITATION

The National Committee on Quality Assurance (NCQA) began accrediting managed care organizations in 1991 and began accrediting managed behavioral healthcare organizations in 1997. NCQA currently reviews and scores plans against more than sixty different standards.

As of June 21, 2010, thirty-two MBHOs had received full NCQA accreditation, good for three years; and several others have reviews scheduled or in progress.

If you visit the NCQA website (<http://hprc.ncqa.org/mbho/>) you can find the most current information about which organizations have been accredited and which are in the process.

NCQA also developed a set of performance measures that can be used to compare health plans, the Health Plan Employer Data and Information Set (HEDIS). To learn more about NCQA in general, visit their website, www.ncqa.org.

APA PRINCIPLES FOR MBHOs

In September 1997, the APA approved a set of “General Principles for the Operation of Managed Mental Health and Substance Abuse Organizations,” which is included in Appendix U.

GETTING ON MANAGED CARE PANELS^{*}

Since most Americans now receive their mental health services through managed care systems, you'll probably want to consider providing care in a way that makes your practice as appealing as possible to MCOs (managed care organizations). The principle of parsimony, that each patient should receive the least expensive treatment at the lowest level of care that will allow a return to health and function, is operational in all managed care settings. This does not mean that patients will receive inadequate care.

There are six core skill sets, with individual skills within each set, that are essential for a modern behavioral practice that will meet the needs of your patients and be compatible with managed care.

I CLINICAL CARE SKILLS

- **Provide problem-oriented, goal-focussed treatment.** Target symptoms need to be identified and a treatment focus developed, and then the two must be melded into treatment goals. The episode of care is complete when the treatment goals have been met.
- **Develop realistic treatment plans.** These plans should aim to return the patient to adequate health and functioning rather than be concerned with underlying disorders.
- **Use group and other treatment modalities.** Groups can be valuable for patients dealing with specific issues such as bereavement, parenting, or anxiety; time-limited, educational groups can help patients build the skills they need; and open-ended groups can help patients with chronic, recurrent, and character disorders.
- **Offer couples and family systems interventions.** These interventions can maximize change. If more than one person is involved with a problem, all of them should be treated.
- **Organize patient care around practice guidelines and preferred practices.** Evidence-based practice guidelines can serve as reliable roadmaps for how patient care should proceed (see Chapter 39).

^{*} This chapter is based on an article by Robert K. Schreter, M.D. that appeared in the May 1997 issue of *Psychiatric Services*. The principles espoused in it still hold true, 13 years later.

-
- **Make appropriate use of inpatient services.** Hospitalization should be used only for stabilization and patient safety. Patients are discharged into lower levels of care or back into the community as soon as possible.

II CLINICAL MANAGEMENT SKILLS

- **Utilize services at the appropriate level of intensity at the appropriate level of care.** There is now a continuum of care that allows patients be placed in the least intensive situation appropriate to their level of illness.
- **Coordinate care with primary and other healthcare practitioners.** Close coordination will amplify the “behavioral offset,” the decrease in the cost of medical-surgical care for patients who’ve been successfully treated for mental health and substance abuse problems.
- **Facilitate the case management process.** Case managers contribute to the treatment process by linking providers, integrating treatment plans, and linking patients to community resources.
- **Deal realistically with personality disorders in a managed care context.** Patients with personality disorders must be identified and treatment approaches developed to meet their needs. There must be easy access for entry and re-entry to keep crises from snowballing. Treatment plans should include alternative interventions when appropriate (i.e., community-based self-help programs, groups, etc).
- **Refer to community-based service alternatives when appropriate.**
- **Organize clinical and management services with the goal of continuous quality improvement.** Institute quality assurance programs that monitor identifying indicators to be sure the highest quality of care is being offered.

III CLINICAL KNOWLEDGE

- **Understand the impact of time limits on care.** Mental health care is coming to resemble primary care. Treatment concludes when the presenting symptoms resolve, so although each episode of care may be short, the treatment relationship may continue over a long period of time.
- **Know and use preventive strategies.** If patients can be treated at the early stages of disorders, a less intense level of care is needed.
- **Master the principles of psychopharmacology appropriate to your discipline.** Psychiatrists should be able to integrate their medication management into treatments provided by others.

-
- **Organize treatment interventions around research into efficacy and outcomes.** Clinicians must base their treatment on scientifically valid evidence.

IV SKILLS WITH SPECIAL POPULATIONS

- **Differentiate substance abuse from mental health problems before initiating treatment.** Diagnosis of a substance use disorder demands a referral for treatment of that disorder, alone or as part of an integrated treatment that addresses the substance abuse along with concurrent psychiatric disorders.
- **Provide care for traditionally underserved populations including children, adolescents, the elderly, and the disabled.**
- **Develop programs for special populations and patients with special needs.** Programs should address the specific needs of the population to be served. Groups with a high incidence of AIDS or high levels of physical or substance abuse require different clinical programs.
- **Work effectively with employee assistance programs (EAPs).** A great deal of behavioral healthcare is currently being delivered through these programs.
- **Understand disability, worker's compensation, and other workplace issues.** Clinicians should anticipate an integration of employee's healthcare and disability insurance.

V ADMINISTRATIVE COMPETENCE

- **Document care effectively, being responsive to the needs of MCOs.** Every provider group and MCO should have a prototype medical record to serve as a template for its providers. This should be viewed as an essential tool for treatment, risk management, and quality assurance. It also means you will be able to document more efficiently.
- **Conform to administrative guidelines and procedures.** Although administrative and billing procedures may seem like annoying and unnecessary burdens, failure to comply with them results in delays, denials of claims, and duplication of administrative services. Noncompliance not only puts your patients at risk, it is one of the leading causes of decertification from provider networks.

-
- **Understand the meaning and implications of the benefit plan.** Psychiatrists need to understand each patient's benefit plan and organize treatment within its offerings and limitations.
 - **Understand the meaning and implications of medical necessity.** Psychiatrists need to organize their treatment plans around the published criteria that define medical necessity.

VI ETHICAL CARE MANAGEMENT

- **Manage care, not dollars.** Care management must focus on providing interventions that offer patients the greatest return for the resources invested. Psychiatrists must become familiar with the continuum of care available to their patients.
- **In any conflict of interest, the patient comes first.**
- **Always advocate in the patient's best interest.** This is the cornerstone of ethical care management, but it must not be viewed as being synonymous with declaring war on managed care practices. Patient advocacy requires flexibility and creative treatment planning as well as the willingness to initiate formal appeals when all else fails.
- **Don't do anything you'd be embarrassed to have to explain publicly.** And conversely, don't fail to do anything if it would be embarrassing to explain why you didn't do it.

REVIEWING AND NEGOTIATING CONTRACTS

The terms of your contract with an insurer, or managed care organization (MCO), can affect many aspects of a psychiatric practice, from how much you are paid to which services you are permitted to provide and how you are expected to provide them. It's vital that you take the time to thoroughly read any contract you sign onto. You cannot just take the word of a colleague who says he signed a contract with the same company, the terms were good, and his lawyer said it was fine.

Each contract is different – even from the same company. For example, an insurance company's contract with a specific employer may change the insurer's basic contract, or a contract with one physician may be written at a different time under different circumstances than the contract a second physician receives. It is also a mistake to assume that a renewal contract is the same as the one received "last year." Often it is not.

As insurers and psychiatrists have become more sophisticated about working in a managed care environment, contracts have become more sophisticated and more complex as well. Companies may include important contract features in appendixes, addendums, or in "attachments" such as provider manuals, which, if you're not careful, you may be unaware of until too late. You must be certain to obtain all documents referenced in a contract and to review them before entering into any contractual agreement. If there is any element you do not understand in the contract, do not sign until it is explained to you and you are clear that element is something you can comply with.

Although in the 1990s insurers, or managed care organizations (MCOs), sometimes used risk-based contracts, which transferred the risk of expensive patient care to the physician through capitation or case rates, over the years this practice has by and large been abandoned.

Now most contracts stipulate the fees that will be paid to in-network physicians for specific procedure (CPT) codes and which physicians will be paid for which CPT codes. For instance, some insurers will only pay psychiatrists for the psychiatry CPT codes (the 908xx series) even though it is just as appropriate for psychiatrists to use the evaluation and management (E/M) codes (the 992xx series) when they do evaluations and medical management of patients.

Contracts may also stipulate the physician's status with the insurer in various settings. Some contracts provide that an in-network psychiatrist is in-network at *every* place of service, others may just be for a specific setting. This is an issue

that has proved problematic for some psychiatrists who practice in clinics where many forms of insurance are accepted, but who choose to have simultaneous private practices where they do not accept insurance. If the clinic's contract with an insurer says it covers the psychiatrist in all settings, then if the psychiatrist sees a patient who has that insurance in her private practice, she will be an in-network provider there as well, and will only be paid the in-network fees negotiated under the clinic contract.

Even if the clinic's contract with the insurer does not state that all places of service are covered, a psychiatrist wishing to be considered out-of-network in another setting will have to notify the insurer in writing of his desire to have a different status in that setting.

Because many insurance companies are having trouble maintaining enough psychiatrists in their networks to meet their enrollees' needs, they may make it difficult for psychiatrists to sever their relationship. The APA's Managed Care Help Line has received calls from members who were unable to get out of their contracts for months and months because the insurer maintained they hadn't received faxes or e-mails that the doctors had used to convey their change in status. We recommend that any notifications about a change in status with an insurer be done in writing and be sent by registered mail, return receipt requested. This way you will have a record of the company's having received your request.

CONTRACT CLAUSES/TERMS YOU NEED TO KNOW

The following are some of the more important clauses that may be found in insurer's contracts.

Fee Schedule

Be sure to find out what you're going to be paid and which codes you're allowed to bill for before you sign any contract. This is most likely incorporated as an appendix or addendum to the contract.

"Most Favored Nation," or Comparable Provider Rate Clauses

In some situations you may encounter a contract with a "most favored nation" clause or comparable provider rate clause, which requires the physician to notify the MCO if you agree to accept a lower pay rate from another insurer. The net effect of this kind of clause is to guarantee the insurance company the lowest price you are willing to accept from *any* private payer. Whenever possible, this kind of clause should be negotiated out of the contract.

Utilization Management Requirements

You should know what prior authorization/precertification protocols you will have to comply with as well as what criteria the insurer uses to determine medical necessity. You also need to understand what retrospective review/audit requirements will apply. This information is also most likely to be found in an appendix or addendum to the actual contract.

Medical Records Disclosure Obligations

Be sure you understand what the requirements are under the contract for medical records disclosure and what the confidentiality provisions are. You don't want to be contractually bound to provide medical information that is potentially in conflict with other legal obligations.

Purchased Network Provision

When a network is permitted to sell or transfer its network to another so that you might find yourself in-network for a plan you never even heard of, and they may even be offering you a lower rate than you negotiated with the original network you contracted with. Be aware of the danger of signing a contract with this kind of clause.

All Products Provisions

These provisions mandate that the psychiatrist participate in all products that the MCO offers (current and future) on whatever terms the plan dictates. You don't want to sign on to anything that's not specifically defined in the contract. Several states have legislation limiting the use of these provisions.

Evergreen Renewals

An evergreen clause allows the insurer to automatically renew your contract without giving you an opportunity to renegotiate terms. Unless the contract provides for amendment of its terms by either party, the terms negotiated for the initial term of the contract will remain in effect throughout each renewal. If possible, you should try to negotiate inclusion-of-amendment provisions in the contract.

Gag Clauses/No Disparagement Clauses

Some contracts contain provisions that prohibit a psychiatrist from making any negative comments about the company or from advising a patient that another plan might be better. Other banned topics may include non-covered treatment options, financial incentives, or adverse plan decisions— any of which may put you in an ethically dicey situation.

Gag clauses may also be a hindrance later, especially if you need to appeal a reimbursement denial. Even apart from the appeals process, gag clauses

should be viewed with extreme caution, since they can greatly affect your ability to advocate for your patient.

Note that many states now have laws that prohibit these clauses.

Incorporation by Reference

These clauses state that documents, such as the provider manual, practice guidelines, and level-of-care criteria, are automatically incorporated in the contractual agreement by reference. Make sure that you have thoroughly reviewed all materials mentioned in the contract.

Indemnification and “Hold-Harmless” Clauses

Some contracts require that the psychiatrist hold the insurer harmless and indemnify the plan for any claims made against it. You should attempt to have these types of clauses deleted. If this cannot be done, you might ask the insurer to substitute language such as, “[Name of insurer] shall be solely responsible for its own acts and decisions concerning this contract, and the psychiatrist shall be solely responsible for his or her own acts and decisions concerning this contract.” Your malpractice carrier should be able to advise you about this.

Psychiatrists should also be aware that there is another type of hold-harmless language, which may be required in certain contracts by federal or state law, that does not implicate their malpractice insurance coverage. An example of this is the following:

Provider shall hold harmless and indemnify Members against non-payment by any Payer for any reason, including but not limited to, insolvency or breach of this Agreement. This provision shall not prohibit Provider from collecting any applicable co-insurance or deductibles in accordance with Member’s contract with Payer.

No-Cause Termination Provisions

If your contract contains termination-without-cause provisions, make sure that the clause is mutual, allowing both you and the insurance company the option to terminate the contract at any time with prior notice (usually sixty to ninety days). You should ask about any appeals processes that may exist, so you are familiar with the process if the company terminates you without cause.

Severability Clauses

Contrary to popular opinion, one illegal or unenforceable section does not necessarily nullify an entire contract. It is increasingly common to see “severability” clauses (which say that if one clause in the contract is unenforceable, the rest of the contract remains binding) combined with “change of law” provisions that allow the parties to renegotiate or restructure certain

aspects of a contract affected by changes in laws, regulations, or court interpretations.

ADDITIONAL TIPS

- Review the contract for any billing and balance billing provisions that restrict your ability to bill patients.
- Review credentialing requirements. Personal information, such as medical history, may be unwarranted if it does not currently affect your ability to practice medicine.
- Study the confidentiality terms in the contract; federal and state laws supersede contractual requirements.
- Study utilization review requirements to learn procedures for prior authorization, concurrent review, retrospective review, use of formulary restrictions, access to physician reviewers, and appeal mechanisms. These topics are frequently covered in the provider manual, which you should review before the execution of a contract.
- Be aware that contracts give insurers have the right to conduct quality assurance audits. This is standard, and if you do appropriate documentation, will not create any problems for you.
- Pay attention to how the insurer will authorize services in an emergency. Most companies have a utilization management process in place that can authorize emergency services at any time, but the flexibility of the authorization process varies. Ask detailed questions about the process before signing a contract.
- Know when your current contract expires and consider renegotiating if you feel you are not being adequately compensated. You have nothing to lose.

ASK QUESTIONS AND NEGOTIATE

Contract negotiation may be possible, especially these days when there is such a shortage of psychiatrists on insurance panels. If you cannot negotiate, be sure to ask questions on the above and any other issues that arise from reviewing the contract to make sure you are not entering into a contract that you can't live with.

ENSURE THAT ALL REPRESENTATIONS ARE IN WRITING

You should obtain any changes or clarifications to the terms of the contract on the body of the contract itself. Any additional clarifications made by

representatives of the insurance company that do not agree with the contract should be incorporated in an amendment that conforms to the contractual requirements.

IN CONCLUSION

It is very important that psychiatrists review *every* aspect of a contract before signing the document. This includes all attachments. Always check with your malpractice carrier to make sure nothing in the contract conflicts with their policy. And always check with your lawyer. Each psychiatrist's situation is unique, and no one "model" contract can protect all of them equally. Don't sign any contract until you're sure you thoroughly understand what you're agreeing to.

The AMA has created a detailed model managed care contract, with annotations that explain the reasons for including its various components. In an ideal world, this is the contract you'd be presented with when you join an insurance network. Reviewing this document will give you a very clear idea of what the various parts of a contract mean and what you should look out for. The model contract is available on the AMA website at http://www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf.

2

NEGOTIATING AN EMPLOYMENT CONTRACT

After you've gone through all the steps described in Chapter 1 and have made a decision about where you want to work and who you want to work with, you'll need to negotiate a contract for your employment. Even though we recommend that you have a lawyer with a background in healthcare law review any contract before you sign it, it is best if you can do your own negotiating. If your lawyer takes too active a role in your contract negotiations, this can sometimes undermine the trust you want to build with your future employers and/or colleagues.

CONTRACT NEGOTIATIONS

The amount of room for negotiation will vary from employer to employer. Generally speaking, the larger the organization, the more structured the compensation package and the less flexible they are in their negotiations. The same is usually true for nonprofit or publicly funded organizations. Decide what you are willing to accept and what you are willing to live without and do not share this information with anyone. Be prepared to turn down offers that don't meet your needs (having more than one offer helps). However, if you find a situation you feel you'd really like to work in, you should be willing to give a little. Perhaps you're not being offered one thing you thought you really needed, but you're being offered something else you hadn't even taken into consideration. You will be better prepared to evaluate an offer if you've done your homework. Information you've gathered on current trends (including average earnings), the local economy, and the cost of living will make this process much easier (see Chapter 1 for sources of this information). Remember, no one expects you to accept a contract exactly as it's written. There's always room for some negotiation.

BEFORE SIGNING A CONTRACT

The following issues should be dealt with in any contract you sign:

- **Compensation** — Don't be surprised if the first-year compensation you're offered is lower than the median you learned in your research. If the practice has some kind of bonus policy, it's probably calculated on a productivity basis. If the job does have a productivity-based bonus package your contract should have provisions allowing you access to the information that's used to make the bonus calculations.
- **Noncompete Clauses** — It is very likely that your contract will contain one of these clauses. You'll want to examine how long it lasts and how wide the

area is that it refers to. A noncompete clause that lasts for a year and extends between five and ten miles should be considered reasonable. However, the concept of what's reasonable depends on many factors. If you are being recruited into an area that currently has no psychiatrists, it may be reasonable for your employer to want you to stay out of their market area if you leave their employ--even if that area extends for fifty miles. This part of your contract may take a lot of negotiating.

- **Termination Provisions** — You'll want to pay careful attention to how and when the employment relationship can be terminated. These provisions can include just about anything. Clearly, if you lose your medical license you can expect your contract to be terminated, but a contract might also state that it can be terminated if you fail to obtain board certification or are denied staff privileges at a particular hospital. If the contract states that you can be terminated "for cause," try to get the employer to specify the events that would constitute "cause." You don't want to sign a contract that allows for termination without cause unless you have the right to terminate without cause as well. Each party should be required to give at least ninety days notice if such a clause is included in the contract.
- **Equity Ownership** — If there's any possibility of a practice buy-in, or equity ownership, this should be addressed in the contract in some way. You should be given an idea of when you might be eligible for consideration to become an owner (the average is usually three years) and some idea as to the amount of the buy-in price and how it is to be paid. You can't expect much of a commitment in this area, since the practice barely knows you at this point and it's unclear how things will work out. The best you can hope for is to have some parameters set down on how long it will take and how much it will cost.
- **Other Provisions** — The employer typically pays for your malpractice insurance. However this works, it should be specified in your contract. The contract should also define the fringe benefits you're entitled to. If it's not included, you might want to negotiate an allowance for continuing medical education (CME) and some time off to accomplish it. You should also try to get any issues like how often you are expected to be "on call" defined in the contract.

HAVE A LAWYER REVIEW THE CONTRACT

A contract is a legal document. As stated in the first paragraph, we recommend that you have a lawyer with experience in healthcare issues review any contract and explain to you exactly what each paragraph means before you sign it. There

may be some issues lurking in the text that you are not aware of, and that could cause you trouble down the line.

The APA Legal Consultation Plan provides contract reviews for a reasonable fee: call 888-357-7924 or 703-907-7300 for more information. Or contact your APA District Branch or the local branch of the AMA or American Bar Association (ABA) for referrals in your area.

30

GETTING PAID

A common complaint from psychiatrists is that managed care companies (MCOs) are slow to pay their claims or don't pay them at all. The following suggestions will increase the likelihood of having your claims paid quickly and correctly. They will help you avoid the common mistakes that cause claims to be denied, delayed due to rerouting, or even misdirected and lost.

AUTHORIZATION NUMBERS

Since some contracts leave the ultimate responsibility for preauthorizations with the physician rather than with the patient or the MCO, and since **it is always the physician's responsibility to verify that the preauthorization process has been completed**, you might just want to do the authorizations yourself for all your patients. This way you'll know you are getting the correct information, and it is more likely you'll be reimbursed properly, because, should you treat a patient who has failed to register care, you will not be able to collect payment from the patient's insurance carrier (or the carrier might pay at a very low "noncompliance" rate). If you are an in-network provider, you will have to write off the expense, and the patient will be held harmless.

If, for whatever reason, you feel it is not possible for your office to do preauthorizations for your patients, then just be sure to always ask your patient for an authorization number before you make an appointment. The patient may not have one when she first calls, but you can request that she call back with one. Usually, if a patient can supply the physician's name when she calls the MCO to register care, the MCO will assign an authorization number. Frequently, however, the patient calls the MCO for a referral, in which case the names of several physicians may be given, and authorization will not be assigned until the patient informs the MCO of her final selection. It is not uncommon for denial of payment to be attributed to "No Preauthorization" even after the patient has told the practitioner that the treatment was "preauthorized." This occurs because although the MCO gave the patient the referral, she failed to report back to them with the name of the doctor she selected and so did not get an authorization number.

INTAKE INFORMATION

Poor intake information, such as incomplete or incorrect insurance information, probably accounts for more lost revenue than all other causes combined. When

a payer receives a claim without sufficient carrier, plan, or employer information, it is likely to be put aside in a “look-up” pile.

These claims are not considered priority items; “clean” claims are always processed first. Incomplete or incorrect claims will be researched, not by a processor, but by a clerical employee who may, for example, have difficulty connecting the patient to the insured party. These searches are frequently fruitless, and, when that is the case, the claim is typically returned to the physician. When the patient can be correctly identified, the claim is returned to the processing cycle. This additional processing can add days, or even weeks, to the turnaround time.

The importance of thorough record keeping--starting with making and filing a copy of the patient's insurance card on the first visit and any time there is a change in insurance--cannot be overstated. Key questions to ask on the first visit are:

- Is the patient the insured or a dependent?
- Is there a secondary carrier?
- Who is the secondary carrier? (If there is a secondary carrier, call the carrier to confirm primary versus secondary coverage because there is substantial variance in companies' rules.)
- Whose name is the secondary insurance in? If it's different than the primary policy, be sure to get the insured's name, birth date, social security number, and the name of the insured's employer.
- Has the care been preauthorized by the secondary carrier? Is it necessary to authorize care through the secondary carrier? Know your plan, and if you do need authorization, be sure to get the name and phone number of the person who grants the authorization.

Get current correct addresses for the insured and the patient, birthdates, and clarification of anything on the insurance card that is unclear. All the intake information is necessary to create a clean, complete claim.

It probably makes sense to ask if there have been any changes in the patient's insurance status at each appointment.

ELIGIBILITY AND BENEFITS

Collecting the patient's coinsurance at the time of service can save a lot of trouble later on. Always call the number on your patient's insurance card to verify eligibility and benefits. In addition to confirming copay and/or coinsurance information, ask for calendar-year maximums, lifetime maximums, plan exclusions, deductibles, out-of-pocket maximum, and timely filing limits. If your

patient has a tiered benefit (e.g., visits 1 through 5 at \$10 copay and visits 6 through 20 at \$25 copay), determine how much of the patient's benefit has been used so far. Remember that the patient's first visit to your office may not be his first visit of the year. It is possible that the MCO authorizes care based solely on medical necessity, irrespective of the patient's eligibility and benefits. **An authorization is not a guarantee of coverage.**

It is important to remember that most MCO/payer contracts state that when a member becomes ineligible, the payer ceases to be responsible financially or otherwise (even if they told you on the phone that they still insured the patient). What this means is that even though you verify a patient's benefits, the MCO can come back to you in a year with the information that, in fact, that person was ineligible on the date you verified and the insurer wants you to pay them back. Because of this, you always want to make it clear to your patient from the outset that he or his guarantor is responsible for payment when coverage stops.

CERTIFIED CARE

Claims are often denied because the services charged do not precisely match the services that were authorized. Automated claim processing systems, in widespread use today, have decreased the claim turnaround time, but at the cost of a human being able to make a decision based on good judgment. A change in the level of care your patient requires or in the frequency of visits can often result in denied charges. This is why it is very important to be in communication with the MCO. **Always call the MCO before changing the type of service provided.**

In some cases, a phone call to the MCO before the submission of the claim is all that is needed. However, some MCOs may require you to submit an updated treatment plan. Familiarize yourself with the MCO's requirements and know your contract.

SUBMIT A "CLEAN" CLAIM

Using the standard CMS 1500 form, a sample of which can be downloaded off the Centers for Medicare and Medicaid (CMS) website (<http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf>), will go a long way toward preventing missed charges or misread claims. The actual forms can be ordered online from a variety of sources, including online from the Government Printing Office at <http://bookstore.gpo.gov>. Computer programs are also available to print these automatically from your billing office. If you do not have such a program, you can increase office efficiency by entering all the intake information in the "Patient" and "Insured" information sections on an original form, which can be permanently stored in the patient's file. Use this form to make

copies, as needed, so that the additional information relevant to a visit can be entered each time a new claim is submitted. Always make sure the information about the patient, the insured, and the plan is complete and correct on this form because, as we noted above, unidentified claims can take months to process or may just disappear. The physician information must still be completed for each claim submitted, or your superbill can be stapled to the copy of the CMS form. Adherence to the following guidelines will ensure that your claim is processed with maximum efficiency:

- List only one charge on a line; date-spanned or combined charges are frequently missed.
- Clearly mark corrected claims as such; automated processing programs may interpret a claim with the same date of service as a duplicate charge.
- Explain codes that may have more than one meaning and indicate length of the visit (e.g., CPT 90841 - 60 minutes, 75 minutes, etc.).
- Supply the name and address of the facility where the services were rendered in addition to your billing address.

FOLLOW UP

The turn-around time for claims payment varies greatly among plans. If you have been waiting longer than usual for payment, call the MCO to inquire about the status of the claim. Be sure to have all pertinent information available when you call.

Many states have statutes that allow charging interests for late payments by an insurer. Find out about your state laws and charge any interest you are due.

IF YOU DON'T GET PAID

If you notice a pattern of slow payment or nonpayment, you might consider taking these steps:

Develop a Paper Trail

Try to find someone in the company who can get claims paid. If the person you first make contact with can't help you, you might want to write the medical director's office to report your problem and request immediate resolution. If you fail to get the help you need, write the chief executive officer and register an official complaint. Send a copy of your correspondence to any or all on the following list. But first learn who the key players are in your state and whose support you can count on.

- **State Insurance Commissioner** — Some commissioners are actively involved in taking complaints about fraudulent insurance practices from both physicians and consumers; others may take complaints only from consumers. If the commissioner's office can't help you, you can contact the state's department of health or department of labor.
- **Attorney General** — If your attorney general is especially active on healthcare issues, write him or her directly.
- **APA District Branch** — Your District Branch (DB) can be an important source of information on MCO activity in your area, and the legislative representative will be able to tell you the status of recent legislation.
- **Consumer Advocacy Groups** — Patients can register complaints with local chapters of Mental Health America (call (800) 969-6642 for local phone numbers) and NAMI (call NAMI's Helpline at (800) 950-NAMI for local phone numbers of chapters and affiliates).
- **The Media** — Many local television stations in large cities have a consumer advocacy segment, and the media have been particularly interested in healthcare issues.
- **Congressional Representatives** — A sympathetic member of Congress can be very effective in negotiating on your behalf.

If you find that you're still having trouble getting paid, call the APA's Managed Care Help Line, 800-343-4671, for assistance.

Stay Informed.

Information *is* power. The APA's "Member2Member" listserv is an excellent way to find out how your colleagues have handled these problems. If you wish to join, send an e-mail to Webmaster@psych.org with the following information: name, member ID number, city, state.

Inform Your Patient

Keep your patient or a responsible family member informed. Your patient should contact her employer's Human Resources Department. The MCOs are under contract to employers to deliver medical services, and employers review these contracts periodically. If enough employees are dissatisfied, the employers may select another plan or advise the MCO to "fix" the problem.

Go to Small Claims Court

This is a last resort, but APA members have done this and won.

YOUR MCO CONTRACT/STATE LAWS

- Review your contract. What, if anything, does it say about the MCO's obligations to pay and within what length of time?
- Know your state laws. What do they have to say about prompt payment and the insurers' obligations? How do they define a late claim?

In general, develop effective collection procedures. Some managed care plans routinely check to see if practices ask for copays at the time of service, and if they do not, the MCOs drop them from their rosters. Bill and follow-up regularly on outstanding claims. Do not let accounts age without knowing their status with the MCO. Banks consider outstanding debts "bad" and uncollectable after three months. Be aware that your contract may set time limits on billing.

30

GETTING PAID

A common complaint from psychiatrists is that managed care companies (MCOs) are slow to pay their claims or don't pay them at all. The following suggestions will increase the likelihood of having your claims paid quickly and correctly. They will help you avoid the common mistakes that cause claims to be denied, delayed due to rerouting, or even misdirected and lost.

AUTHORIZATION NUMBERS

Since some contracts leave the ultimate responsibility for preauthorizations with the physician rather than with the patient or the MCO, and since **it is always the physician's responsibility to verify that the preauthorization process has been completed**, you might just want to do the authorizations yourself for all your patients. This way you'll know you are getting the correct information, and it is more likely you'll be reimbursed properly, because, should you treat a patient who has failed to register care, you will not be able to collect payment from the patient's insurance carrier (or the carrier might pay at a very low "noncompliance" rate). If you are an in-network provider, you will have to write off the expense, and the patient will be held harmless.

If, for whatever reason, you feel it is not possible for your office to do preauthorizations for your patients, then just be sure to always ask your patient for an authorization number before you make an appointment. The patient may not have one when she first calls, but you can request that she call back with one. Usually, if a patient can supply the physician's name when she calls the MCO to register care, the MCO will assign an authorization number. Frequently, however, the patient calls the MCO for a referral, in which case the names of several physicians may be given, and authorization will not be assigned until the patient informs the MCO of her final selection. It is not uncommon for denial of payment to be attributed to "No Preauthorization" even after the patient has told the practitioner that the treatment was "preauthorized." This occurs because although the MCO gave the patient the referral, she failed to report back to them with the name of the doctor she selected and so did not get an authorization number.

INTAKE INFORMATION

Poor intake information, such as incomplete or incorrect insurance information, probably accounts for more lost revenue than all other causes combined. When

a payer receives a claim without sufficient carrier, plan, or employer information, it is likely to be put aside in a “look-up” pile.

These claims are not considered priority items; “clean” claims are always processed first. Incomplete or incorrect claims will be researched, not by a processor, but by a clerical employee who may, for example, have difficulty connecting the patient to the insured party. These searches are frequently fruitless, and, when that is the case, the claim is typically returned to the physician. When the patient can be correctly identified, the claim is returned to the processing cycle. This additional processing can add days, or even weeks, to the turnaround time.

The importance of thorough record keeping--starting with making and filing a copy of the patient's insurance card on the first visit and any time there is a change in insurance--cannot be overstated. Key questions to ask on the first visit are:

- Is the patient the insured or a dependent?
- Is there a secondary carrier?
- Who is the secondary carrier? (If there is a secondary carrier, call the carrier to confirm primary versus secondary coverage because there is substantial variance in companies' rules.)
- Whose name is the secondary insurance in? If it's different than the primary policy, be sure to get the insured's name, birth date, social security number, and the name of the insured's employer.
- Has the care been preauthorized by the secondary carrier? Is it necessary to authorize care through the secondary carrier? Know your plan, and if you do need authorization, be sure to get the name and phone number of the person who grants the authorization.

Get current correct addresses for the insured and the patient, birthdates, and clarification of anything on the insurance card that is unclear. All the intake information is necessary to create a clean, complete claim.

It probably makes sense to ask if there have been any changes in the patient's insurance status at each appointment.

ELIGIBILITY AND BENEFITS

Collecting the patient's coinsurance at the time of service can save a lot of trouble later on. Always call the number on your patient's insurance card to verify eligibility and benefits. In addition to confirming copay and/or coinsurance information, ask for calendar-year maximums, lifetime maximums, plan exclusions, deductibles, out-of-pocket maximum, and timely filing limits. If your

patient has a tiered benefit (e.g., visits 1 through 5 at \$10 copay and visits 6 through 20 at \$25 copay), determine how much of the patient's benefit has been used so far. Remember that the patient's first visit to your office may not be his first visit of the year. It is possible that the MCO authorizes care based solely on medical necessity, irrespective of the patient's eligibility and benefits. **An authorization is not a guarantee of coverage.**

It is important to remember that most MCO/payer contracts state that when a member becomes ineligible, the payer ceases to be responsible financially or otherwise (even if they told you on the phone that they still insured the patient). What this means is that even though you verify a patient's benefits, the MCO can come back to you in a year with the information that, in fact, that person was ineligible on the date you verified and the insurer wants you to pay them back. Because of this, you always want to make it clear to your patient from the outset that he or his guarantor is responsible for payment when coverage stops.

CERTIFIED CARE

Claims are often denied because the services charged do not precisely match the services that were authorized. Automated claim processing systems, in widespread use today, have decreased the claim turnaround time, but at the cost of a human being able to make a decision based on good judgment. A change in the level of care your patient requires or in the frequency of visits can often result in denied charges. This is why it is very important to be in communication with the MCO. **Always call the MCO before changing the type of service provided.**

In some cases, a phone call to the MCO before the submission of the claim is all that is needed. However, some MCOs may require you to submit an updated treatment plan. Familiarize yourself with the MCO's requirements and know your contract.

SUBMIT A "CLEAN" CLAIM

Using the standard CMS 1500 form, a sample of which can be downloaded off the Centers for Medicare and Medicaid (CMS) website (<http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf>), will go a long way toward preventing missed charges or misread claims. The actual forms can be ordered online from a variety of sources, including online from the Government Printing Office at <http://bookstore.gpo.gov>. Computer programs are also available to print these automatically from your billing office. If you do not have such a program, you can increase office efficiency by entering all the intake information in the "Patient" and "Insured" information sections on an original form, which can be permanently stored in the patient's file. Use this form to make

copies, as needed, so that the additional information relevant to a visit can be entered each time a new claim is submitted. Always make sure the information about the patient, the insured, and the plan is complete and correct on this form because, as we noted above, unidentified claims can take months to process or may just disappear. The physician information must still be completed for each claim submitted, or your superbill can be stapled to the copy of the CMS form. Adherence to the following guidelines will ensure that your claim is processed with maximum efficiency:

- List only one charge on a line; date-spanned or combined charges are frequently missed.
- Clearly mark corrected claims as such; automated processing programs may interpret a claim with the same date of service as a duplicate charge.
- Explain codes that may have more than one meaning and indicate length of the visit (e.g., CPT 90841 - 60 minutes, 75 minutes, etc.).
- Supply the name and address of the facility where the services were rendered in addition to your billing address.

FOLLOW UP

The turn-around time for claims payment varies greatly among plans. If you have been waiting longer than usual for payment, call the MCO to inquire about the status of the claim. Be sure to have all pertinent information available when you call.

Many states have statutes that allow charging interests for late payments by an insurer. Find out about your state laws and charge any interest you are due.

IF YOU DON'T GET PAID

If you notice a pattern of slow payment or nonpayment, you might consider taking these steps:

Develop a Paper Trail

Try to find someone in the company who can get claims paid. If the person you first make contact with can't help you, you might want to write the medical director's office to report your problem and request immediate resolution. If you fail to get the help you need, write the chief executive officer and register an official complaint. Send a copy of your correspondence to any or all on the following list. But first learn who the key players are in your state and whose support you can count on.

- **State Insurance Commissioner** — Some commissioners are actively involved in taking complaints about fraudulent insurance practices from both physicians and consumers; others may take complaints only from consumers. If the commissioner's office can't help you, you can contact the state's department of health or department of labor.
- **Attorney General** — If your attorney general is especially active on healthcare issues, write him or her directly.
- **APA District Branch** — Your District Branch (DB) can be an important source of information on MCO activity in your area, and the legislative representative will be able to tell you the status of recent legislation.
- **Consumer Advocacy Groups** — Patients can register complaints with local chapters of Mental Health America (call (800) 969-6642 for local phone numbers) and NAMI (call NAMI's Helpline at (800) 950-NAMI for local phone numbers of chapters and affiliates).
- **The Media** — Many local television stations in large cities have a consumer advocacy segment, and the media have been particularly interested in healthcare issues.
- **Congressional Representatives** — A sympathetic member of Congress can be very effective in negotiating on your behalf.

If you find that you're still having trouble getting paid, call the APA's Managed Care Help Line, 800-343-4671, for assistance.

Stay Informed.

Information *is* power. The APA's "Member2Member" listserv is an excellent way to find out how your colleagues have handled these problems. If you wish to join, send an e-mail to Webmaster@psych.org with the following information: name, member ID number, city, state.

Inform Your Patient

Keep your patient or a responsible family member informed. Your patient should contact her employer's Human Resources Department. The MCOs are under contract to employers to deliver medical services, and employers review these contracts periodically. If enough employees are dissatisfied, the employers may select another plan or advise the MCO to "fix" the problem.

Go to Small Claims Court

This is a last resort, but APA members have done this and won.

YOUR MCO CONTRACT/STATE LAWS

- Review your contract. What, if anything, does it say about the MCO's obligations to pay and within what length of time?
- Know your state laws. What do they have to say about prompt payment and the insurers' obligations? How do they define a late claim?

In general, develop effective collection procedures. Some managed care plans routinely check to see if practices ask for copays at the time of service, and if they do not, the MCOs drop them from their rosters. Bill and follow-up regularly on outstanding claims. Do not let accounts age without knowing their status with the MCO. Banks consider outstanding debts "bad" and uncollectable after three months. Be aware that your contract may set time limits on billing.

MAINTAINING CONFIDENTIALITY IN THE ERA OF MANAGED CARE

It is sometimes necessary to forward patient information to third-party payers (private and governmental), managed care organizations (MCOs), utilization review entities, pharmacies, pharmacy benefits management companies, and companies that provide various auditing functions--to name a few. Consequently, maintaining patient confidentiality can seem like a demanding task.

MCO REQUESTS FOR RECORDS

Psychiatrists are often contacted by representatives of MCOs who request immediate access to confidential patient information. They often state that their authority rests on the consent form the patient signed when he joined the health plan.

This may be technically correct, but the consent form the patient signs is usually a blanket consent for release of medical records for reimbursement purposes. At the time the patient signed the consent, she may not have anticipated having psychiatric treatment or understood the extent to which information could be accessed. The patient may not even remember signing such a consent. Is this really informed consent? (See Chapter 22.)

The standard of practice in releasing psychiatric treatment records is that the patient should be specifically informed of, and consent to, a specific release of information for a specific purpose. Only that information necessary to perform the authorized function can be released. Therefore, when faced with a request for specific records, a psychiatrist should inform the patient of the request and get the patient's consent to release the information before passing it along to the MCO.

Ideally, the psychiatrist should know the MCO's policies and procedures on confidentiality before signing a contract, including its medical record review procedures for utilization review, credentialing, auditing, quality of care review, etc. The psychiatrist should also find out how much notice is given before on-site audits or reviews are conducted. (Remember, an MCO has no authority to see the records of patients who are not members of the MCO.)

A CAUTION ABOUT "PERSONAL NOTES" AND SUMMARY STATEMENTS

Some psychiatrists keep personal notes, which would be defined as psychotherapy notes under HIPAA (see Chapter 41A) separate from the patient

treatment record. Under HIPAA, these notes are specifically defined as “documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session, and that are separated from the rest of the individual’s medical record.” The psychiatrist is not required to release these personal notes to insurers as part of the patient treatment record (nor is the psychiatrist required to release them to the patient).

However, case law has shown that a psychiatrist can’t count on the courts to protect these personal, or psychotherapy, notes from potential discovery should they be required as part of a legal procedure. Additionally, it may be very difficult, if not impossible, for a psychiatrist to justify withholding or destroying records by labeling them “personal notes.” This would be very difficult to overcome in a malpractice action and could cause major problems in circumstances where the psychiatrist is being audited, for example, by government officials to determine evidence of fraud and abuse. Because of this, it is recommended that any such notes be kept to a minimum.

Similarly, psychiatrists should be aware of the professional liability hazards involved in the practice of providing a summary of a patient’s record, instead of providing a copy of the treatment record, when a valid request for release of patient information is received. In some cases patients have disputed the accuracy of the summary, claimed that it is in conflict with the record, and sued the psychiatrist, alleging that it caused them injury.

PROCEDURES FOR THE RELEASE OF INFORMATION

- Accompany the released record with a copy of the signed release form and written notification to the receiver of the medical record that further disclosure of information is not authorized without the patient’s specific consent. **(Original patient records should never be released – only legible copies.)**
- Inform the patient whenever a request for release of information is received, even if the patient has already given consent. If it has been some time since the patient signed an authorization for release of medical records form, the patient may want to revoke her consent.
- Keep a copy of all requests for release of information in the patient record along with the signed authorization for release of medical records form.
- Release only that portion of patient information that is necessary in order to comply with the request.

- If you communicate about patient information with third-party payers, MCOs, provider networks, etc., via electronic means, you are covered by HIPAA, and must be sure that you are in compliance with HIPAA's privacy rule (see Chapter 41A). All employees must be trained and understand these policies. Remember that the psychiatrist can be held responsible for the actions of employees, affiliates, and contractors. Even if you do not transmit patient information electronically and are not covered by HIPAA, you must still be sure to have adequate safeguards in place for paper records. Authorized individuals should have access to information on a need-to-know basis only.

HANDLING MEDICAL RECORD REVIEWS

In order to obtain a variety of certifications and accreditations, managed care organizations, insurance companies, and other entities may need to conduct a review of how your practice manages its medical records. Typically these reviews focus on ensuring that information is complete and is kept in a standardized, compact format, with appropriate security mechanisms.

To cooperate with these reviews without compromising patient confidentiality or encumbering your practice with too much additional work, we recommend the following six steps:

1. Prepare a brief summary sheet of where and how you store medical records and other sensitive information, including details on the procedures you have in place to protect patient privacy.
2. Ask if a “dummy” record will suffice.
3. If not, make sure that you and your staff have sufficient advance notice to “cleanse” your medical records of all patient-identifying information prior to the review.
4. If the review is being conducted by a particular managed care organization, be sure to share only the records of those patients who are covered by that organization.
5. Do not allow the reviewing body to remove records from your office.
6. Obtain patient consent for the release of records, where appropriate, and keep these on file (see Appendix N).

If you are uncomfortable with any aspect of an on-site medical records review, contact the APA’s Managed Care Help Line.

33

AVOIDING DESELECTION

Note: This chapter from 1999 doesn't have much relevance in today's managed care world where many MCOs are finding difficulty in filling their network spots for psychiatrists. We leave it here in its entirety primarily as a historical document.

June 2010

Deselection is a method managed care companies use to control costs and the quality and quantity of care delivered. Many psychiatrists express concern that deselection, or termination, from a managed care network will have a detrimental affect on their livelihoods, but more importantly, deselection often severely disrupts patient care.

It is helpful to understand the major reasons companies deselect physicians so that you are better equipped to argue your case if this should happen to you.

- **Provider profiling:** MCOs systematically evaluate practitioners on clinical outcome, service quality, utilization, costs, and administrative compliance with the company's policies and procedures. If a physician happens to fall below their standards at the time, the MCO will often opt to deselect him or her from their panel.
- **Capitation and risk-sharing:** Many MCOs are developing stronger relationships with fewer doctors, keeping only their most favored clinicians with whom they can share financial risk for treatment services and reduce administrative oversight.
- **Loss of contracts:** An MCO's contract with a given payer can expire, resulting in a need for fewer clinicians in a given location.
- **Mergers and acquisitions:** As MCOs consolidate into fewer and larger conglomerates, the resulting network of any one "surviving" MCO may be too large to be administered efficiently and cost-effectively, particularly with respect to information management, credentialing, and recredentialing processes.
- **Supply and demand:** There may be a surplus of psychiatrists in your geographic location.

This issue is further complicated by the use of contract clauses that allow MCOs to deselect "without cause"—without having to provide the clinician with the reasons for the deselection. In some cases physicians may not even be informed that they have been deselected; they simply start receiving drastically

fewer or no referrals. MCOs use such strategies to minimize their risk of law suits.

NINE WAYS TO MINIMIZE YOUR RISK OF DESELECTION

1. Review the MCO's contract to determine the protocols for deselection. Pay special attention to "without cause" termination language (see Chapter 28).
2. Ask your colleagues about their experiences with the MCO. It's particularly important to inquire about referral volume.
3. Ask the MCO about the number, size, nature, and duration of its contracts with payers, including how many referrals you can expect to receive.
4. Keep your malpractice insurance, credentials, and recredentialing materials up-to-date.
5. Maintain medical staff/membership privileges at facilities under contract with the MCO.
6. Provide flexible hours and schedule appointments quickly.
7. Submit concise, focused documentation that includes treatment goals and clear explanations of the medical necessity of proposed services.
8. Be polite to MCO staff during referral, authorization, billing, eligibility, and other processes.
9. Promote your unique qualities to the MCO—particularly if you speak multiple languages, offer flexible hours, or practice in a subspecialty that is in demand, such as child and adolescent psychiatry.

WHAT TO DO IF YOU ARE DESELECTED

- If you receive a deselection notification or notice a significant decline in referrals, make an inquiry of the provider relations director and/or medical director of the MCO (see Appendix T for a list of Managed Behavioral Healthcare Organizations). Some deselections turn out to be administrative errors that can be easily corrected. Others can be overturned if the decision maker is impressed by your desire to continue in a cooperative relationship with his organization. There may also be a standard appeals mechanism.
- If appropriate, ask your patients to complain to their employer. MCOs may be more motivated to reinstate clinicians if their paying clients make the request.
- Call the APA's Managed Care Help Line at (800) 343-4671 for assistance.

STATE LEGISLATION

Check with your local APA District Branch about the latest legislative actions in your state. At least fourteen states—Colorado, Iowa, Idaho, Indiana, Maine, Maryland, Minnesota, Missouri, New Jersey, New York, Oregon, Rhode Island, Texas, and Virginia—have enacted some type of law to protect physicians against deselection, including no-cause terminations. Some physicians now express concern about the “right to disclosure,” which could mean that an MCO’s decision to deselect a physician based on the quality of his or her work could end up in the National Practitioner Data Bank (see Chapter 44).

34 MANAGED CARE RESOURCES

APA MANAGED CARE HELP LINE

The Managed Care Help Line, (800) 343-4871, which we refer you to throughout this book, assists APA members in locating up-to-date information on managed care, including Medicare. Help Line staff may also intervene with managed care companies on behalf of members who have been unable to negotiate appropriate solutions to difficulties they are having with the companies on their own. The Help Line serves as a clearinghouse for managed care issues, documenting APA members' experiences that exemplify the shortcomings as well as the successes of managed care. The data collected from the Help Line is reviewed periodically by the appropriate governing bodies within the APA to identify trends and determine if action needs to be taken on a national level.

APA LEGAL INFORMATION AND CONSULTATION PLAN

The APA also has a Legal Information and Consultation Plan that's available to its members for an additional fee. Nancy Wheeler, J.D., is the director of the Plan, which provides information and consultations related to the practice of psychiatry. For more information, call (301) 384-6775 or e-mail apaplan@verizon.net.

WRITTEN MATERIALS

The APA's Office of Healthcare Systems and Financing contributes a *Psychiatric Practice and Managed Care* page to *Psychiatric News* several times a year. This page provides practical information on issues generally gleaned from the calls received through the Managed Care Help Line.

The APA's Office of Healthcare Systems and Financing also publishes a number of informational papers. Topics covered relating to managed care include:

- Avoiding Common Procedure Coding Problems
- Appealing Treatment and Reimbursement Denials
- Terminating Physician/Patient Relationships
- Documentation of Psychotherapy by Psychiatrists
- Opting Out of Medicare
- Unpaid Claims – What to Do About Them

APA POSITION PAPERS

The APA Board of Trustees has approved several documents important to psychiatrists working in managed care settings. They are listed here and included as appendices.

- General Principles for the Operation of Managed Mental Health and Substance Abuse Organizations (Appendix U)
- Patient Pamphlet on Managed Care (Appendix W)
- Concepts for Creating a Better Managed Care System (Appendix X)

PRINCIPLES OF MEDICAL ETHICS

The following are the basic principles of medical ethics as defined by the American Medical Association (AMA) with annotations added by the APA that are specific to the practice of psychiatry. The full document, including Procedures for Handling Complaints of Unethical Conduct and an addendum providing Guidelines for Ethical Practice in Organized Settings is available online at - <http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/PrinciplesofMedicalEthics.aspx>. All physicians practicing in the United States are expected to practice in accordance with the AMA's code of ethics, and the annotations make it clearer how these basic tenets apply to psychiatry. The AMA's principles are italicized, and the annotations follow them in Roman type.

PREAMBLE

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals, and to self. The following Principles, adopted by the American Medical Association, are not laws but standards of conduct, which define the essentials of honorable behavior for the physician.

SECTION 1

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus upon the well being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.
2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.
3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital

administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:

- a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.
- b. Appeal to the governing body itself.
- c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.
- d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.
- e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.
- f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

SECTION 2

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

1. The requirement that the physician conduct himself/herself with propriety in his/her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.
2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power

- afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.
3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.
 4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.
 5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the treating physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.
 6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his or her circumstances.
 7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based upon a mutually agreed upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

SECTION 3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.
2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

SECTION 4

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.
2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy.

This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students' explicit permission

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.
4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.
5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.
6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.
7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.
8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.
9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by

- extension, to unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.
10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering, if the confidentiality of the presentation is understood and accepted by the audience.
 11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.
 12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.
 13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.
 14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because: (a) any treatment of a patient being supervised may be deleteriously affected; (b) it may damage the trust relationship between teacher and student; and (c) teachers are important professional role models for their trainees and affect their trainees' future professional behavior.

SECTION 5

A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.
2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.
3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.
4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.
5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

SECTION 6

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.
2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

SECTION 7

A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health..

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., "Psychiatrists know that...").
2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.
3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an

examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his/her certification to be used for the involuntary treatment of any person only following his or her personal examination of that person. To do so, he or she must find that the person, because of mental illness, cannot form a judgment as to what is in his/her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others.
5. Psychiatrists shall not participate in torture.

SECTION 8

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

New Section recently adopted by the AMA.

SECTION 9

A physician shall support access to medical care for all people.

New Section recently adopted by the AMA.

OPINIONS OF THE ETHICS COMMITTEE

Over the years, the APA's Ethics Committee has been frequently asked to provide its opinion on whether specific behaviors are ethical or not. Basing its answers on the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (see Chapter 35 for the 2006 edition) and the AMA's 2000-2001, *Current Opinions with Annotations of the Council on Ethical and Judicial Affairs*, the Ethics Committee has responded to the questions posed by physicians.

A book containing the answers the Ethics Committee has provided that address specific practice issues was published in 2009. It contains the Ethics Committee's opinions on the kinds of issues you will probably encounter in your everyday practice. A sampling of these questions and answers appears below. Here we have arranged them under the section of the *Principles of Medical Ethics* that the Ethics Committee felt covered the issue in question. In the 2009 book, they are arranged by topic, and then by section, which should make it easier to find a specific issue of concern. The entire book can be accessed at <http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/OpinionsofPrinciples.aspx>.

SECTION 1

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

Question: A reviewing psychiatrist for an insurance company has not examined my patient. Is it ethical for the reviewing psychiatrist to tell me how to treat my patient?

Answer: No; but it is ethical for the reviewing psychiatrist to raise questions about the care or offer suggestions. The treating psychiatrist is the decision maker about the treatment. However, the contract between the patient and the insurance company includes the right of review and the right of the insurer, in some circumstances, to terminate the benefits. Generally, there is also a right of appeal by the patient and the treating physician. Outright rejection by the reviewing psychiatrist may result in benefit termination, throwing the financial responsibility upon the patient. Ultimately, the patients have a right to participate in the decision to have their care undergo review, understanding that refusal to allow review might jeopardize their insurance coverage.

Question: Many people in my area are very busy or have transportation problems. I propose to offer them consultation by telephone or letter or audiotape. Among other things, I am prepared to offer stress management, bereavement and divorce counseling, and flexible, creative psychoanalytic therapy. Is this ethically permissible?

Answer: There are several questions: 1.) Is the treatment contract explicit and does it allow fully informed consent? 2.) Will you provide a face-to-face thorough psychiatric examination prior to initiating this treatment plan? 3.) Will you be available to provide face-to-face intervention when clinically necessary? 4.) Are you properly trained to carry out these treatments, especially are you trained in psychoanalysis? 5.) Have you thought out carefully why you want to do this and are you guided by the best interests of your prospective patients? If the answer to any of these questions is no, your plan is unethical.

Question: Is it ethical for a staff member in a psychiatric treatment facility to continue treating a patient that the staff member has brought criminal charges against? Similarly, is it ethical for a staff member to continue treating a patient when the staff member is or will be aiding in the criminal investigation and/or prosecution of that patient?

Answer: Either of these dual role situations would be fatal to the establishment or continuation of a mental health professional-patient relationship. The treatment relationship factors necessary -- like trust, beneficence, empathy, and confidentiality -- cannot genuinely exist in these two examples. It would be necessary to assign other staff members to work therapeutically with this patient preferably assigning the patient to a separate unit with no contact to the staff member pressing criminal charges. While the need for a legal response to some patients' acts is at times necessary, the facility still has an ethical duty to provide reasonable and appropriate care for the patient.

SECTION 2

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

Question: A new psychiatrist in town who works for a local clinic needs a part-time office where he can start up his private practice. To help him, I told him he could use my office in the evenings and pay me a small percentage of his billings. Is this ethical?

Answer: The proper arrangement is to negotiate a reasonable charge for the use of space, secretarial coverage, and other expenses. Greater use, or lesser, would require renegotiation of what constitutes reasonable charges. Though the agreed upon amount might be similar to what would have resulted from a

percentage arrangement, the appearance of fee splitting—the office owner benefiting from referring patients to the new psychiatrist—would be avoided.

Question: Is it ethical for psychiatrists to charge for telephone calls from their patients?

Answer: Yes, if this was established in the treatment contract. (See Section 2, Annotation 5 in Chapter 35.)

Question: Quite often I have patients in my psychiatric practice who let large balances accumulate over and above what their health insurance pays. I've heard that some offices ask the patient in continuing treatment to sign a payment schedule agreement when this happens. Is this ethical?

Answer: Yes. This should be established with the patient's consent as part of the contractual agreement. See Section 2, Annotation 5 (Chapter 35). It would also be permissible to add a service charge for the actual administrative costs of rebilling.

Question: Is it ethical for a psychiatrist to have a platonic friendship with a sibling or a parent of a former patient?

Answer: The Ethics Committee advises caution regarding the establishment of a platonic friendship between a former patient and a psychiatrist. Both the APA and the AMA hold that significant third parties (e.g., relatives and caretakers) are afforded the same considerations as are patients. Thus the psychiatrist also must guard against boundary violations, third party exploitation, and breaches of patient confidentiality in interactions with third parties. For example, the psychiatrist may seek such a friendship based on information that was acquired in the context of a doctor-patient relationship. Would this ensuing friendship in any way exploit the third party? Another potential pitfall relates to confidentiality as a cornerstone of treatment. Could such a friendship exist without threatening patient confidentiality? In sum, it cannot be determined *a priori* that a social relationship of this type would be ethical or not. In most cases establishing a friendship of this sort would be ill-advised given these concerns.

Question: Is it ethical to allow the father of a former patient to provide construction services to me to pay off the bill and to pay off his own bill since the father is now my patient?

Answer: It is ethical to receive goods or services in lieu of fees for the son's bill as long as it is at fair market value and does not exploit the patient. However, while not clearly unethical relative to the father's bill, we recommend against such an arrangement with a current patient because of the likelihood of impairing the treatment relationship.

Question: May I send out notices to doctors and lawyers in my neighborhood stating I would appreciate referrals?

Answer: Yes, as long as the notices are not deceptive, misleading, or false. Claims of unusual or special competence would be improper.

SECTION 3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

Question: As a military psychiatrist, I have responsibility to examine personnel who have used drugs to determine if it is medically safe to proceed with the administrative process of rehabilitation and separation. Some of these people are one-time users and do not need rehabilitation or deserve separation. I object to such participation and believe it is unethical. Am I correct?

Answer: We do not believe you are, although we recognize your dilemma. The service regulations are the law under which you, as a military officer, serve. You may advise as to your belief that the law is incorrect. However, your opinion that it is medically safe to proceed with the requirements of regulations does not place you in an unethical position.

Question: Am I unethical if I abide by court decisions prohibiting necessary treatment (medications) for my patient? Is it unethical to continue to practice in a hospital controlled by such court decisions?

Answer: No to both questions. The public has a right to make decisions with which we may disagree and our recourse is to convince the public otherwise.

SECTION 4

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences within the constraints of the law.

Question: Can I give confidential information about a recently deceased mother to her grieving daughter?

Answer: No. Ethically, her confidences survive her death. Legally, this is an unclear issue varying from one jurisdiction to another. Further, there is a risk of the information being used to seek an advantage in the contesting of a will or in competition with other surviving family members.

Question: As a condition of referring patients to our hospital, Employee Assistance Program staff requires we keep them informed about treatment progress and even sit in on treatment planning conferences. Is it ethical to agree to such a condition?

Answer: EAPs are very much a part of the current scene and it is acceptable, in fact advisable, to develop working relationships with them. However, patient confidentiality cannot be compromised. To avoid this, information provided to an EAP, or attendance at a treatment planning conference, requires informed and uncoerced consent from the patient. The latter is especially important if there is any suggestion that refusing consent may negatively impact the patient's job.

Question: Do I have an ethical responsibility to complete insurance forms for a former patient for services I rendered; for a current patient I am treating?

Answer: Yes to both questions.

Question: A couple I am seeing eventually divorces and a bitter child custody dispute ensues. One spouse asks me to testify and the other asks me not to. What do I do, especially if I am subpoenaed?

Answer: You are obligated to protect the confidences of each equally. If ordered to testify, you should raise the issue of confidentiality; however, you may have no choice but to respond to proper legal compulsion if the best interests of the child are paramount. One possible way to avoid this unfortunate situation is to ask such a couple, as a requirement for treatment, to sign an agreement that they will not attempt to use you in any legal struggles.

SECTION 5

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

Question: Is it ethical for a psychiatrist to refer a patient to a qualified mental health professional who happens to be his wife?

Answer: Yes. However, the psychiatrist has the same ethical responsibilities in making that referral as he would have if the person were not his wife. He cannot refer cases requiring medical care to her, nor can he give her only token supervision. He should also make clear to the patient that the referral is to the spouse.

Question: Is it proper for a psychiatrist to be the “medical director” of a private clinic, the rest of whose staff are nonmedical professionals, when he spends very little time at the clinic?

Answer: It is not ethical for the psychiatrist to lend his name to the clinic merely to legitimize it. The psychiatrist must spend sufficient time at the clinic to assure that proper care is given and that nonmedical staff are not assuming responsibilities requiring medical training.

Question: Is it ethical for a supervising psychiatrist to sign a diagnosis on an insurance form for services provided by another professional that he or she is supervising and when the psychiatrist has not examined the patient.

Answer: Section 5, Annotation 3 (see Chapter 35) clearly states the supervising psychiatrist must expend sufficient time to assure that proper care is given and not allow the role to be that of a figurehead. Further, the insurance form must indicate the role of both supervisor and the person supervised. If these provisions are met, the answer is yes.

SECTION 6

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

Question: Is it ethical for a psychiatrist to continue to see a patient in his or her private practice whom the psychiatrist began seeing as an employee of a public clinic: can other professional members of the clinic refer patients to him?

Answer: The issue is what is best for the patient, rather than for the physician or the clinic. Patients must have the right of free choice of their physician.

Question: In our underserved area, the doctors at a local mental health center do not have or want privileges at a local hospital and do not feel they have responsibility if a patient of theirs needs to be hospitalized. Is this ethical?

Answer: The decision does not appear to be ethical and may constitute patient abandonment. A solution could be provided by a contract between the mental health center and the hospital and its medical staff to provide services when needed that are not provided by the mental health center and its psychiatrists.

Question: I am leaving a hospital where I am the only child psychiatrist. Is it ethical for me to turn over my child patients to psychiatrists whose competency is not known to me?

Answer: You owe it to your patients that they be transferred to competent replacements. If you believe they are not, to avoid possible abandonment, the hospital should be advised to seek competent replacements.

MANAGING RELATIONSHIPS WITH PATIENTS

Besides the necessities of the personal relationship you must establish with your patient to be able to provide appropriate treatment, the psychiatrist-patient relationship has formal rules that must be adhered to in the interest of protecting yourself from malpractice liability. Once you have agreed to having a treatment relationship with a patient, you are legally and ethically obligated to continue that relationship until it is terminated in a proper manner (see below).

AVOID CREATING AN INADVERTENT PHYSICIAN-PATIENT RELATIONSHIP

The following are several situations where you might inadvertently establish what could legally be construed to be a psychiatrist-patient relationship and advice on how to avoid doing this.

Informal Counseling or Prescribing for Friends

Just answering general questions at a social gathering would not constitute establishing a physician-patient relationship, but any time a colleague or friend asks to discuss a problem with you and perhaps get some advice, you're running a risk. In such a situation you must be careful to make it clear that you are not functioning as the person's physician, but only as a friend, and cannot make treatment decisions. It is also important to know that, as far as the law is concerned, prescribing or dispensing medication to a person establishes the physician-patient relationship.

Initial Visit or Consultation

In private practice, you may see a patient one time and decide, for whatever reason, that you do not want to provide treatment for this individual. This shouldn't create a problem as long as you, or the member of your staff who sets up the appointment, makes it clear that the first meeting is just an opportunity for you and the patient to meet each other and see if you want to establish a treatment relationship. If you do not do this, you will be obligated to help the patient find a new doctor and remain available until she does, just as you would with a long-time patient. If you're working in managed care you may be contractually obligated to agree to take any patient who is referred to you, so this first-visit exception would not apply.

Limited Purpose Examinations or Consultations

If you are asked to examine a patient for a specific purpose (i.e., to meet a requirement of an employer, insurer, or government agency) you should be sure to explain the limited purpose of the examination at the outset to make it clear that no physician-patient relationship is being established. Although you are clearly not liable for continuation of care in such a situation, you are still liable for any negligence in carrying out the examination. So remember to examine people you see under these circumstances with the same care you'd use with your regular patients.

Informational or Educational Activities

If you participate in any of the community outreach programs we mention in Chapter 7 you'll want to be sure to make it clear that by addressing a group about psychiatric issues and answering questions from the audience, no matter how specific those questions may be, you are just providing general information and are not establishing a physician-patient relationship

EMERGENCIES

Once a physician provides care for a patient in an emergency situation, she takes on an obligation to continue treating the patient until other assistance arrives. Beyond that she has no duty to continue to provide care for the patient, and, in fact, in most jurisdictions physicians are not even required to offer assistance in emergency situations at all (there are exceptions to this rule, so you should check your state's laws).

TERMINATING TREATMENT

For whatever reasons—a patient's failure to follow treatment instructions or failure to pay; a psychiatrist's belief that another therapist would provide better treatment; a determination that therapy is no longer needed; a psychiatrist's retirement—it is sometimes necessary to terminate a relationship with a patient. To do this without risking liability for abandonment, a psychiatrist must:

- Give the patient reasonable notice and time to find a new therapist
- Assist the patient in the process of finding a new therapist
- Provide records and information as requested by the new therapist

Appendix Y is a sample letter that could be used to inform a patient that you are terminating treatment.

Although thirty days notice is generally considered appropriate, in a rural or other underserved area it may be necessary to provide longer notice. When

terminating a relationship with a patient it is also necessary to give proper instructions concerning any medication the patient is taking (e.g., if stopping medication abruptly could cause injury).

If one of your patients chooses to terminate the relationship, or simply fails to show up, it is also appropriate to acknowledge in writing that the relationship has been terminated and recommend further treatment if you feel it's needed.

It is never appropriate to sever a treatment relationship when a patient is in an emergency situation unless the patient agrees to see another clinician or is hospitalized.

REDUCING MALPRACTICE RISK

When practicing in any medical specialty, there is always the risk of a malpractice suit by a patient. This chapter deals with the steps you can take to reduce your chances of being sued.

COMMUNICATE EFFECTIVELY

Communication is essential, not only between you and your patients, but also among clinicians and with other staff. Patients know whether or not their physician is really paying attention to them. They also can tell whether or not she honestly cares about them. Happier patients are more likely to comply with treatment, which should facilitate better outcomes, and they are also more likely to be understanding if there is an adverse outcome to treatment. Good communication involves not only speaking in terms the patient can understand, but being a good listener as well.

It is also important that you and other staff members function as a cohesive team and communicate effectively. Clear policies should be in place that address how to handle confidentiality, record-keeping, release of information, billing, telephone contacts, adverse events, patient complaints, referrals, after-hours coverage, and emergency situations.

OBTAIN INFORMED CONSENT

Informed consent (see Chapter 22 for a more complete discussion of informed consent) is permission given by a patient who is fully aware of all the material aspects of a situation for his physician to initiate a certain action or procedure. In the psychiatric profession, it is necessary to obtain informed consent in a variety of situations. Not only do patients need to be informed about their course of treatment, including medication options, possible side effects, and any possible adverse reactions to nontreatment; they also need to be informed about, and give express permission for, information on their case to be released to any third party. Under managed care, many people may request to see patient records. No one may receive such information without the patient's knowledge and permission. Patients' confidentiality release forms, and all other consent forms should be kept on file.

MAINTAIN RECORDS APPROPRIATELY

Many lawsuits can be prevented by maintaining accurate and detailed records. (See Chapter 24, Medical Records.) Records should include the following:

- Documentation of having received informed consent from the patient;
- A list of significant problems as determined from the initial evaluation;
- Ongoing and one-time issues as determined by each encounter, including related life problems;
- Notations of resolutions of problems as they occur--if the problem recurs, it can be added back to the list;
- A medication list, including names of medications, dosages, when medication is prescribed, and any adverse reactions;
- Blood levels and results of other tests;
- Documentation of contacts with a managed care organization or other reviewer when care is denied;
- Specific instructions given to the patient, and whether or not there were any questions; and
- An annual summary of treatment if the patient is in therapy for a year or longer.

This information can help reduce the risk of a malpractice suit and increase your chances of winning a suit if one is brought against you.

In addition, it is important to follow certain guidelines when keeping a handwritten medical record:

- Always write clearly and legibly. Do not try to cram words on a line where there is not enough space and draw a line through any spaces that are not used when making an entry.
- Always write the patient's name and the date and time of each entry on each page.
- Never erase an entry. If something is incorrect that you later want to fix, put a line through the incorrect information with the date of the correction. In addition, you should never add anything to a previous entry, unless it is in a separate note that includes the new date. It is possible to calculate the date ink is put on paper, and therefore a test can determine if something was added to the original record.

If the medical record is maintained electronically, the program you use should ensure that any changes to the record are noted appropriately. There are many organizations emerging to certify electronic health records (EHRs). One of them, the Certification Commission for Health Information Technology, states that any

EHR must “provide the ability to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note” and must “provide the ability to record and display the identity of the user who added or corrected a note and the date and time of the change.”

SUSTAIN APPROPRIATE OFFICE PROCEDURES

It is imperative that all office staff work to ensure the appropriate handling of records, billing, and other responsibilities to minimize errors in the system and therefore reduce the chances of a malpractice suit. Office staff should follow these guidelines:

- **Inform the psychiatrist of any incoming reports:** Filing reports, whether they be lab results or letters/reports from other physicians or therapists, without the knowledge of the psychiatrist can lead to errors in treatment and possible malpractice claims.
- **Inform the psychiatrist of a patient’s noncompliance:** The doctor needs to know about missed appointments and tests that were ordered and not taken so that the patient can be contacted if necessary.
- **Maintain accurate and up-to-date billing:** Incorrect repeated billing of a patient can cause unnecessary annoyance and dissatisfaction. If a patient contests a certain bill, cease billing until the matter is resolved.
- **Do not discuss patient cases among office staff:** Patient medical records and cases should only be discussed among office staff with consent from the patient.
- **Maintain a supportive atmosphere:** Patients respond to a friendly environment and individual attention. All members of the office staff contribute to the patient’s overall impression of the psychiatrist and treatment.

FOLLOW APPROPRIATE PROCEDURES WHEN AWAY FROM YOUR PRACTICE

It is important that patients have access to the same high-quality care from another psychiatrist when you are away or otherwise unavailable. If patients receive substandard care when you are away, both you and the covering

psychiatrist can be held liable. If you plan to be away from your practice for an extended period of time, be sure to take the following precautions:

- Carefully choose who will cover your practice, and make sure it is someone whom you trust and know to be responsible.
- Inform the covering psychiatrist of your most difficult cases so that if a problem arises, she will be better prepared to deal with it. Be sure to leave a number so you can be consulted in case of an emergency.
- Prepare your patients for scheduled absences. Be specific about the length of time you'll be away and provide them with written materials with all the necessary information about their care during your absence.
- If you work in an inpatient facility, it is helpful to introduce your co-worker to your patients before you leave, so that both the doctor and patient will know better what to expect.
- Inform your answering service of whom your replacement is and how he can be contacted.
- Carefully check your managed care contracts to see if there are any limitations imposed on your choice of coverage providers.
- Instruct staff not to release confidential information to anyone without your advance approval.
- Leave instructions for staff on how to deal with suicidal patients. After patient is directed to the proper care, you should be notified immediately.
- Be aware of potential breaches of confidentiality if you must communicate by cell phone, fax, or voice mail.
- Be wary of treating patients by phone if a follow-up office visit can't be scheduled in the near future.
- Maintain documentation of all calls to and from a patient and to and from a third party about a patient. (This may require you keep a small notebook or pack of forms with you when you're away from the office, so that the record can be filled in upon your return)
- Save documentation such as your plane tickets, hotel bills, and your coverage instructions. They may prove vital if you are accused of malpractice during a time when you were, in fact, out of town.

If others turn their practices over to you when they are away, remember that you must treat these new patients as if they were your own. Depending on the situation, you alone may be held liable if something goes wrong. Be sure to: find out about any patients who will likely require your assistance during your colleague's absence; find out how to gain access to any medical information you may need about patients; know to which institutions your colleague refers if in-

patient care is required and be sure you have privileges there; and be clear about any other situations that might arise while you will be covering the practice.

MANAGED CARE ISSUES

More and more of today's psychiatrists are affected by managed care. It is important to remember that patients' rights and appropriate treatment are still of greatest priority. There are a number of "staples" of managed care that can potentially get psychiatrists into trouble.

Utilization Review

A basic tenet of managed care is that requests for treatment are reviewed by the third party, so that excessive (and overly expensive) care is not given. This can pose some problems for psychiatrists. There is often a lag time before the care is approved, and if something happens to the patient during that time, the psychiatrist may be held accountable. Problems can also arise when the managed care company denies the requested care. If you feel that the care is absolutely necessary for your patient, you are obligated to appeal the denial, and it is best to continue providing care during the appeal. If you do not appeal, and there is a negative outcome, such as suicide, you may be held liable. In at least one case on record, the psychiatrist was held accountable with the managed care organization, because it was felt that the psychiatrist did not do everything possible to help the patient.

Gag Clauses

Patients have the right to know all the treatment options available for their illness. They also should be aware of the physician's payment arrangements, such as capitation. If the psychiatrist is not permitted to inform the patient fully because of restrictions imposed by the managed care organization, and there is an adverse outcome, the psychiatrist may be held liable. Psychiatrists should be wary about signing any contracts with gag clauses in them (see Chapter 28 on managed care contracts).

Formulary Exclusions

In addition to restrictions of speech, as required by gag clauses, restrictions in formularies can also pose problems for psychiatrists. If a patient 1.) is denied access to a particular medication because it is not in the formulary, or 2.) was on a medication with positive results and had to switch because the medication is no longer covered, and in either case has an adverse reaction, the patient can

sue the psychiatrist. It is important to appeal any denials for medications that you prescribe.

Patient Records

Managed care organizations often want to see patient records to authorize continued care or for quality assurance purposes. Always obtain informed and written consent from the patient, and never give a managed care organization a chart for a patient covered by a different organization. Following these procedures will reduce your chances of malpractice suits.

ENCOURAGE ETHICAL BEHAVIOR

Generally promoting and adhering to ethical standards is your safest bet for avoiding malpractice suits. Following the procedures laid out in this chapter and practicing good medicine should decrease your overall chance of risk for a lawsuit and put you in better stead should a lawsuit occur.

LICENSING AND BOARD CERTIFICATION

LICENSING

Before you can be a practicing psychiatrist, you must obtain a physician's license from the state in which you are going to work and a federal narcotics license and registration number from the Drug Enforcement Administration (DEA).

State Licensure

Each state has its own requirements, and reciprocity agreements between states vary, as do the lengths of time a state license is good for and how much it costs. To find out about state licensure, contact the state's medical board (a full listing appears in Appendix I). The medical board should also be able to provide you with reciprocity information if you are licensed in another state.

Note: You will not be able to receive medical staff privileges until you have been licensed by the state where the facility is located.

Federal Narcotics License/DEA Number

To register with the DEA:

1. Call (800) 882-9539 to request an application or go online to www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html to fill out an application online.
2. Mail in the application.
3. The application will be investigated, and if it is approved you will be assigned a number and be granted a license for three years (because of an oddity in the system used to assign DEA numbers, the first time your license is issued, it may only be good for two and a half years, but all renewals will be for three years.) The fee is currently \$551 for the three-year period.
4. Forty-five days before your license runs out, the DEA will send you a renewal notice.
5. It is your responsibility to let the DEA know if you move.

A sample DEA application is included as Appendix J, but you must apply online or using an official application form you receive from the DEA.

Note: The following states and territories also require a state narcotics license: Alabama, Connecticut, Delaware, the District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Missouri,

Nebraska, Nevada, New Jersey, New Mexico, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Texas, Utah, and Wyoming.

The National Provider Identifier (NPI) and Medicare and Medicaid

If you weren't issued an NPI during your medical training, once you are practicing medicine in your state, you will need to obtain one so that you can treat Medicare and Medicaid patients (and so that you can bill private insurers as well). The NPI, which will be required starting in May 2007, functions like a Social Security Number for physicians and other healthcare providers. It will follow you wherever you go, and will not be changed except in very rare cases (such as identity theft). You can apply for your NPI online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, or you can request a paper application form (CMS-10114) by calling 1-800-465-3203.

Once you have your NPI you can contact the Medicare Carrier in your state to enroll as a Medicare provider. A list of Medicare Carriers and their contact information is available in Appendix AA.

To register as a Medicaid provider, you will need to contact the state agency that deals with health and social service issues—the Department of Health and Human Services, or Social Services. If you have difficulty finding out where you should call to enroll as a Medicaid provider, call the Office of Healthcare Systems and Financing Help Line (1-800-343-4671) and they will tell you who to contact in your state.

Licensing for Other Staff

When working in a group practice, if you are the one responsible, it is also important to verify that others in the group are appropriately licensed. Different states have different licensing requirements for various professions. You will need to check with the state licensing office (see Appendix I).

BOARD CERTIFICATION

In addition to needing a state medical license to practice, many psychiatrists are required by managed care organizations (MCOs) and others to be board certified in psychiatry. The American Board of Psychiatry and Neurology (ABPN) provides certification in psychiatry as well as in neurology and a number of other subspecialties, including neurology, child and adolescent psychiatry, clinical neurophysiology, forensic psychiatry, geriatric psychiatry, addiction psychiatry, pain medicine, and sleep medicine. Every certification exam is not given every year. The registration deadline for each year's psychiatry and neurology exams is February 1. Although you can register after that, up until a "late deadline," a late fee \$500 is added to the fees for the exam. The subspecialties have

separate deadlines. For more information, you can visit the ABPN's website, www.abpn.com.

There are two parts to the psychiatry exam, and there are fees associated with each part of the examination process. The fee schedule for Part I of the psychiatry exam for 2007 is: \$700 nonrefundable application fee and \$950 examination fee.

You must send both the application fee and the Part I examination fee with the application and the required accompanying documents (these include copies of all medical licenses or renewal registration cards for them; documentation of residency training; and documentation of any subspecialty fellowship training). Applications without appropriate fees and documentation will not be accepted. Once you have taken the Part 1 exam, you will receive your score and a bill for the Part 2 exam.

You can download applications and information about the examinations from the ABPN's website (www.abpn.com) or contact the ABPN's executive offices at:

500 Lake Cook Road, Suite 335
Deerfield, IL 60015-5249
(847) 945-7900

PRACTICE GUIDELINES

In the waning days of the twentieth century, both the American Medical Association (AMA) and the Institute of Medicine (IOM), a component of the National Academy of Sciences dedicated to advancing and disseminating scientific knowledge in the service of human health, established standards for the development of clinical practice guidelines. The AMA recommended that guidelines: 1.) be developed by or in conjunction with physician organizations; 2.) use reliable methodologies that integrate relevant research findings and clinical expertise; 3.) be as comprehensive and specific as possible; 4.) be based on current information; and 5.) be widely disseminated. The IOM recommended that practice guidelines have the following attributes: 1.) validity, based on the strength of evidence and expert judgment and estimates of health and cost outcomes compared with alternative practices; 2.) reliability/reproducibility; 3.) clinical applicability and flexibility; 4.) clarity; 5.) attention to multidisciplinary concerns; 6.) timely updates; and 7.) documentation.

The AMA has recently more specifically defined standards for the development of guidelines that may inform performance measures. Simultaneously, a new effort by the Institute for Medicine, sponsored by the U.S. Agency for Healthcare Research and Quality, is also defining standards for the development of “trustworthy” practice guidelines as well as standards for systematic evidence reviews. The IOM reports will be published in early 2011. Going forward, it is highly likely that guidelines will have to be developed according to the new IOM standards in order to have the necessary credibility to inform performance measures.

Practice guidelines have been developed by most medical specialty groups, and managed care organizations publish their own guidelines, attempting to set parameters for how medicine is to be practiced within their particular settings. Whether all of these guidelines will meet the new standards is yet to be seen. In anticipation of the publication of the new IOM standards, the APA has recently updated its guideline development process to improve its rigor and transparency. The existing process has included a clear disclosure and conflict of interest policy; appointment of a work group of volunteer APA members who have both research and clinical expertise in the guideline topic; systematic review of available evidence; broad iterative review of drafts by stakeholders including patient advocacy groups, other experts, and the entire APA membership; and review and approval by the APA Assembly and Board of Trustees. Going forward, APA's process will also include use of a formal evidence grading system

that separately rates strength of recommendation and quality of supporting evidence; structured surveys of research and clinical experts to assess expert opinion on topics for which high-quality evidence is lacking; and a formal process for determining consensus.

APA PRACTICE GUIDELINES

APA practice guidelines provide evidence-based recommendations for the treatment of patients with psychiatric disorders. The first APA guideline, on major depressive disorder, was published in 1991. Fourteen guidelines are now available on the following topics:

- Acute stress disorder and posttraumatic stress disorder
- Alzheimer's disease and other dementias
- Bipolar disorder
- Borderline personality disorder
- Delirium
- Eating disorders
- HIV/AIDS
- Major depressive disorder
- Obsessive-compulsive disorder
- Panic disorder
- Psychiatric evaluation of adults
- Schizophrenia
- Substance use disorders, including disorders related to use of nicotine, marijuana, alcohol, cocaine, and opioids
- Suicidal behaviors

The guidelines are published as supplements to the *American Journal of Psychiatry* (AJP); online at <http://www.PsychiatryOnline.com> (no subscription required); and in print compendiums available for purchase from American Psychiatric Publishing, Inc. (APPI), at <http://www.appi.org> or by calling 800-368-5777. Quick reference guides also are available.

Guideline “watches” describing major developments in the scientific literature or practice since original guideline publication are posted periodically on Psychiatry Online. Users of APA guidelines are advised to check www.psychiatryonline periodically for watches. There are currently seven watches available.

The primary purpose of APA practice guidelines is to aid the clinical decision making of psychiatrists. The guidelines also inform educational activities, including APA programs related to maintenance of certification (available at <http://www.apaeducation.org>), and they help APA to advocate for the availability of effective treatment options for patients. Although the guidelines may be used to help define a standard of care, they are intended as guidelines only, not standards. The front matter of every APA guideline specifically recognizes that treatment should be individualized and collaborative, always taking into account the patient's values and preferences.

In a reformed U.S. healthcare system, performance measurement is expected to become highly integrated into the practice of medicine, including Medicare reimbursement determinations. The American Medical Association, through its Physician Consortium for Performance Improvement, has asserted that performance measures should be derived from clinical practice guidelines developed by medical specialty societies. APA agrees that measures for psychiatry should be derived from APA practice guidelines rather than other sources, improving the likelihood that such measures will be clinically meaningful and consistent with available evidence and expert opinion.

The development of APA guidelines is not supported by any commercial organization.

If you are working for an MCO and find that its practice guidelines disagree with the APA's, the APA would appreciate hearing from you so that these kinds of conflicts can be resolved. Call the Managed Care Help Line at 800-343-4671.

MEDICARE AND MEDICAID

The U.S. government sponsors several programs designed to provide health insurance for people who meet specific criteria. Medicare provides coverage for medical expenses for people age sixty-five and over and for younger people who qualify for Social Security because of a disability. Medicaid provides benefits for low-income individuals.

Although these programs serve different populations and are funded by different mechanisms, they are both subject to complex federal rules and regulations, which cover everything from who is eligible to receive services to how much physicians can charge for those services. Working with these programs is complicated by the fact that the government does not administer them directly. Rather, it contracts them out to state governments, third-party administrators, and large insurance companies. These administrative arrangements result in a great deal of variation in how specific program policies are interpreted and implemented.

The following presents a brief overview of the Medicare and Medicaid programs and provides tips for achieving compliance with each. It is extremely important to remember that different administrators may have different interpretations of program rules, and that rules may change frequently. If you have specific questions about a program, contact the program administrator in your area directly for assistance.

MEDICARE

Medicare was created in 1965 as part of the Social Security Act. The program was divided into two parts. Part A is hospital insurance and helps to pay for care provided in a hospital, skilled nursing facility, nursing home, or hospice. It covers the room, board, and ancillary charges billed directly by the facility. The covered portion of expenses is based on the number of days the patient has received care. Until recently Part A was administered within each state by insurers that were designated as *Fiscal Intermediaries* (FIs). Part B covers the professional services of physicians and nonphysician healthcare providers and a variety of outpatient services including x-rays, laboratory work, and durable medical equipment. Until recently it was administered in each state or part of a state by an insurer that served as the *Medicare Carrier*. Medicare is currently transitioning to having “Medicare Administrative Contractors” (MACs) that will be in charge of

both Parts A and B for the 15 regions the country has been divided into. Currently there are MACs in place in 9 regions (see Appendix AA).

As a psychiatrist, you will almost always be working with Part B. Part A coverage is automatic upon reaching age sixty-five. Part B coverage is voluntary, and beneficiaries are required to pay a monthly premium for coverage. Medicare generally covers 80 percent of allowed medical charges, and the patient is responsible for paying the remaining 20 percent. Until this year, for most mental health services, Medicare only paid 50 percent and the patient is responsible for paying the other 50 percent. This inequity is being phased out gradually, and by 2014, mental health services will be paid just like all other medical services.

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) created Medicare Part D, Medicare's outpatient prescription drug benefit, which was implemented on January 1, 2006. The MMA mandated that Part D be managed by private prescription drug plans (PDPs), which would negotiate their own contracts with pharmaceutical companies for medications. Medicare beneficiaries must choose between the many plans offered in their states, and in the first months of the benefit, there has been a great deal of confusion about exactly what these plans are offering and how beneficiaries can access this information.

With the advent of Medicare Part D, dual eligible beneficiaries, who have both Medicare and Medicaid, had their drug coverage automatically switched from Medicaid to Part D. Although there were efforts to put safeguards in place to provide for their special needs, the transition to the new coverage created many problems with continuity of care for these beneficiaries, who are often among the most fragile medically. For more information about Part D and how it's working, you can go to www.MentalHealthPartD, the website sponsored by the APA and other mental health physician and advocacy groups.

Key Medicare Part B Information

- For outpatient mental health care (unless it's a diagnostic service, or treatment for a patient with Alzheimers or an Alzheimers-like dementia), the Medicare payment is currently 65 percent of the allowed amount; the patient is responsible for the other 35 percent. In 2012, the reimbursement rate will be 60 percent; in 2013 it will be 65 percent; and, finally, in 2014, it will be the full 80 percent. (The Medicare payment for inpatient mental health care has always been at the normal 80 percent of the fee-schedule amount.)

- If a patient has a Medigap policy (supplemental insurance to Medicare), that insurance may pick up the patient's entire copay or some part of it, depending on the particular policy.
- Physicians may choose to be either *participating* or *nonparticipating* Medicare providers. Participating providers must "accept assignment," which means they are responsible for filing the claims for treatment to Medicare patients and are paid the Medicare-allowed fee (minus the patient copay) directly by their Medicare Carrier. Nonparticipating providers can choose to accept assignment on a case by case basis or can choose to be paid the Medicare-allowed amount by their patients, *but the physician is still responsible for filing the claims with the Carrier* so the patient will be reimbursed. When nonparticipating providers do accept assignment they are paid 5 percent less than the Medicare-allowed amount.
- You can only "opt out" of Medicare by filing an affidavit with your Medicare Carrier that states you will not see *any* patients under Medicare for a period of at least two years. Once you have opted out, Medicare allows for private contracting between a physician and a Medicare beneficiary. See below for details.
- Although private contracting is allowed for physicians who opt out of Medicare entirely, a physician who sees any patients under Medicare cannot negotiate fees above the Medicare allowed amount. (Beneficiaries can request that you not file their claims with Medicare, but you are still limited to charging the Medicare allowed amount for your services.)
- The best way to keep on top of the changes in the Medicare program is to call your local Medicare Carrier or MAC and request that you be placed on its mailing list. Carriers are required to notify physicians of all changes to program rules, coverage guidelines, and fees. A list of Medicare Carriers is provided in Appendix AA.

Opting Out and Private Contracting Under Medicare

Since January 1, 1998, federal law has permitted a physician to opt out of Medicare altogether and enter into private contracts with Medicare patients that allow the provision of physician services entirely outside of Medicare. Payment

for these services is to be negotiated between the physician and patient and is not limited by the Medicare fee schedule.

A nonparticipating physician may opt out of Medicare at any time. A participating physician may opt out if he/she terminates the Medicare part B participation agreement and submits the required affidavit to the Medicare carrier at least thirty days before the first day of the next calendar quarter. The affidavit must show an effective date of the first of that quarter. See Appendix Z for opt out affidavit and private contract templates. More complete information about opting out can be found on the APA website, www.psych.org, under the heading Psychiatric Practice.

The law requires that the private contract with the patient stipulate that the patient agrees in writing that she will not submit any claims to Medicare and will not ask the physician to submit any claims. The patient also acknowledges that Medigap plans (and possibly other supplemental plans as well) will not make payments for services rendered by the contracting physician; agrees to be fully responsible for payment to the contracting physician for services rendered; and acknowledges that Medicare's fee schedule amounts and charge limits do not apply to the contracting physician. Physicians must use a contract that meets Centers for Medicare and Medicaid Services (CMS) regulatory requirements and have it signed by the patient or his legal representative. (The contract provided in Appendix Z meets these requirements and some MACs and Medicare Carriers have contracts available on their websites.)

Although a patient may agree to a private contract with one or more physicians, a physician who opts out of Medicare may not see *any* Medicare patients except under private contracts for two years.

State law may affect private contracts and physicians should check with their insurance commissioner, APA district branch, and/or a local attorney.

MEDICAID

Like Medicare, the Medicaid program was created under the Social Security Act of 1965. Medicaid, however, is a joint federal-state program, with funding coming from both sources. Medicaid is an entitlement program that provides medical assistance to families and certain individuals with low incomes. The federal government sets broad guidelines for the Medicaid program, but each state determines its own eligibility standards, scope of services, and payment rates.

Key Medicaid Information

- Because the program covers low-income individuals, Medicaid recipients typically have nominal, if any, copayments for services.
- Prescription drugs are not a required Medicaid benefit but are covered under most programs. Medicaid beneficiaries who also have Medicare, dual eligibles, receive their drugs through Medicare Part D.
- For dual eligibles, Medicare is the primary insurer and should be billed first.
- Medicaid reimbursement rates are typically significantly lower than usual and customary fees, and are often lower than managed care and Medicare fees.
- Due to the extreme variance inherent in the program structure, specific questions about program services and fees should be directed to the Medical Assistance office in your state.

40A

HOW TO APPEAL DECISIONS BY MEDICARE CARRIERS AND

Under Medicare Part B, if you are denied payment for services you have provided to a Medicare beneficiary, or are not paid the full amount you believe you're entitled to, there is currently a very specific five-level appeals process established for you to follow.

The Carrier Redetermination

Within 120 days after the issuance of a Medicare claims decision that you feel is incorrect, you may request a **redetermination** of the decision that was made. Your written request should be sent to the Medicare Carrier or Medicare Administrative Contractor (MAC) whose decision you are contesting. A request for a redetermination must be in writing. The most convenient way to do this is by using a Medicare Redetermination Request Form (Form CMS-20027), which can be accessed online at <http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf> or can be obtained from the APA's Office of Healthcare Systems and Financing by calling the Managed Care Help Line at 800-343-4671. Be sure to include your NPI number on the request form even though there is not a specific space for this. We suggest putting it on the line with your name. The form states that if you have evidence to submit it should be attached to the form. This means that any documentation you have supporting the claim should be copied and included with the form. You should receive the Medicare Redetermination Notice (MRN) within 60 days of your request.

If the decision you receive is unacceptable, you can move on to the next level of the appeals process. The MRN, which informs you of the Carrier or MAC's decision, should also provide instructions on how to access the next level of appeal, reconsideration by a Qualified Independent Contractor (QIC). There are four QICs serving four geographical regions. The MRN will tell you which QIC serves your locale.

It is important to note that many Carrier/MAC decisions are overturned at subsequent levels of appeal.

Reconsideration by a Qualified Independent Contractor (QIC)

After you receive notice of the Carrier/MAC redetermination you have 180 days to request the next level of appeal, the **reconsideration by the QIC**. This request can be submitted to the appropriate QIC using a Medicare Reconsideration Request Form (Form CMS-20033), which can be found on the CMS website at <http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf>, but you should also send a letter that explains in detail why you disagree with the redetermination decision the carrier made, provides a chronology of the patient's care (referring to where documentation is in the patient records you provided), and essentially makes your case that the redetermination should be reversed.

You will also need to include any evidence/documentation the redetermination stated was missing as well as any other documentation you feel will help your case. The MRN you received with the denial of your redetermination will indicate where you should send the request to continue the appeals process. The QIC should send its decision to you within 60 days of receiving your request for reconsideration. If the decision is not favorable it will contain detailed information on the next level of appeal, the Administrative Law Judge (ALJ) Hearing. If the QIC is not able to make its decision in a timely manner, it will also inform you of your right to go on to the ALJ level. However, there must be at least \$110 in controversy for the appeal to be eligible for an ALJ Hearing. (This amount may be adjusted in future years. You can check with the APA's Managed Care Help Line for the amount when you make your appeal, 800-343-4671.) If there is less money involved, the appeal process ends at the QIC level.

The Administrative Law Judge (ALJ) Hearing

Within sixty days after your receipt of the notice of the QIC decision, if there is at least \$110 in question, you can file a written request for an ALJ Hearing, using the instructions sent to you with that decision. There is a form that can be used to make this request, CMS-20034 A/B, which can be accessed at <http://www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf>.

When filing for an ALJ Hearing, two or more physicians may aggregate claims to meet the dollar requirement if they involve the delivery of similar or related services to the same beneficiary or if the claims involve common issues of law and fact with respect to services provided to two or more beneficiaries. The only other stipulation is that all of these claims must have been subject to a Hearing Officer decision within sixty days of the ALJ Hearing request.

ALJ hearings are usually held via video-teleconference or by telephone. You may request an in-person hearing if you can establish good cause as to why the other methods won't do. If you wish, you may ask the ALJ to make a decision without a hearing—just on the basis of the written record.

ALJs are expected to issue decisions within ninety days of receiving the hearing request for standard appeals. However, the requirement for an in-person hearing or the need for more evidence may delay this. As with the previous levels of appeal, the ALJ Hearing decision is binding on all parties unless there are further appeals or revisions of the decision.

Further Appeals

There are two levels of appeal beyond the ALJ Hearing, the Medicare Appeals Council Review and the Federal District Court Hearing. The requirements for these appeals are complex and stringent, and you should consult with a

healthcare lawyer or a practice consultant before considering going on to these levels of appeal.

Note: If you receive a notice from your Medicare Carrier or Administrative Contractor stating that you owe Medicare money because of a postpayment review it was determined the claim should not have been paid, you have a right to appeal that just as you would appeal a claim that is initially denied. Medicare cannot recoup the money they request while the appeal is in process, but should you lose, you will have to pay the amount owed as well as the interest that has accrued on the owed amount during the course of the appeal.

40B

COMPLIANCE PROGRAMS

In October of 2000, the Office of Inspector General (OIG) of the Department of Health and Human Services, published its Compliance Program Guidance for Individual and Small Group Physician Practices, and this guidance is still in effect. The OIG is the office within the Centers for Medicare and Medicaid Services (CMS) that conducts audits of Medicare and Medicaid programs.

While the OIG's guidance acknowledges that compliance programs are not compulsory and takes into account the fact that many smaller practices will not have sufficient financial or staffing resources to implement a full-scale program it describes, it is wise for all physicians to at least make an effort to integrate some of the elements it sets forth into the administration of their practices. Any practice in which Medicare billings are moderate or greater will benefit from acting on at least some of the OIG's suggested measures to better assure compliance with the rules and regulations of the Medicare program.

Having a compliance program in effect should make it far less likely that you will run into trouble if you are audited by your Medicare Carrier or Medicare Administrative Contractor. If an audit should find something improper, the fact that you have a compliance program in place, which shows that you are genuinely trying to do the right thing, can serve as a mitigating factor in how you will be dealt with.

Physicians are likely to have to deal with "compliance" in some form or another within their practices for the next several years -- if only because Medicare audits have proved to be so successful in reducing improper payments. Inevitably, there will also be a spillover into the private sector in areas such as credentialing and private insurance billing. The first step we recommend is for you to become familiar with the elements of the OIG's compliance program, as given here, and to then assess whether or not it is feasible for you to implement one or more of the components of a compliance program in your practice.

AN OVERVIEW OF THE OIG'S GUIDANCE

The program guidance provides the OIG's views on the fundamental components of physician practice compliance programs, as well as the principles to consider when developing and implementing such a program. Though the guidance presents basic procedural and structural information, it also states that "there is no 'one size fits all' compliance program." Emphasis is placed on the notion that a compliance program must be "living and breathing" and an active part of day-to-day operations, and that it must be woven into the practice's culture to achieve maximum benefit.

According to the OIG, the benefits of a voluntary compliance program may include: enhancement of patient care due to improved accuracy of documentation; improvement of

claim processing and payment; reduction of billing mistakes; reduction of the likelihood of a CMS or OIG audit; and avoidance of conflicts with self-referral and anti-kickback statutes. Having a compliance program sends a message to employees that they have an affirmative duty to come forward and report any erroneous or fraudulent conduct so that it may be corrected. The underlying, fundamental principle driving the OIG's compliance guidance is that all healthcare providers have a duty to reasonably ensure "that claims submitted to Medicare and other federal health care programs are true and accurate." Although your compliance program's focus should be on claims submitted to federal healthcare programs, it will also assist you with private payer claims.

The OIG guidelines describe seven basic components of a voluntary compliance program, but acknowledge that full implementation of all components may not be feasible for all practices. As a starting point, a practice may adopt only the components deemed necessary based on its specific history with billing problems or other compliance issues. The adoption of other components will depend on the size and resources of a practice. To minimize costs, the OIG encourages practices to participate in other provider compliance programs such as those available through hospitals, physician practice management companies, etc. A small practice could also collaborate with other practices, enabling them to conduct training and education programs based on the policies and procedures mandated by Medicare that would not be possible for a practice working alone.

THE SEVEN BASIC COMPONENTS OF A COMPLIANCE PROGRAM

1. CONDUCTING INTERNAL MONITORING AND AUDITING

There are two types of audits. One involves a review of the "practice's standards and procedures to determine if they are current and complete." The second is a claims submission audit in which bills and medical records are reviewed for compliance with coding, billing, and documentation requirements. The practice can determine whether to review retrospectively or concurrently and who should conduct the audit. After the initial audit, periodic audits should be conducted no less than once per year. There is no set formula on how many records should be reviewed. The suggestion is to do five or more per federal payer or five to ten per physician. Responding appropriately to any problem discovered during one of these audits is key. Circumstances may merit the refund of an overpayment, conferring with a coding billing expert, etc. It is extremely important to document identification of a problem and its ultimate resolution.

2. IMPLEMENTING COMPLIANCE AND PRACTICE STANDARDS THROUGH WRITTEN STANDARDS AND PROCEDURES

After the internal audit identifies risk areas, the next step is to develop a method for dealing with those risk areas through the development of written standards and procedures. Many practices have something similar called "practice standards," and other practices have adopted the standards and procedures of third parties where appropriate. If your practice

has no standards and procedures in place, you can develop your own written standards and procedures manual and update clinical forms periodically. Another possibility is to create a resource manual from publicly available information such as relevant CMS (or HCFA, for documents published prior to June 14, 2001) directives, carrier bulletins, etc.

Specific risk areas for coding and billing that psychiatrists need to be aware of are: billing for services not provided as claimed; submitting claims for services that are not reasonable and necessary; double billing resulting in duplicate payment; billing for noncovered services as if covered; knowing misuse of provider identification numbers; unbundling; failure to properly use coding modifiers; clustering; and, upcoding. Your practice should be able to provide documentation to support appropriateness (reasonable and necessary) of services provided. As for documentation risk areas, one of the most important compliance issues is the appropriate documentation of diagnosis and treatment. In that regard, the medical record: may be used to validate site of service, appropriateness of services, accuracy of billing, and identity of a care giver; must be complete and legible; and must document each patient encountered, reason for the encounter, relevant history, physical exam findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan of care, and date and identity of observer. CPT and ICD-9-CM codes must be supported by documentation, and the medical record and health risk factors must be referenced; the patient's progress, his or her response to and changes in treatment, and any revision in diagnosis must also be documented. As on the HCFA 1500 Form, the diagnosis code must be linked with the reason for the visit or service; modifiers must be appropriate; and Medicare must be provided with all information regarding other insurance coverage.

The practice's standards and procedures should also address any improper inducements, kickbacks, and self-referrals. The standards and procedures should provide, for example, that all business relationships where the practice refers or receives services are based on fair market value. If the practice intends to enter into a business relationship that involves making referrals, such arrangements should be reviewed by legal counsel. The practice should be careful not to offer inducements to patients such as waiver of co-pays, deductibles, etc.

Standards and procedures concerning the retention of records are also important. There should be a section on retention of compliance, business, and medical records. Record retention policies should specify the length of time various records are to be retained; how medical records should be secured against loss, unauthorized access, etc.; and the direct disposition of medical records in the event that practice is sold or closed.

3. DESIGNATING A COMPLIANCE OFFICER AND/OR OTHER CONTACTS TO MONITOR COMPLIANCE EFFORTS AND ENFORCE PRACTICE STANDARDS.

Once audits are complete, an individual needs to be designated to develop a corrective action plan, if necessary, and oversee adherence to the plan. If this role is outsourced, the compliance officer must have sufficient interaction with the practice to be able to

understand its inner workings. Suggested duties of compliance officers include: overseeing and monitoring the compliance program; establishing methods to improve practice efficiencies and reduce vulnerability to fraud and abuse; periodically revising the program in light of changes in the law; ensuring that compliance materials and training are up to date and appropriate; ensuring that all employees, contractors, and partners are checked against the OIG's List of Excluded Individuals and Entities; and investigating any report or allegation concerning unethical or improper conduct.

4. CONDUCTING APPROPRIATE TRAINING AND EDUCATION

The OIG guidance lists three steps for establishing educational objectives: 1.) determine who needs training; 2.) determine the type of training needed; and 3.) determine when and how often the training is needed. Items that should be part of a training program include: the importance of the compliance program and how it works; the consequences of violating its standards; and the role of the employee in the compliance program. The goal is that all employees will receive training and that each employee will understand that compliance is a condition of employment. As for coding and billing training, this will be necessary for certain members of the staff, depending on their responsibilities. Some examples of items that could be covered in coding and billing training include: coding requirements; claim development and the submission process; proper documentation of services rendered; proper billing standards and procedures; and legal sanctions for submitting false or reckless billings. The training program may be conducted by an inside or outside source. It may be through a community college and/or professional association, carrier, third party billing company, or other entity. It is advisable for the practice to maintain updated ICD-9, HCPCS and CPT manuals

There is no set formula for training, but at least annual training is recommended.

5. RESPONDING APPROPRIATELY TO DETECTED VIOLATIONS THROUGH INVESTIGATION OF ALLEGATIONS AND DISCLOSURE OF INCIDENTS TO APPROPRIATE GOVERNMENT ENTITIES.

Any allegations of wrongdoing must be investigated to determine whether a violation of the law has occurred. If a violation has occurred, the practice must take decisive steps to correct the problem. This may involve a corrective action plan; the return of any overpayments; a report to the government; or, if necessary, referral to law enforcement authorities.

6. DEVELOPING AN OPEN LINE OF COMMUNICATION WITHIN STAFF

The OIG suggests that in a small practice the communication element of the compliance program can be met with a clear, "open door" policy between physicians, compliance personnel, and other employees. The office compliance program should require that employees report any conduct that a reasonable person would believe to be erroneous or

fraudulent; should create a user-friendly anonymous means for reporting, such as a drop box or hot line; should specify in the written standards and procedures that failure to report errors or fraud is a violation of the program; should develop simple and readily accessible procedures for followup; should establish a procedure for communicating to the billing company, if one is used, regarding areas of concern; should maintain the anonymity of persons involved in reporting; and should ensure that there is no retribution for good faith reporting.

7. ENFORCING DISCIPLINARY STANDARDS THROUGH WELL PUBLICIZED GUIDELINES

Last, but not least, a practice's compliance program should include procedures for disciplining individuals who violate compliance or other practice standards. Such disciplinary actions can include warnings, reprimands, probation, demotion, temporary suspension, termination, restitution of damages, and, of course, referral for criminal prosecution.

CONCLUSION

Take a hard look at the OIG's seven recommendations and then decide whether or not to implement one or more of them into your practice. You may already have some of the components in place, albeit under other names. You may be able to weave other components into your practice without much burden. What is important is that any effort to implement compliance measures must be genuine, and sufficient time and attention must be invested to make them work. Compliance endeavors do confer a net benefit on a practice -- and individual physicians are well advised to consider the efforts they can reasonably undertake to make compliance a more viable, active component of their practice.

41

FRAUD AND ABUSE

When Medicare first came into being in 1965 there was only a general prohibition in the Social Security Act against making false statements in applications for benefits. Since then, due to reports that healthcare providers were routinely abusing both the Medicare and Medicaid programs and an estimate by the General Accounting Office that as much as 10% of the cost of healthcare in the United States was going to reimburse fraudulent claims, the laws pertaining to Medicaid and Medicare fraud and abuse have multiplied and become increasingly specific, and enforcement has increased as well. Today it is vital that every physician be aware of the laws governing the concepts of fraud and abuse and know how to avoid even the appearance of being in conflict with them.

DEFINITIONS

Fraud

Fraud is defined as “knowingly or willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain by means of false and fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody of or control of any healthcare benefit program.”

The types of activities currently governed by federal law on healthcare fraud are:

- False claims and other fraudulent billing practices;
- Illegal referrals under the Medicare/Medicaid antikickback statute; and
- Physician self-referral practices proscribed by the Stark legislation

Abuse

Abuse is defined as unintentionally following practices that violate the guidelines of the Medicare or Medicaid programs, which may directly or indirectly result in unnecessary costs to the program. If the abuse persists after a practitioner has been warned, the abuse may come to be considered fraud.

FALSE CLAIMS AND FRAUDULENT BILLING PRACTICES

Under the current statutes, false claims and billing practices include billing for services that were known to be medically unnecessary, or were not rendered at all; consistently using CPT codes that describe more extensive services than those that were actually provided; falsifying information on applications, medical records, or billing statements; and consistently failing to collect coinsurance

payments in order to induce beneficiaries to use your services. You are expected to know the rules and to abide by them.

In fact, if a claim is returned for coding corrections, this officially constitutes a warning that abuse is being committed. If claims continue to be filed with coding errors, those errors may be considered fraud (a felony) rather than abuse since a warning had been issued when your claims were returned for correction.

ILLEGAL REFERRALS UNDER THE ANTI-KICKBACK STATUTE

The issues of illegal referrals and kickbacks were first dealt with in the 1989 Ethics in Patient Referrals Act, known fondly as Stark I. In 1993 the law was expanded to cover more healthcare services under what is known as Stark II. Because of this anti-kickback statute, many arrangements between healthcare providers that would have previously been considered ordinary (i.e., joint ventures, discounts on goods and services, space and equipment leases) now must be evaluated to be certain they don't violate the law. Although there are some exceptions defined within the law itself, basically, anyone who solicits or receives any remuneration for a referral or for the purchase of goods that are covered by a federal healthcare program can be found guilty of violating the anti-kickback statute. Violations can result in both criminal penalties and civil sanctions, including imprisonment, fines, and exclusion from federal healthcare programs.

SELF-REFERRAL PRACTICES

Under Stark, doctors are also forbidden to refer patients to any facility in which they or any members of their immediate families have financial interests. The AMA has published recommendations on the issue of self-referrals as an ethical issue as well. The AMA recommendations state that physicians should not refer to a facility at which they do not directly provide care or services when they have a financial interest in that facility. However, they make an exception for cases where there is a demonstrated need in the community for the facility and there is no alternative financing available.

ENFORCEMENT

The federal government has put into law several mechanisms for policing fraud and abuse: 1.) the Fraud and Abuse Control Program, a joint project of the Health and Human Services (HHS) Office of the Inspector General (OIG) and the Department of Justice; 2.) the Health Care Fraud and Abuse Control Account, which provides funds for the administration of healthcare fraud and abuse control

programs; 3.) the Medicare Integrity Program, which authorizes HHS to contract with private organizations to review the activities of healthcare professionals and entities who receive federal payments for their services, and generally set standards for Medicare and provide investigative, enforcement, and educational assistance to HHS; and 4.) the Beneficiary Incentive Program, which establishes a bounty system to encourage individuals to turn in information on any healthcare professionals or entities they suspect of committing fraud and abuse. A central database to record final adverse actions against healthcare professionals, providers, and suppliers has also been established under the Health Care Fraud and Abuse Data Collection Program.

41A

HIPAA

(Health Insurance Portability and Accountability Act of 1996)

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed to address concerns arising from the increasing complexity of the medical delivery system and the increasing dependence of that system on electronic communications. Although many states already had laws in place protecting patient privacy, it was felt there should be a federal standard that would establish a minimum level of protection. In cases where state laws are more stringent than HIPAA in protecting patients' records and their access to them, those state laws take precedence over HIPAA.

HIPAA mandates that the federal Department of Health and Human Services (HHS) develop rules covering the transmission and confidentiality of individually identifiable health information, with which all entities covered under HIPAA (see box below) must comply.

The first two rules finalized under HIPAA were the Transactions Rule and the Privacy Rule. The Transactions Rule is meant to facilitate the ability to transfer health information accurately and efficiently, and the Privacy Rule was created to protect the confidentiality of patient information. The third rule that has been finalized is the Security Rule, which was created to protect the confidentiality of patient records kept on computers.

The underlying premise of Privacy Rule is that a patient's individually identifiable health information belongs to the patient, and that the patient has the right to access that information (except in the case of psychotherapy notes, which would seem to be designated as the property of the psychotherapist who created them--see below) and to control what is done with it.

Under the Transactions Rule, the Department of Health and Human Services (HHS) has created regulations that establish a uniform set of formats, code-sets, and data requirements that will permit the efficient, easily transferable, and secure electronic exchange of information for all healthcare administrative and financial transactions. The agency that administers the Medicare program, the Centers for Medicare and Medicaid Services (CMS), has been charged with overseeing the implementation of the Transactions Rule. The Privacy Rule is administered by the Office for Civil Rights (OCR) at HHS.

The Security Rule can be seen as an extension of the privacy rule, it requires that HIPAA-covered entities "protect against any reasonably anticipated threats

or hazards to the security or integrity of protected health information, and protect against any reasonably anticipated uses and disclosures not permitted by the Privacy Rule and other more stringent laws.”

Introduction

Following the publication of the Transactions Rule (Standards for Electronic Transactions) and the Privacy Rule (Standards of Privacy for Individually Identifiable Health Information), both of which fall under the Administrative Simplification part of HIPAA, there was a great deal of concern about how compliance with these rules would affect the day-to-day practice of psychiatry.

In point of fact, compliance with HIPAA should not have proven all that difficult for psychiatrists. Those who see patients under the Medicare program were already using the code-sets required by the Transactions Rule. And psychiatrists, who have always been aware of the absolute necessity for maintaining the confidentiality of their patient information, were very likely to already have in place the confidentiality safeguards required by HIPAA.

Although HIPAA is a very complex law, the steps a psychiatric practice must take to comply with its two current rules are all eminently doable and should not require excessive retooling of a practice that is already functioning properly.

Note: If your office does not participate in *any* electronic transactions and you do not have any business associates who participate in any electronic transactions on your behalf, you are not covered under HIPAA and are not required to comply with its rules. You should know, however, that if your practice has ten or more full-time employees (or the equivalent of ten full-time employees) you are required to file Medicare claims electronically unless you can establish that you have no means of doing so, which means you will have to be covered by HIPAA. Also, even though you may not be covered by HIPAA, you are still bound by the rules of your state concerning the privacy and transmission of patient information.

The Transactions Rule

The Transactions Rule defines standards and establishes code-sets and forms to be used for electronic transactions that involve the following kinds of healthcare information:

1. Claims or Equivalent Encounter Information

2. Eligibility Inquiries
3. Referral Certification and Authorization
4. Claims Status Inquiries
5. Enrollment and Disenrollment Information
6. Payment and Remittance Advice
7. Health Plan Premium Payments
8. Coordination of Benefits

The rule also requires the use of employer and provider identification numbers. The National Provider Identifier (NPI) became available in 2006, and is supposed to have replaced all other provider identifiers, including the UPIN previously issued by Medicare. (Despite this, it should be noted that Medicare still asks for a legacy number (the UPIN, now referred to as the PTAN) for identification purposes when providers call in for assistance on provider assistance lines.)

The Transactions Rule code-sets replaced the approximately four hundred different formats that had been in use for healthcare claims processing. The code-sets required under the Transactions Rule are:

- **Procedure Codes:** AMA CPT (Current Procedural Terminology) and HCPCs (Healthcare Common Procedure Coding System) codes
- **Diagnosis Codes:** ICD-9 CM (International Classification of Diseases, 9th Revision, Clinical Modification) codes [**note:** When the ICD-10 is approved for use in the United States its codes will coincide with the codes in the DSM-IV and V, but until then a crosswalk will be necessary for a few codes that are not yet in sync.]
- **Drugs and Biologicals:** NDCs (National Drug Codes)
- **Dental Codes:** Code on Dental Procedures and Nomenclature for Dental Services

The Privacy Rule

The Privacy Rule went into effect on April 14, 2003. It is good to note here that psychiatrists who had been practicing according to the privacy standards recommended by Professional Risk Management Services, manager of the APA-endorsed Psychiatrists' Professional Liability Insurance Program, were already doing just about everything demanded by the Privacy Rule.

The Privacy Rule was enacted to address public concerns that the increased use of electronic technology and changes in the way healthcare is delivered were undermining the confidentiality of the individually identifiable health information maintained and shared by physicians, health plans, and the other entities involved in patient care (however peripherally). The Privacy Rule establishes a federal floor of standards for the use and disclosure of patient information. Many states had already passed legislation to deal with this issue, and in cases where

the state law is more stringently protective of patients' rights, the state laws take precedence over the federal Privacy Rule. Contact your state medical society to find out whether there are state laws that preempt HIPAA in your jurisdiction.

Patients' Rights

Under the Privacy Rule your patients have statutory rights regarding their individually identifiable health information:

- You must give your patients written notice of their privacy rights and the privacy policies of your practice, how you will use, keep, and disclose their health information; and you must make a good faith effort to obtain your patients' written acknowledgment that they have seen this notice.
- Patients must be able to get copies of their medical records and request amendments to those records within a stated time frame (usually 30 days). Patients do not have the right to see psychotherapy notes (see below for definition).
- Upon request, you must provide your patients with a history of most disclosures of their medical records (there are some exceptions)
- You must obtain your patients' specific authorization for disclosures of their information other than for treatment, payment, and healthcare operations (these three are considered to be "routine" uses). [note: Although HIPAA does not require that you obtain your patients' consent before disclosing their health information for treatment, payment, and healthcare operations, psychiatric ethics demand that you obtain written consent for these releases as well.]
- Patients may request alternative means of communication of their protected information, i.e., they may ask that you only contact them at a specific address or phone number.
- You generally cannot condition treatment of patients on obtaining their authorization for disclosure of their information for nonroutine uses
- Your patients are authorized to complain about violations of the Privacy Rule to you, their health plan, or to the Secretary of HHS

Psychotherapy Notes

The writers of the Privacy Rule acknowledged that psychotherapy notes should be subject to a more stringent standard of confidentiality than other medical records. Psychotherapy notes are the only part of their files patients do not have access to. According to the rule, *psychotherapy notes* are specifically defined as the notes taken by a psychotherapist "documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record." Essentially, psychotherapy notes are the notations kept during therapy sessions that deal with the patient's personal life and the psychiatrist's reactions, rather than with the patient's disorder. It is vital to understand that

psychotherapy notes must be kept separate from the rest of the medical record (i.e., on a different sheet of paper) if they are to be protected as a separate entity. If psychotherapy notes cannot be separated from the rest of a patient's record, then they must be released with the rest of the record.

It is important to be clear about the definition of psychotherapy notes under HIPAA. Psychotherapy notes do **not** include references to medication prescribing and monitoring; session start and stop times; modality and frequency of treatment furnished; results of clinical tests; or any summary of the following items: diagnosis, symptoms, functional status; treatment plan; progress to date; and prognosis. All of this information is part of the medical record.

Minimum Necessary

The concept of minimum necessary disclosure is the rule for all routine disclosures of patients' individually identifiable information under HIPAA. However, when a patient gives authorization for a specific nonroutine disclosure, minimum necessary does not apply.

What a Physician's Office Must Do to Comply with the Privacy Rule

To be in compliance with HIPAA, every practice must:

- Have written privacy procedures that include administrative, physical, and technical safeguards establishing who has access to individually identifiable patient information, how this information is used within the practice, and when the information will and will not be disclosed to others.
- Ensure its business associates protect the privacy of health information.
- Train employees to comply with the Privacy Rule
- Designate a person to serve as a privacy officer (this can be the psychiatrist if you are in a solo practice)
- Establish grievance procedures for patients who wish to inquire or complain about the privacy of their records.

The Security Rule

According to the Professional Risk Management Services, the Security Rule's requirements may be viewed as a standard for the protection of electronic health information, which all providers, even those not covered by HIPAA can be expected to meet or exceed. The Security Rule does not set forth any specific technology to be used to protect electronically maintained health information, it rather demands that protections be in place against *reasonably anticipated*, breaches of security. Most commercially available electronic health record systems should enable compliance with the HIPAA Security Rule

For HIPAA updates, check the APA's website, www.psych.org .

42

ERISA

If your practice includes patients covered by managed care plans or other private, employer-sponsored insurance, you should be aware of ERISA, the Employment Retirement Income Security Act, and its effect on these plans.

ERISA was passed by Congress in 1974 in an effort to protect employees covered by self-funded plans. Self-funded plans are pension and healthcare plans in which an employer pays directly for employee benefits rather than purchasing an insurance policy and paying premiums. The intent of ERISA was to protect workers if their employer, for whatever reason, failed to provide them with benefits to which they were entitled. Although ERISA is primarily concerned with pensions, it also deals with health benefits, and this is why you need to be aware of it

PROCESS AND DISCLOSURE

The main focus of the ERISA regulations is on process and assurance that benefit plans follow correct procedures. Of primary importance to psychiatrists are the disclosure provisions. ERISA contains extensive requirements about how, what, and when plans must provide information to beneficiaries. This includes information on plan provisions, covered services, and appeals procedures. ERISA sets uniform, minimum standards to ensure that employee benefit plans are established and maintained in a fair and financially sound manner. In terms of health benefits, the law contains little substantive information.

ERISA VIOLATIONS

As noted above, ERISA focuses primarily on process and consequently contains no specific information on issues such as pre-existing conditions, universal coverage, portability, or managed care. If you believe that the insurance company administering a patient's plan is withholding information from the patient in terms of reasons for denial or procedures to appeal or is denying access to covered benefits, this may be a violation of ERISA regulations. In such a situation, you should appeal the denial and ask for evidence that the plan is complying with ERISA. You can also make your concerns known to the plan administrator, usually the employer. In particularly egregious cases, you may want to consult an attorney who specializes in ERISA.

PREEMPTION OF STATE LAW

As a federal statute, ERISA preempts state law in certain areas (e.g., parity). There is currently controversy over the extent to which this preemption applies in terms of malpractice claims filed against insurance plans, as opposed to malpractice claims filed against plan physicians.

Efforts are underway by the APA, the American Medical Association, and other concerned groups to close the loopholes in ERISA, which currently protect insurance companies and managed care organizations at the expense of patients. These efforts include legal action, as well as lobbying Congress to change the law. This process takes time, however, and it may be several years before significant changes are made to the ERISA regulations. Due to the extremely complex nature of the regulation, you should consult an attorney who specializes in ERISA for assistance with specific questions.

AN OVERVIEW OF ANTITRUST LAWS AFFECTING PHYSICIANS

From a legal perspective, the sale of medical services by physicians is considered to be the same as the sale of any other service or product in the marketplace. All of the factors that affect other businesses are involved: seller-buyer relationships, supply and demand economics, bargaining, volume discounts, competition, and rivalry. In the economy of the United States, the linchpin of these market factors is competition. It is believed that a reduction in competition will give rise to monopolies and other anticompetitive entities that can erode the natural ebb and flow of market forces and may, among other things, impose high prices and low quality on consumers.

It was because of the anticonsumer effects of monopolization during the late nineteenth century that legislators originally enacted the Sherman Antitrust Act (1890) to preserve competition. The Clayton Act was passed in 1914 to give Congress more ability to enforce the Sherman Act. Over the past thirty years it seems that physicians have been affected more by these laws, originally passed to curb the activities of the early industrialists, than any other professionals in the country. The peer review process, hospital privileges, a hospital's exclusive contract with a single group of physicians, joint pricing, managed care contracts, and practice mergers are some of the areas to which antitrust laws may apply.

Different antitrust laws address the varieties of anticompetitive conduct. The most common of the laws that affect physicians is the grandfather of antitrust law, the Sherman Act. The Sherman Act has two sections: Section 1, which prohibits conspiracies to reduce competition and Section 2, which prohibits monopolization and attempted monopolization by one or more parties.

CONSPIRACIES TO REDUCE COMPETITION **Sherman Act, Section 1**

A conspiracy is defined by law as a concerted action by two or more persons to commit an unlawful act, or a lawful act that becomes unlawful if committed by concerted action. For example, the activities listed below are not unlawful if committed by an individual physician, but become illegal when two or more physicians agree to such conduct. It should be noted that some of the violations under Section 1, such as price-fixing can be prosecuted criminally.

Price-Fixing

Any discussion between two or more independent physicians about fee-related matters may be labeled as price-fixing and as such can be criminally prosecuted. Price-fixing may include, for example, two or more physicians collectively setting minimum or maximum fees and copayments for patients covered by a health plan. Individual practitioners or corporations, however, are generally free to set

any charges they wish when acting alone. It should be noted that joint pricing by independent physicians is allowed under certain conditions: if the physicians are part of a single corporation, members of an Independent Practice Association (IPA), or Physician-Hospital Organization (PHO); and are in compliance with Department of Justice guidelines.

Market Allocation

It is considered illegal if individual physicians agree to divide up therapeutic or geographic territory, i.e., if the psychiatrists in a town agree in advance that Dr. Brown will see all the bipolar patients, Dr. Green will see all borderline patients, and that Dr. Black will see all patients with eating disorders; or if they agree that Dr. Brown will see all patients residing in the northeast quadrant of the town, Dr. Green patients from the northwest, and Dr. Black patients from the south part of town. However, if these three psychiatrists enter into a joint venture, they can then allocate the market as they wish to, so long as they are not perceived as having undue market power.

Concerted Boycott

While a single business (or independent physician) is free to refuse to deal with anyone it chooses, if two or more competitors agree to boycott a third party, that may be considered a concerted boycott, and hence would be illegal under the Sherman Act. For physicians this means that although an individual doctor is free to accept or reject the fees and other terms offered by a managed care organization, if two or more doctors get together and decide they will only deal with an MCO if certain terms are met, that may be considered an illegal boycott.

Exclusive Dealings

Doctors are often denied privileges by a hospital because it has an exclusive contract with another physician or group of physicians. In the antitrust cases filed by physicians, based on this section of the Sherman Act, alleging that other physicians and hospitals are conspiring to restrain trade through “exclusive dealings,” courts have generally ruled that such conduct is not unlawful if the hospital does not have market power and has a good business reason for its exclusive contract. Hospitals usually cite numerous efficiencies and economic reasons to support their exclusive dealing arrangements.

Tying Arrangements

A tying arrangement is defined as a situation where a seller sells a product (tying product) or service on the condition that the buyer also purchases a different product (tied product). For example, a hospital will provide surgical services to patients, but only if the patients agree to pay for the anesthesiology services, which the hospital provides through a contractor with which the hospital has an exclusive arrangement. Courts require two conditions for such conduct to be unlawful under the antitrust laws: 1.) the seller (hospital) has the market power, and 2.) the customer is “coerced” into purchasing the tied product. Note,

however, that some courts have clearly distinguished coercion from aggressive marketing and persuasion.

MONOPOLIZATION

Sherman Act, Section 2

It may be perfectly legal for a business, or physician, to have a monopoly, provided the monopoly has not resulted from curbing competition. Anyone who challenges a monopoly or attempted monopolization must show that the defendants have sufficient market power to raise prices and exclude competition. For physicians, monopolization claims arise in some of the following areas.

Staff Privileges

Physicians who lose their hospital privileges as the result of a negative finding in the peer review process often claim that the reviewing physicians recommended an adverse action against them, not for quality-of-care reasons, but because the reviewers compete in a specialty that the reviewers wish to monopolize. Such claims are also filed under Section 1 of the Sherman Act if more than one party is involved in the alleged conduct.

Essential Facility

Courts generally recognize a claim for access to an essential facility if the use of that facility is indispensable to the person in need of it. When physicians are denied privileges at a hospital, they sometimes file antitrust lawsuits under Section 2, claiming that access to the given hospital is essential for the practice of their profession and that the hospital has denied them access because it wants to monopolize the medical services in that market. These cases have not often been successful, mainly because courts, as a matter of public policy, have usually refused to force hospitals to grant privileges to physicians.

Buyers' Market Power

In various healthcare markets, buyers of hospital and physician services, such as large health insurance companies or MCOs, often exercise their market power in the purchase of these services for their subscribers. These insurers and MCOs have become a major concern for physicians in recent years as they've become larger and larger. Doctors claim they have been forced to sell their services to these powerful buyers at extremely low or below-cost prices. Unfortunately, courts have generally ruled that hard bargaining does not violate antitrust laws unless there are other issues involved that may restrain trade and reduce competition.

PRACTICE MERGERS

Clayton Act, Section 7

When big businesses merge, the government's major concern is whether such a merger will cause a reduction in competition, which may, in turn, enable the

merging entities to raise prices. Although medical practices are not generally considered to be big businesses, a merger of two large practices in a small town could have the effect of limiting the choices of patients and health plans in their purchase of healthcare services. Because managed care is causing unprecedented expansion and mergers of physician practices, the antitrust law enforcement agencies have become very diligent in monitoring and analyzing the effects of practice mergers on competition, and have, in fact, blocked many practice mergers. Section 7 of the Clayton Act is usually the statute used to challenge a merger that may result in a substantial reduction of competition.

TYPES OF VIOLATIONS

Legally, there are two types of antitrust violations. When an antitrust case is filed, the first step in the court's analysis is to determine which type of violation is being alleged.

Per Se

There are certain types of conduct that are automatically considered to be so detrimental to the market that they are seen as being without possible redeeming merit. For example, it is believed that price-fixing or market allocation simply cannot benefit society in the long run. These are known as **per se** violations, since they are considered to be inherently antisocial. Courts generally do not allow any defense in justification of these behaviors.

Rule of Reason

In the other category of violations, the facts of the case are analyzed under the **rule of reason**, in which the courts allow defendants to present evidence that justifies their conduct. If the reasons presented can be deemed to be procompetitive and/or the challenged conduct is likely to bring efficiency to the market and improve the lot of consumers, the courts may exonerate the defendants.

STANDING TO SUE UNDER THE ANTITRUST LAWS

Besides federal antitrust laws like the Sherman and Clayton Acts discussed above, there are a variety of antitrust laws that have been enacted by the various states.

Federal antitrust laws are enforced by the Department of Justice and the Federal Trade Commission (FTC). State antitrust laws are enforced by the state attorney generals. Besides this government enforcement, private parties who are directly affected by a violation of antitrust laws also have a right to sue. Plaintiffs must be able to prove a direct injury caused by the alleged violations, or ask for an injunction to stop certain conduct of the defendants or to require them to do certain acts. Not surprisingly, antitrust cases are extremely complex, expensive, and time consuming.

THE NATIONAL PRACTITIONER DATA BANK

The National Practitioner Data Bank (NPDB) was established as part of the Health Care Quality Improvement Act of 1986 as an information clearinghouse to collect and release certain information related to the professional competence and conduct of physicians, dentists, and, in some cases, other healthcare practitioners. There was concern on the part of Congress that incompetent healthcare providers could move from state to state without anyone ever knowing of a previous damaging or incompetent performance, and that this undermined the quality of healthcare in the United States. The NPDB is intended to remedy this problem.

The National Practitioner Data Bank defines itself as a flagging system, intended to alert those who review professional credentials that there may be something to look into on the basis of information that it has on file. The NPDB makes it clear in its literature that the information it has is not intended to be used as the sole basis for making decisions about credentialing, but is meant to indicate that there may be cause to undertake an in-depth look into a practitioner's past work. Access to the data bank is limited, and all information obtained from it is considered confidential, with considerable fines levied should this confidentiality be breached.

WHAT IS REPORTED TO THE NPDB

Medical Malpractice Payments

As it stands now, all malpractice payers (be they insurers or facilities) are required to report to the NPDB about any payments they make. Reports of payments must be submitted regardless of how the matter was settled. This means that if your insurer chooses to settle a case because it will cost them less to settle than to fight-- even though you were not really at fault-- the malpractice payment is registered against your name (see Chapter 4).

Adverse Licensure Actions

State medical boards must report certain disciplinary actions related to professional competence or conduct taken against the licenses of physicians and dentists. Specified licensure actions include: revocation, suspension, censure, reprimand, probation, and surrender.

Adverse Clinical Privileges Actions

Hospitals and other eligible healthcare entities are required to report to the data bank any actions they take against physicians or dentists that adversely affect

privileges for more than thirty days. They must also report incidents of the surrender or restriction of clinical privileges that occur when a physician or dentist is under investigation for possible professional incompetence or improper professional conduct or if those privileges were surrendered in return for the healthcare entity agreeing not to conduct an investigation or professional review action. Revisions to such actions must also be reported. The reporting of actions against other healthcare professionals is optional.

Medicare/Medicaid Exclusion Reports

CMS is responsible for making these reports when a provider has been excluded from participating in Medicare or Medicaid.

Adverse Professional Membership Actions

Professional societies must report specific information to the data bank when any professional review action, based on professional competence or conduct, adversely affects the membership of a physician or dentist. Revisions to such actions must also be reported.

QUERYING THE NPDB

Mandatory Querying

Hospitals are required to query the data bank when a practitioner applies for privileges and to check the data bank every two years on practitioners who are on the medical staff or hold privileges.

Voluntary Querying

- **Healthcare entities** that have a formal peer review process may query the data bank when a physician or other healthcare worker applies for employment for affiliation or in conjunction with professional review activities.
- **State licensing boards** may query at any time.
- **Healthcare practitioners** may self-query at any time to find out what information about them is contained in the data bank. They also may dispute the factual accuracy of a report or whether a report was submitted according to the NPDB's reporting requirements. **Note:** Any disputes about an adverse action or how an insurer settled a claim need to be resolved with the entity that did the reporting, and then changes to the NPDB may be submitted only by the reporting entity.
- **Plaintiff's attorneys** may query under certain circumstances (i.e., when a hospital has failed to conduct its mandatory query).
- **Self queries:** Practitioners may self-query at any time to check on their status in the NPDB.

Note: Fees are charged for all queries.

DISPUTING AN NPDB REPORT

If you are the subject of a medical malpractice payment report or an adverse action report in the NPDB, you may “add a statement to the report, dispute either the factual accuracy of the information in the report or whether the report was submitted in accordance with NPDB requirements or both.” If the issues in dispute cannot be resolved between the subject and the reporting body, the subject may request that the Secretary of HHS review the disputed report.

NPDB ASSISTANCE

The NPDB maintains a help line at (800) 767-6732 from 8:30 to 6:00 (EST), Monday through Thursday, and from 8:30 to 5:30 on Fridays. You can find information about NPDB policies here and get information you might need if you’re the one responsible for submitting reports or if you want to self-query. The NPDB also maintains an information rich website at <http://www.npdb-hipdb.hrsa.gov> .

APPENDIX A

SELF-ASSESSMENT QUESTIONNAIRE

Where do I (and my family) want to live?

How close or far away do I/we want to be to extended family members; how often do I/we plan to visit them, and how will I/we travel to get there?

What type of climate is acceptable to me/us?

How far am I/we willing to live from a metropolitan area, etc.?

Are places of worship important to me/us?

What kind of recreational or cultural activities do I/we enjoy?

Are educational facilities important to me/us?

Are there employment opportunities available to my spouse/significant other?

Do I/my family have any special needs that must be considered?

What are my strengths and my weaknesses?

What motivates me?

What are my accomplishments?

What kind of practice setting(s) do I see myself working in (solo, group, HMO, CMHC, general hospital, psychiatric hospital, medical school or university, correctional facility, etc.)?

If I prefer a group, would it be single specialty, multispecialty, multidisciplinary?

Do I want to work for a publicly funded (city, county, state, federal), nonprofit, or for-profit organization?

Do I prefer to work in an inpatient setting, outpatient setting, or a combination of the two?

What kind of services do I hope to provide through my clinical duties (psychiatric evaluations, psychopharmacology, psychotherapy, consultations, supervision, education, research, etc.) And which are most important to me?

On a scale of 1-10, how desirable/important are the following:

_____ Working with Special Populations	_____ Research
_____ Job/Financial Security	_____ Advancement Opportunities
_____ Administrative Duties	_____ Teaching

How many hours a week do I want to work?

How many hours a week do I want to spend "on call"?

Do I want to be an employee or a partner?

What salary will I be happy with?

What is the lowest salary I could comfortably accept?

What would I like to have included in the compensation package:

_____ Health insurance	_____ Disability insurance	_____ Life insurance
_____ Malpractice insurance	_____ Annual leave	_____ Sick leave
_____ CME leave	_____ CME stipend	_____ Hospital staff fees
_____ APA/AMA dues	_____ Subscriptions	_____ Pension/profit-sharing

Which are most important to me?

4

PRACTICE OPTIONS

Psychiatrists today have a number of practice options open to them. In this chapter we'll attempt to define some of those options and give you an idea of what they have to offer. As noted in Chapter 1, each practice option has its advantages and disadvantages, and, not only that, most of them don't have to be exclusive. You need to choose what makes the most sense for you both practically and emotionally.

SOLO PRACTICE

Clearly if you go into solo practice, you're the one in charge. Whatever rewards are to be gleaned will be all yours, and whatever debts accrue will also be all yours. Although consolidation seems to be more and more the norm, there will always be room for some fee-for-service and non-managed-care niche business. And as a solo practitioner you can also try to get on as many managed care panels as you can, at least until you get your own referral system going.

IPA (INDEPENDENT OR INDIVIDUAL PRACTICE ASSOCIATION)

The IPA is an open-service HMO (health maintenance organization) model. Unlike closed-service HMOs, which are staffed by salaried physicians, the IPA is a physician organization with which an HMO contracts to provide medical care to its patient population. Sometimes an IPA may have its own subscribers. The IPA negotiates on the part of the physicians, setting fees, reviewing and altering contracts, and performing utilization and peer reviews. The physician-members of the IPA practice in their own offices and are generally paid on a fee-for-service basis. The key characteristics of IPAs are:

- Subscribers pay a fixed monthly amount in advance, as with all HMOs. The sum of these prepaid monies is used to reimburse the physicians on a fee-for-service basis.
- Physician reimbursement reflects an agreed upon schedule that is based on usual and customary guidelines.
- Each IPA physician allows a percentage (usually 10-20 percent) of each charge to be withheld and placed in a shared risk pool. If the IPA is under budget at the end of the year, any remaining funds may be distributed or may be used to cover an overextended hospital fund.
- Each IPA has some type of utilization and/or quality assurance program.
- Subscribers may only select physicians from within the IPA.

GROUP PRACTICE WITHOUT WALLS (GPWW)

A group practice without walls, also known as a clinic without walls, is a group of physicians who share administrative and management costs, but maintain their practices in separate locations instead of working together in the same place. Some GPWWs are like IPAs, with physicians sharing some administrative services but maintaining their own billing. Others are more integrated, and the legal entity that is the GPWW may employ the physicians, purchase assets from the individual practices, and set compensation schedules. As a member of a practice without walls, you still maintain the financial emphasis on your own practice, but as part of the group you have joint marketing capability.

MULTISPECIALTY GROUP PRACTICE

If you become part of a multispecialty behavioral group practice, you'll have offices at one or more sites with other psychiatrists, psychologists, and social workers with whom you'll work and share cases. Practitioners in a multispecialty group practice are often on salary and receive bonuses based on their productivity and other factors. Instead of having to market your own psychiatric practice, you are part of a very marketable, multifaceted healthcare group. If your group is successful enough and has the administrative capacity, you may even be able to compete directly with MCOs for contracts. This is happening in parts of California.

PHYSICIAN HOSPITAL ORGANIZATION (PHO)/ INTEGRATED DELIVERY SYSTEM (IDS)

A PHO/IDS is similar to an IPA, but represents a broader group of practitioners. It unites a hospital, a group of physicians, and, possibly, other healthcare providers. A PHO/IDS is usually so large that it's governed by a board of directors. Since hospitals often provide the startup capital for the group, they generally want a lot of say in what happens. Ideally, at least one of the elected board members will represent your interests. A PHO/IDS has the capacity to be a very efficient and effective operation for patient-care delivery. In theory there is an information system based on the patient's medical care records. Under such a system, your patient's primary care physician, or another specialist, can know immediately when you've prescribed a new medication, and you will always have access to what they're doing. Physicians usually receive a salary plus bonuses.

SALARIED STAFF POSITION WITH AN HMO OR DEPARTMENT OF PSYCHIATRY OF A MEDICAL GROUP

When you become a salaried staff member of an HMO or medical group you may not receive as much of a financial reward as you could in other forms of practice, but neither will you have to deal with the financial risks. You probably will not have much influence on how the practice functions and may have to adjust your practice style to comply with the group's system of care. On the positive side, you will be free of having to deal with the business aspects of practicing medicine. It's important to remember, however, that psychiatry is usually a very small part of an HMO or general medical group, and because of that you may have difficulty influencing policy and getting access to resources.

APPENDIX B

COVER LETTER AND CURRICULUM VITAE

April 28, 2006

Bob Smith, M.D.
145 K Street
Santa Fe, NM 22205

Dear Doctor Smith:

I am writing in response to your advertisement in the April 21, 2006, issue of *Psychiatric News* for the position of Chief, Department of Psychiatry, at Doctors Hospital.

As you can see from my enclosed curriculum vitae, I have been employed in an inpatient setting since completing my residency in 2000, specializing in psychopharmacology. I currently hold licenses to practice in both Texas and New Mexico.

I am now seeking a leadership position where I can offer my experience in psychopharmacology and inpatient psychiatry. I have a strong interest in relocating to Santa Fe, my place of birth.

I look forward to learning more about your practice and discussing how my experience might contribute to its growth. You can reach me on my cell phone (999-555-1212); at my home, anytime after 7:00 p.m. (999-333-5757), or at Park Center Hospital (999-222-4939), Monday, Wednesday, and Friday mornings from 8:00 a.m. to 11:30 a.m. Your discretion when leaving a message at my office will be appreciated.

Sincerely,

Jane E. Doe, M.D.
123 Main St.
Walnut, TX 00221
Home: (999) 333-5757
Office: (999) 222-4939
Cell: (999) 555-1212
E-mail: jdoe@asd.com

CURRICULUM VITAE

Jane E. Doe, M.D.
123 Main St.
Walnut, TX 00221

Home Telephone: (999) 333-5757
Office Telephone: (999) 222-4939
E-mail: jdoe@asd.com

LICENSURE/CERTIFICATION

Licensure FLEX, 1996
 Texas, 1996
 New Mexico, 1999

Certification: Board Certified, Psychiatry, American Board of Psychiatry and
Neurology, April 2002

EDUCATION/TRAINING

1997 - 2000 Psychiatry Residency
 Texas Medical Center, East Walnut, Texas

1991 - 1997 Internship in Internal Medicine
 Texas Medical Center, East Walnut, Texas

1992 - 1996 M.D. Georgetown University School of Medicine, Washington, D.C.

1988 - 1992 B.S. Fordham University, Magna Cum Laude, Bronx, New York
 (Major - Chemistry)

PROFESSIONAL EXPERIENCE

6/2001 - Present Private Practice
 10 Logan St.
 Pecan, Texas 03333

Provide individual and group diagnostic and psychotherapeutic
services as well as family therapy in private office setting for
approximately 10 hours a week.

7/00 – Present Staff Psychiatrist, Park Center Hospital,
1165 Hospital Drive
Pecan, Texas 03333

Inpatient treatment of adolescents and adults on a 35-bed acute care general psychiatric unit. Provide direct patient care which includes psychiatric evaluations, psychopharmacology, and limited psychotherapy, as well as supervision of other mental health professionals, including psychologists, clinical social workers, and nurses.

STAFF PRIVILEGES

2000 – Present Park Center Hospital, Pecan, Texas

PROFESSIONAL SOCIETIES/MEMBERSHIPS

American Psychiatric Association
Texas Psychiatric Society
American Medical Association

PUBLICATIONS/PRESENTATIONS

2002 Doe, Jane E.; Goode, John H.: *Street Drugs*, J.D. York and T.L. Mogen (Eds.) New York: Paramount Press, 1996

May, 2001 American Psychiatric Association Annual Meeting,
New York, New York. Workshop: Psychotropic Drug Update

REFERENCES FURNISHED UPON REQUEST

APPENDIX C

SOURCES OF PRACTICE MANAGEMENT INFORMATION

APA Organizational Directory (partial list)

American Psychiatric Association	(888) 357-7924 (703) 907-7300
APA Home Page	www.psych.org
APA Job Bank	888-884-8242 or www.psych.org
APA Managed Care Help Line	(800) 343-4671
Office of Healthcare Systems and Financing	(703) 907-7320
Office of Education	(703) 907-8631
Office of Membership	(703) 907-7360
Legal Information and Consultation Plan	(301) 384-6775
American Professional Agency (malpractice insurance for APA members)	(800) 421-6694
APA District Branches (located in each state), see Appendix E	
American Psychiatric Press, Inc.	(703) 907-7322
Order Line	(800) 368-5777

Information on Board Certification and Added Qualifications

American Board of Psychiatry and Neurology (General, Child and Adolescent, Addiction, and Geriatric Psychiatry)	(847) 945-7900
American Board of Adolescent Psychiatry	(301) 718-6520
American Board of Forensic Psychiatry	(410) 539-0872

Salary Surveys

American Medical Group Association	www.amga.org/
American Medical Association	www.ama-assn.org
Hospital & Healthcare Compensation Service	www.hhcsinc.com/
Medical Group Management Association (MGMA)	www.mgma.com/
Physician Executive Management Center	www.physicianexecutive.com/
Sullivan, Cotter, and Associates	www.sullivancotter.com/
William M. Mercer	www.mercer.com/

Related Organizations Serving Specific Populations

For an extensive list of related organizations see Appendix G.

American Academy of Child and Adolescent Psychiatry www.aacap.org/	(202) 966-7300
American Academy of Addiction Psychiatry www.aaap.org/	(401) 524-3076

American Association for Geriatric Psychiatry www.aagpgpa.org/	(301) 654-7850
Association for Academic Psychiatry www.academicpsychiatry.org/	(770) 222-2265

Other Organizations

American Medical Association,	(312) 464-5000
Chambers of Commerce (located in each state), call US Chamber of Commerce for information	(202) 659-6000
National Association of Psychiatric Health Systems	(202) 393-6700

Informative Periodicals

APA District Branch newsletters, etc.	(see Appendix E)
<i>Psychiatric News</i> , and <i>Psychiatric Services</i> (APA)	(703) 907-7300
<i>Psychiatric Research Report</i> (APA research newsletter)	(703) 907-8625
<i>Medical Economics</i>	(800) 432-4570
<i>Modern Healthcare</i>	(800) 678-9595
<i>Unique Opportunities</i>	(800) 888-2047

APPENDIX D

UTILIZING THE APA AND ITS RESOURCES

The following are APA departments and services that you can take advantage of as an APA member, along with their phone numbers and brief descriptions. Bulleted items are products or services that fall under the department.

AMERICAN JOURNAL OF PSYCHIATRY (AJP) **(703) 907- 7884**

APA members receive this monthly scientific journal free of charge. As the official journal of the APA, the *AJP* covers all of the latest clinical, biological, and research-oriented undertakings in psychiatric medicine. It is considered vital reading for all psychiatrists.

AMERICAN PSYCHIATRIC FOUNDATION **(703) 907-8512**

The Foundation is a charitable and educational subsidiary of the APA. Its mission is to improve the lives of patients, families, and their communities through support of education, advocacy, and research that advances the understanding, prevention, and treatment of mental illness.

The Foundation administers a grants program that provides funding for projects and activities that raise awareness of mental illness and the importance of seeking timely treatment. It supports research through APIRE (see directly below) that enhances access to quality mental health services. In addition, it manages targeted public education activities such as the National Partnership for Work Place Mental Health, which seeks to educate employers and employees about the benefits of a mentally healthy workforce and the Minority Mental Health Awards Program, which recognizes exemplary individuals and programs that are raising awareness of mental health issues and reducing barriers to care in minority communities.

AMERICAN PSYCHIATRIC INSTITUTE FOR RESEARCH AND EDUCATION (APIRE) **(703) 907- 8630**

The Institute for Research and Education conducts programs and projects of national significance. Although it is a separate entity, the institute is affiliated with the APA and maintains close ties with the Division of Research. The Practice Research Network (PRN), a network of APA members who collaborate to conduct clinical and health services research, is one of the ongoing projects of APIRE.

AMERICAN PSYCHIATRIC PRESS, INC. (APPI)**(800) 368- 5777**

APPI publishes and markets the DSM-IV and all other APA publications.

ANSWER CENTER**(888) 357-7924 or (703) 907- 7355**

The Answer Center is the place to start if you want general information or do not know with whom you need to speak for specific information. An Answer Center coordinator will either provide you with the information you need or direct you to the person in the APA who can best address your questions or concerns.

APA'S MANAGED CARE HELP LINE**(800) 343- 4671**

Call this toll-free phone number or send an e-mail to hsf@psych.org for assistance with questions, to register complaints, or for information on managed care organizations (including Medicare) and/or managed care issues.

DIVISION OF EDUCATION AND CAREER DEVELOPMENT (703) 907- 8631

The Division of Education oversees the work of the Department of CME, the Scientific Program Office, the Office of Graduate and Undergraduate Education, the Office of Ethics and DB/SA Relations and the APA Library and Archives. For more information about the individual offices, see their separate listings.

DIVISION OF GOVERNMENT RELATIONS (DGR)**(703) 907- 7800**

The Division of Government Relations is the APA's advocacy arm. At the national level, DGR advises Congress, the White House, and the federal agencies on APA positions and priorities; lobbies Congress and the federal agencies on legislation and regulations of concern to APA members (including laws and regulations affecting the practice of psychiatry and psychiatric reimbursement); and acts as a resource to facilitate communication between psychiatrists and their federal legislators and regulators. At the state level, DGR provides resource assistance to the District Branches/State Associations on state legislative and regulatory issues, serving as a clearinghouse on these key issues. In addition to tracking healthcare legislation affecting psychiatrists and their patients, as part of its state-level assistance DGR provides on-site training programs to the DBs on grassroots advocacy.

DIVISION OF RESEARCH**(703) 907- 8630**

The Division of Research coordinates the development of updates of the Diagnostic and Statistical Manual of Mental Disorders (DSM), currently in a revised text of its fourth edition. The division is also in charge of reviewing scientific developments on behalf of the APA to assess their health policy implications. Dissemination of information about research results and about

funding opportunities for research and research training are also coordinated by the Division of Research.

- ***Diagnostic and Statistical Manual of Mental Disorders* (800) 368-5777**

Fourth Edition, Text Revision

The last few years have seen many advances in our knowledge of psychiatric illnesses. The *DSM-IV Text Revision* bridges the gap between *DSM-IV* and *DSM-V* to ensure that the most relevant new information since the *DSM-IV* literature review in 1992 is made available. Specifically, new information on associated features, including associated laboratory and physical findings, has been added for many of the disorders; sections on prevalence, gender, age, culture, course, and familial pattern have also been revised to reflect recent research findings; more comprehensive differential diagnoses have been incorporated for many of the disorders; and changes have been made in the diagnostic coding procedures.

- DSM-5 www.dsm5.org

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)* will be published in 2013. The 18-year period between the introduction of the *DSM-IV* in 1994 and the release of *DSM-V* may prove to be the most scientifically productive era in the history of psychiatry. Researchers have generated a wealth of knowledge about the prevalence and distribution of mental disorders worldwide, the physiology of the brain, and the lifelong influences of genes and environment on a person's health and behavior. Moreover, the introduction of scientific technologies ranging from brain imaging tools to sophisticated new methods for mathematically analyzing research data has greatly enriched the potential for significant enhancements of *DSM-V* over previous editions of the manual.

- ***Handbook of Psychiatric Measures* (800) 368-5777**

The *Handbook of Psychiatric Measures* describes how to choose and use psychiatric assessment tools and evaluate available measures. These measures cover a range of domains of assessment, including symptoms, functions, and outcomes. The psychiatric measures are evaluated for their components, reliability, validity, strengths, and weaknesses. The manual's main purpose is to provide clinicians working in mental health or primary care settings with a compendium of the available rating scales and tests that may be useful in the clinical care of their patients or for their interpretation of treatment and services research studies.

LIBRARY AND ARCHIVES

(703) 907- 8648

The APA Library is responsible for maintaining an array of psychiatric literature and is able to conduct on-line searches. It also archives APA documents and is the repository for many historic books and manuscripts dealing with psychiatric issues.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

(703) 907- 8665

The Department of Continuing Medical Education (DCME) holds primary responsibility for developing CME policies and programs, and for ensuring they comply with APA and Accreditation Council for Continuing Medical Education (ACCME) requirements. The DCME is also responsible for maintaining the APA's accreditation with the ACCME, which is critical to sponsorship of CME activities. In order to develop programs of interest and value to members, the DCME also undertakes ongoing needs-assessment activities.

The department provides sponsorship of credit for APA Annual Meetings and regional meetings, and also participates in joint sponsorship of CME activities with District Branches that belong to the Subcommittee on Joint Sponsorship. DCME staff also oversee self-study and self-assessment programs, including *Focus: The Journal of Lifelong Learning in Psychiatry* and the FOCUS self-assessment, APA Practice Guideline Courses, and online CME programs on the APA website that can be accessed at <http://www.apaeducation.org>

DCME staff process members' three-year CME report forms to provide the APA three-year certificate and the department maintains reciprocity with the American Medical Association for its Physician Recognition Award.

MEETINGS AND CONVENTIONS DEPARTMENT (MCD)

(703) 907- 7814

The Meetings and Conventions Department coordinates the logistics of APA's Annual Meeting and the Institute on Psychiatric Services. The MCD is also responsible for all logistical arrangements for governance meetings (Board of Trustees, Area Councils, Assembly, and fall component meetings), in addition to other meetings of the APA.

OFFICE OF ETHICS & DISTRICT BRANCH/STATE (DB/SA) ASSOCIATION RELATIONS

(703) 907- 8589

In keeping with the APA's strategic goal of defining and supporting professional values, this office works closely with the Ethics Committee and the District Branches to ensure ethics education and enforcement are carried out. The District Branch/State Association Relations function of this office has a focus on advocacy, working with offices throughout the APA to ensure that issues critical to the District Branches receive proper attention and resolution.

OFFICE OF HEALTHCARE SYSTEMS AND FINANCING (HSF) (703) 907-7320

The Office of Healthcare Systems and Financing (formerly the Office of Economic Affairs and Practice Management) handles practice management issues for APA members. These include issues relating to coding, managed care, and Medicare, as well as any other problems that may arise during the course of maintaining a psychiatric practice. The office maintains the Managed Care Help Line (800-343-4671) where members can call for assistance with questions relating practice management.

- ***Psychiatric Practice & Managed Care*** (800) 343-4671
This bimonthly column in *Psychiatric News* covers practice management issues critical to psychiatrists, including billing and coding, Medicare, industry updates, contracts, office procedures, and finances.
- ***CPT Handbook for Psychiatrists, 3rd Edition*** (800) 368-5777
The 2004 CPT Handbook thoroughly covers all of the psychiatric codes and explains in detail how and when to use them. It can be ordered by calling American Psychiatric Press, Inc. at the above number.
- ***Educational Handouts*** (800) 343-4671
The Office of Healthcare Systems and Financing provides information on many issues that have been found to be of particular concern to APA members. The topics available in free educational handouts include:
 - Opting Out of Medicare*
 - Terminating Patient Relationships*
 - Outcomes Assessment*
 - Medicare Coding and Compliance*
 - Avoiding CPT Coding Problems*
 - Medicare Appeals*
 - Guidelines of Practice for Managed Care Reviewers*
 - Medicare Private Contract Templates**
 - Sample Patient Satisfaction Survey**

* these documents are included as appendices in this book

OFFICE OF HIV PSYCHIATRY (703) 907- 8668

This office was established to support psychiatrists who are involved in providing care for people with HIV/AIDS. For more specific information, call or visit their website, www.psych.org/aids.

OFFICE OF SCIENTIFIC PROGRAMS (703) 907- 7808

The Office of Scientific Programs coordinates the scientific programs for APA meetings and works closely with the Scientific Program Committees of

those meetings on the oversight, selection, and presentation of formats for continuing medical education (CME) credit.

MEMBERSHIP DEPARTMENT

(703) 907-7360

The Membership Department has overall responsibility for APA membership business operations. The department works closely with the District Branches to process new member enrollments and reinstatements. Staff also manage the membership invoice and renewal process, facilitate member class and status changes, coordinate the Fellowship application and Distinguished Fellowship nomination processes, and help coordinate District Branch transfers of membership.

MEMBER SERVICES

(888) 357- 7924

APA offers its members a number of professional and personal benefits. For a complete listing of services currently available to members call the APA Answer Center toll free at 888-35-PSYCH, 888-357-7924, or 703-907-7300. This information can also be accessed online at www.psych.org/benefits.

- **Personal Web Page**

APA members may sign up for a free 3 year trial "Personal" web page on www.PsychSites.com. Register by completing the online application at PsychSites and entering **001APA** in the discount promotion field, or call toll-free to (877) 793-2204.

- **Bank of America Credit Card Products**

Through Bank of America, APA offers an array of products that help you finance business and personal expenses, generate interest income, and increase your cash flow with these options:

APA Platinum Plus® WorldPoints® Master Card

Earn points with the freedom to redeem for cash back or other rewards. For every new account that is opened and every purchase made with the card, Bank of America will make a contribution to the APA — at no additional cost to you.

For information about rates, fees, other costs and benefits associated with the use of this credit card, [click here](#) and refer to the disclosures that accompany the online credit card application.

APA Rewards American Express Card, Unlimited cash rewards; tickets on major U.S. airlines with no blackout dates; discounts on car rentals and hotel stays in the U.S.; and merchandise and gift certificates from select merchants. Call 1-866-227-1553.

APA MasterCard BusinessCard, separate account for practice related expenses. Call 1-888-470-6262.

APA GoldSavers Money Market Account and GoldCertificate DC Account. Call 1-800-414-4229.

- **APA Job Bank**

The APA's Job Bank allows you to search for jobs by specialty and geographic location. You can also just post your resume online and let employers find you. Employers list open opportunities online and can access the candidates' database. The Job Bank can be accessed through the APA website or by calling 888-884-8242.

- **Malpractice Insurance for APA Members**

Provided by the American Professional Agency, Inc. This leading provider of mental health professional liability insurance offers policies exclusively to APA members. For more information, call 800-421-6694.

- **Online Drug Alerts**

Register to receive drug alerts online through the [Health Care Notification Network \(HCNN\)](#), a service of PDR Network. The HCNN delivers drug and medical device recalls and Patient Safety Alerts to physicians securely online, replacing the current paper process. It takes only a few minutes to enroll in the HCNN. [Register now](#). More information regarding the HCNN is available at www.hcnn.net or by calling 1-866- 925-5155.

- **Epocrates Discount**

APA members receive discounts of 20% off retail pricing on clinical reference applications at the point of care through Epocrates. **To receive your APA member discount, you must order through this link: [APA Discount](#). Your APA discount will be applied at check out.** For more details on this member benefit, please call 650-227-1700 or visit www.epocrates.com.

- **Magazine Subscription Services**

APA members can receive discounts on subscriptions to hundreds of popular magazines. Call 800-289-6247 or visit www.buymags.com/psych.

- **Office Supplies**

Discounts and free shipping on all office supplies ordered through Penny-Wise Office Products (U.S. shipments only). Visit www.penny-wise.com or call 1-800-942-3311. Mention American Psychiatric Members Savings Code: APA.

- **Payment Processing Program**

[Solveras Payment Systems](#) provides negotiated group discounts on MasterCard and Visa processing in addition to other benefits. Call

Solveras Payment Systems at 1-800-613-0148 to request a free savings analysis.

- **Retirement/ Financial Services**

Merrill Lynch—APA members can meet with Merrill Lynch Financial Advisors in person or by phone to discuss important financial goals, such as retirement, college savings and investing and small business solutions. Call Merrill Lynch at 888-9ML-OFFER (965-6333) between 8 a.m. - 6 p.m. (ET), Monday through Friday and reference your Partner Code: 1844.

- **Shipping Discounts**

For member information about the FedEx Advantage[®] Program call 1-800-MEMBERS (1.800.636.2377, 8 a.m.–6 p.m. EST, M-F).

- **Car Rental Discounts**

Alamo—www.alamo.com

APA Member Discount Code: 275562

Reservations: 1-800-462-5266

Avis—www.avis.com

APA Member Discount Code: A880000

Reservations: 1-800-698-5685

Budget—www.budget.com

APA Member Discount Code: T915100

Reservations: 1-800-527-0700

Hertz—www.hertz.com

Reservations in U.S.: 1-800-654-2210

Reservations in Canada: 1-800-236-0600

APA Member Discount Code: 422054

National—www.nationalcar.com

Reservations: 1-800-227-7368

APA Member Discount Code: 5601333

- **APA Legal Information and Consultation Plan**

For an annual fee the Plan offers legal consultation and information related to your psychiatric practice. It provides APA members with practice-related legal consultations and contract reviews (the Legal Consultation Plan is not available in the state of North Carolina).

Contact Anne M. “Nancy” Wheeler, J.D. at Legal Consultation Plan, apaplan@verizon.net or by calling 301-384-6775.

OFFICE OF MINORITY AND NATIONAL AFFAIRS (OMNA) (703) 907- 8639

The Office of Minority and National Affairs (OMNA) seeks to bring a more powerful voice to minority and under-represented (MUR) groups within

psychiatry. The office handles five resident fellowships: the APA/SAMHSA Minority Fellowship, the Diversity Leadership Fellowship Program, the Spurlock Congressional Fellowship, the Child and Adolescent Psychiatry Fellowship, and the American Psychiatric Leadership Fellowship. OMNA also presents “OMNA on Tour,” a traveling national disparities in mental health elimination education program, and oversees the APA Council on Minority Mental Health and Health Disparities, Council on Children, Adolescents and Their Families, and Assembly MUR Caucuses and annual recognition lecture awards for these groups.

OFFICE OF COMMUNICATIONS AND PUBLIC AFFAIRS (703) 907- 8640

The Office of Communications and Public Affairs (OCPA) is the primary APA office for developing and disseminating information to the public about APA policies, programs, and activities, as well as the source for public information on psychiatry and its impact on those suffering from mental illness. OCPA provides support to APA members, including leadership, and to District Branches and State Associations by screening media requests, assisting with interviews, and developing talking points and media tool kits on important issues.

QUALITY IMPROVEMENT AND PSYCHIATRIC SERVICES (QIPS) (703) 907- 8608

The mission of APA's Department of Quality Improvement and Psychiatric Services (QIPS) is to facilitate the optimal provision of quality psychiatric care. The department develops evidence-based practice guidelines; advances the perspectives and needs of psychiatrists in the area of health information technology and performance measurement; identifies, advances and disseminates quality standards, measures, and interventions for systems of care; and advocates for the improved care of individuals with substance use disorders.

- The department monitors government initiatives intended to accelerate adoption of health information technology by physicians as outlined in the American Recovery and Reinvestment Act (ARRA) of 2009. These initiatives must be monitored to ensure that the standards improve the quality of psychiatric care without compromising the confidentiality of patient-identifiable health information. Information regarding these initiatives as well as other topics relevant to health information technology and member submitted software reviews are available on APA's website at <http://psych.org/ehr>.
- APA practice guidelines enhance clinical decision-making by providing treatment recommendations that are supported by available evidence, including both clinical trial data and expert opinion. The complete text of all published practice guidelines can be downloaded on [Psychiatry Online](#) with additional tools and resources for each guideline.

- APA collaborates with other medical specialty societies to monitor national initiatives to develop, endorse, and implement physician-level performance measures for purposes such as quality improvement, board certification, public recognition and financial incentives (pay-for-performance).
- The department works closely with oversight and accreditation groups, such as The Joint Commission and URAC, to represent the interests of psychiatrists in the development of quality standards and measures.
- The department also collaborates with APA's Department of Government Relations and allied medical specialty organizations to advocate for improved policies that significantly impact the availability, access and quality of treatment of substance use disorders.

PSYCHIATRIC NEWS

(703) 907- 8570

Published on the first and third Friday of each month, *Psychiatric News*, which is free to APA members, serves as a valuable medium for communication between the association and its membership. The newspaper keeps members up-to-date on all of the latest psychiatric news, including clinical and research news, public mental health issues, meetings, and all APA activities.

PSYCHIATRIC SERVICES

(800) 368-5777

This monthly, interdisciplinary, peer-reviewed journal focuses on the delivery of mental health services in large systems of care, especially for people with serious and persistent mental illness. It is available only by subscription. A one-year subscription for individuals within the U.S. is \$112 (\$84 for APA members); for individuals outside the U.S. the price is \$168 (\$152 for APA members). Individuals can purchase an online-only subscription for \$101 (\$33 for students). Institutional subscriptions are tier priced; for pricing or to order a subscription call Customer Service at the number above or visit the Website of American Psychiatric Publishing, Inc., at www.appi.org. *Psychiatric Services* is sent free of charge to psychiatric residents in the U.S.

APPENDIX F WEBSITES

MENTAL HEALTH ASSOCIATIONS

Academy of Organizational and Occupational Psychiatry (AOOP)

www.aoop.org

Academy of Psychosomatic Medicine

www.apm.org/

Administrators in Academic Psychiatry

www.adminpsych.org

American Academy of Child and Adolescent Psychiatry

www.aacap.org

American Academy of Addiction Psychiatry

www.aaap.org

American Academy of Psychiatry and the Law

www.aapl.org

The American Association of Community Psychiatrists (AACP)

www.communitypsychiatry.org/

American Association for Geriatric Psychiatry

www.aagpgpa.org/

American Board of Psychiatry and Neurology

www.abpn.com/

American Neuropsychiatric Association

www.anpaonline.org

American Psychiatric Association

www.psych.org

American Psychoanalytic Association

www.apsa.org

American Psychological Association

www.apa.org/

The American Psychological Society

www.psychologicalscience.org

Association of American Medical Colleges, Council of Teaching Hospitals and Health Systems
www.aamc.org/members/coth

The Association of Gay and Lesbian Psychiatrists
www.aglp.org

National Alliance on Mental Illness
www.nami.org

MENTAL HEALTH RESOURCES

American Psychiatric Press, Inc.
www.appi.org
APPI's online catalog.

BehaveNet
www.behavenet.com
Behavioral healthcare information and publishing.

Bioethics On-line Service Articles
www.mcw.edu/bioethics
Provides abstracts of bioethics journal articles, news accounts, legislative actions and court decisions.

Center for Medicare Advocacy
www.medicareadvocacy.org
Committed to Medicare advocacy and healthcare rights in general.

Council for Children with Behavioral Disorders
www.ccbd.net

Depression Central
www.psycom.net/depression.central.html
Clearinghouse for depressive and mood disorder information for a lay and professional audience.

ERIC Clearinghouse on Assessment and Evaluation
www.ericae.net
This site houses a test locator of psychological measurements.

Expert Consensus Guideline Series
www.psychguides.com
Psychiatric treatment guidelines written by expert panels.

InterPsych
www.fsu.edu/~trauma/ip.html or isu.edu/~bhstamn/InterPsych.htm

InterPsych was one of the first groups to organize forums, or listservs, on psychiatric topics. This organization has grown to operate nearly fifty forums on a diverse range of mental health topics.

Mental Health Meetings

www.umdnl.edu/psyevnts/psyjumps.html

Events listed by sponsor, date, or location. Compiled by Myron Pulier, M.D.

Mental Health Net

<http://mentalhelp.net>

Large, comprehensive guide to mental health online, featuring over 3,500 individual resources.

PubMed

www.ncbi.nlm.nih.gov/entrez/

The National Library of Medicine's search service, with access to over 9 million citations

Treatment Advocacy Center

www.psychlaws.org

Designed for legal, legislative, medical, and media professionals, as well as for individuals looking for guidance in helping a family member.

GENERAL MEDICINE

American Medical Association

www.ama-assn.org

Doctor's Guide to Medical Conferences and Meetings

<http://www.docguide.com/crc.nsf/web-bySpec>

DXPLAIN (Medical Decision Support at the Laboratory of Computer Science)

www.lcs.mgh.harvard.edu

Users are presented with detailed discussion and literature references.

Health Privacy Project

www.healthprivacy.org

The Health Privacy Project, maintained under Georgetown University's Institute for Health Care Research and Policy, offers online summaries of state confidentiality statutes.

Joint Commission on the Accreditation of Health Care Organizations

www.jointcommission.org

Martindale's Health Science Guide

www.martindalecenter.com/HSGuide.html

Resources in pharmacy, pharmacology, and clinical pharmacology and toxicology.

Medical Matrix

www.medmatrix.org

The Medical Matrix Project is devoted to posting, annotating and continuously updating “full content, unrestricted access, Internet clinical medical resources.” The target audience is primarily United States physicians and other healthcare providers.

Medical Meetings

<http://medicalmeetings.com>

Worldwide conference list with a search engine. There is also a conference entry form so that you can add your events to the calendar.

Medical Outcomes Trust

www.outcomes-trust.org/

Dedicated to improving health and healthcare by distributing standardized, high quality instruments that measure health and the outcomes of medical care.

Medscape

www.medscape.com

Medscape bills itself as “The Web’s most robust and integrated multispecialty medical information and education tool.” It has specialty sites and primary care sites, providing up-to-date news articles, journal articles, and summaries of presentations at major medical meetings. It is a massive source of medical information.

Merck Manual

www.merck.com/mmhe/index.html

Virtual Hospital

www.vh.org/

From the University of Iowa, the Virtual Hospital is a continuously updated digital health services library stored on computers and available over high speed networks twenty-four hours a day. The VH provides patient care support and distance learning to practicing physicians and other healthcare professionals. [On 1/1/2006 VH ceased operation due to lack of funding; much content remains available online at www.vh.org.]

GOVERNMENT

CDC Diseases, Prevention, Guidelines and Strategies

www.cdc.gov/publications.htm

Includes prevalence, cost, and treatment statistics for common disorders.

Center for Mental Health Services

<http://mentalhealth.samhsa.gov>

Good source for statistics

Centers for Medicare and Medicaid Services

www.cms.hhs.gov

Medicare and Medicaid information. CMS forms for downloading can be found at www.cms.hhs.gov/CMSForms/ [Click on CMS Forms to be redirected to links for individual forms.]

Fedstats

www.fedstats.gov/

The Federal Interagency council on Statistical Policy maintains this site to provide access to the full range of statistics and information produced by federal agencies for public use.

Food and Drug Administration

www.fda.gov/

Health and Human Services (HHS)

www.hhs.gov

The official website of the Department of Health and Human Services. From here you can go to any of the agencies and offices under HHS, including the CDC, FDA, and Office of the Inspector General, which can be reached at www.hhs.gov/progorg/oig.

Healthfinder

www.healthfinder.gov

Gateway consumer health information website. Links to selected online publications, websites, government agencies, and news organizations.

IGnet (Federal Inspectors General)

www.ignet.gov

National Center for Health Statistics

www.cdc.gov/nchs

National Institute of Mental Health

www.nimh.nih.gov

NIMH home page. Contains information about programs and clinical updates.

National Library of Medicine

www.nlm.nih.gov

NLM site has access to its book catalog (locator), databases, and programs.

National Mental Health Services Knowledge Exchange Network

www.mentalhealth.samhsa.org/

The National Mental Health Services Knowledge Exchange Network (KEN) provides information about mental health via toll-free telephone services, an electronic bulletin board, and publications.

National Practitioner Data Bank

<http://www.npdb-hipdb.hrsa.gov/>

Occupational Safety and Health Administration (OSHA)

www.osha.gov

PubMed

www.ncbi.nlm.nih.gov/entrez

Run your own MEDLINE searches on the National Library of Medicine's Internet access to MEDLINE.

The Substance Abuse and Mental Health Services Administration.
www.samhsa.gov

Thomas
<http://thomas.loc.gov/>

A service of the Library of Congress, providing access to Congressional information including summaries and status of bills, the Congressional Record, committee reports, and historical documents.

U.S. Department of Justice
www.usdoj.gov

U.S. Department of Labor
www.dol.gov

U.S. Federal Trade Commission (FTC)
www.ftc.gov

HEALTH POLICY, ECONOMICS, AND PRACTICE MANAGEMENT

A.M. Best
www.ambest.com

WWW Sources on Health Administration/Policy
www.duc.auburn.edu/~burnsma/ha.html
Comprehensive links to sites dealing with health administration, policy, and managed care.

HealthEconomics.com
www.HealthEconomics.com
A guide to health and medical economics resources on Internet. Serves those interested in healthcare management and health outcomes. Links to health economics, medical, and pharmacy resources

Hospitals
www.aamc.org
A list of all U.S. teaching Hospitals, with addresses, contact names, and telephone numbers.

Medical Group Management Association
www.mgma.com

NCQA Managed Care Performance Measurements
www.ncqa.org
Managed care quality improvement activities, including accreditation standards and the HEDIS performance measurement set. Allows on-line search for the accreditation status of individual plans.

PERIODICALS

American Journal of Psychiatry

www.ajp.psychiatryonline.org

Canadian Medical Association Journal

www.cmaj.ca

Electronic Mental Health Journals and Newspapers

<http://www.hsls.pitt.edu/>

WPIC's site connects you to electronic versions of mental health journals.

Electronic Journals and Periodicals

<http://psych.hanover.edu/Krantz/journal.html>

This site is maintained by the American Psychological Society and has links to many psychology and psychiatry journals.

Health Services Research Journal

<http://www.hsr.org/>

Mental Health InfoSource (from *Psychiatric Times*)

www.mhsource.com

Open Minds

www.openminds.com

Behavioral health publications and consulting

Psychiatric News

<http://pn.psychiatryonline.org>

Psychiatric Services

<http://psychservices.psychiatryonline.org>

MentalHelp. Net

<http://www.mentalhelp.net/>

An electronic publication devoted to issues in psychology, psychiatry, and the social sciences.

Psychotherapy Finances

www.psyfin.com

Reuters Health Information Services

www.reutershealth.com

Science

www.sciencemag.org

The full text of the journal's Perspectives section is available.

How to keep on top of new websites: Medical Matrix, www.medmatrix.org, maintains a frequently updated website full of links to online medical information. It's a good place to start if you're having trouble finding information online.

APPENDIX G

RELATED ORGANIZATIONS

ACADEMY FOR EATING DISORDERS

Tel: (847) 498-4274/Fax: (847) 480-9280
Email: info@aedweb.org
Website: www.aedweb.org

ACADEMY OF ORGANIZATIONAL AND OCCUPATIONAL PSYCHIATRY

Tel: (877) 789-2667 or (703) 683-4999
Fax: (877) 789-6050 or (703) 683-0018
Email: staff@aop.org
Website: www.aop.org

ACADEMY OF PSYCHOSOMATIC MEDICINE

Tel: (301) 718-6520/ Fax: (301) 656-0969
Email: apm@apm.org
Website: www.apm.org

AMERICAN ACADEMY OF ADDICTION PSYCHIATRY

Tel: (202) 393-4484/ Fax: (202) 393-4419
Email: information@aaap.org
Website: www.aaap.org

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Tel: (202) 966-7300/ Fax: (202) 966-2891
Email: membership@aacap.org
Website: www.aacap.org

AMERICAN ACADEMY OF CLINICAL PSYCHIATRISTS

Tel: (860) 633-5045/ Fax: (860) 633-6023
Email: aacp@coxnet.net

AMERICAN ACADEMY ON COMMUNICATION IN HEALTHCARE [formerly AMERICAN ACADEMY ON PHYSICIAN AND PATIENT]

Tel: (636) 449-5080/ Fax: (636) 449-5051
Email: chris@aachonline.org
Website: www.aachonline.org

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Tel: (800) 274-2237 or (913) 906-6000
Fax: (913) 906-6093

Email: fp@aafp.org
Website: www.aafp.org

AMERICAN ACADEMY OF NEUROLOGY

Tel: (800) 879-1960 or (651) 695-1940
Fax: (651) 695-2791
Email: memberservices@aan.com
Website: www.aan.com

AMERICAN ACADEMY OF PAIN MEDICINE

Tel: (847) 375-4731/ Fax: (847) 734-8750
Email: info@painmed.org
Email for resources: aapm@amctec.com
Website: www.painmed.org

AMERICAN ACADEMY OF PEDIATRICS

Tel: (847) 434-7500/ Fax: (847) 434-8000
Email: csc@aap.org
Website: www.aap.org

AMERICAN ACADEMY ON PHYSICIAN AND PATIENT renamed: AMERICAN ACADEMY ON COMMUNICATION IN HEALTHCARE

Tel: (636) 449-5080/ Fax: (636) 449-5051
Email: chris@aachonline.org
Website: www.aachonline.org

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW

Tel: (860) 242-5450/ Fax: (860) 286-0787
Email: office@aapl.org
Website: www.aapl.org

AMERICAN ACADEMY OF PSYCHOANALYSIS & DYNAMIC PSYCHIATRY

Tel: (888) 691-8281/ Fax: (860) 286-0787
Email: info@aapsa.org
Website: www.aapsa.org

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE

Tel: (202) 326-6400
Email: membership@aaas.org
Website: www.aaas.org

AMERICAN ASSOCIATION OF CHAIRS OF DEPARTMENTS OF PSYCHIATRY

Tel/Fax: (717) 270-1673
Email: aacdp@verizon.net
Website: www.aacdp.org

AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS

Tel: (972) 613-0985/Fax: (972) 613-5532
Website: www.comm.psych.pitt.edu

AMERICAN ASSOCIATION OF DIRECTORS OF PSYCHIATRIC RESIDENCY TRAINING, INC.

Tel/Fax: (717) 270-1673
Email: aadprt@verizon.net
Website: www.aadprt.org

AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY [merged with AMERICAN ASSOCIATION OF GENERAL HOSPITAL PSYCHIATRISTS]

Tel: (888) 945-5430/ Fax: (860) 286-0787
Email: aaep@emergencypsychiatry.org
Website: www.emergencypsychiatry.org

AMERICAN ASSOCIATION OF GENERAL HOSPITAL PSYCHIATRISTS [now merged with AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY]

AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

Tel: (301) 654-7850/ Fax: (301) 654-4137
Email: main@aagponline.org
Website: www.aagponline.org

AMERICAN ASSOCIATION OF HEALTH PLANS now AMERICA'S HEALTH INSURANCEPLANS

Tel: (202) 778-3200/ Fax: (202) 331-7487
Email: ahip@ahip.org
Website: www.ahip.org

AMERICAN ASSOCIATION FOR THE HISTORY OF MEDICINE, INC.

Tel: (252) 744-2797/ Fax: (252) 744-2319
Email: savittT@mail.ecu.edu
Website: www.histmed.org

AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

Tel: (703) 838-9808/ Fax: (703) 838-9805
Email: central@aamft.org
Website: www.aamft.org

AMERICAN ASSOCIATION ON MENTAL RETARDATION

Tel: (800) 424-3688 or (202) 387-1968
Fax: (202) 387-2193
Email: dcroser@aamr.org
Website: www.aamr.org

AMERICAN ASSOCIATION OF NEUROPATHOLOGISTS

Tel: (216) 368-3671/ Fax: (216) 368-8964
Email: aanp@caseo.edu
Website: www.aanp-jnen.com

AMERICAN ASSOCIATION OF PASTORAL COUNSELORS

Tel: (703) 385-6967/ Fax: (703) 352-7725
Email: info@aapc.org
Website: www.aapc.org

AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS

Tel: (800) 650-5888 or (972) 613-0985
Fax: (972) 613-5532
Email: frdal@airmail.net
Website: www.psychiatricadministrators.org

AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS, & THERAPISTS

Tel: (804) 725-0026/ Fax: (804) 725-0056
Email: aasect@aasect.org
Website: www.aasect.org

AMERICAN ASSOCIATION FOR SOCIAL PSYCHIATRY

Tel: (410) 938-3401/ Fax: (410) 938-3406
Email: sprovenza@sheppardpratt.org

AMERICAN ASSOCIATION OF SUICIDOLOGY

Tel: (202) 237-2280/ Fax: (202) 237-2282
Email: info@suicidology.org
Website: www.suicidology.org

AMERICAN BAR ASSOCIATION

Tel: (800) 285-2221 or (312) 988-5000
Fax: (312) 988-5151
Email: askaba@abanet.org
Website: www.abanet.org

AMERICAN BOARD OF MEDICAL SPECIALTIES

Tel: (847) 491-9091/ Fax: (847) 328-3596
Email: smiller@abms.org
Website: www.abms.org

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

Tel: (847) 945-7900/ Fax: (847) 945-1146
Email: questions@abpm.com
Website: www.abpn.com

AMERICAN COLLEGE OF CARDIOLOGY

Tel/Fax: (202) 375-6000
Email: resources@acc.org
Website: www.acc.org

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Tel: (800) 798-1822 or (972) 550-0911
Fax: (972) 580-2816
Email: membership@acep.org
Website: www.acep.org

AMERICAN COLLEGE OF MENTAL HEALTH ADMINISTRATION

Tel/Fax: (502) 822-5038
Email: executive.director@acmha.org
Website: www.acmha.org

AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY

Tel: (615) 343-2068/ Fax: (615) 343-2069
Email: oray@acnp.org
Website: www.acnp.org

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

Tel: (847) 818-1800/ Fax: (847) 818-9266
Email: mnutt@acoem.org
Website: www.acoem.org

AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

Tel: (800) 523-1546 x2600 or (215) 351-2600
Fax: (215) 351-2829
Email: mle@acponline.org
Website: www.acponline.org

THE AMERICAN COLLEGE OF PSYCHIATRISTS

Tel: (312) 662-1020/ Fax: (312) 662-1025

Email: angel@acpsych.com
Website: www.acpsych.org

AMERICAN COLLEGE OF PSYCHOANALYSTS

Tel: (972) 613-0985
Email:
Website: www.acopsa.org

AMERICAN COLLEGE OF SURGEONS

Tel: (312) 202-5000/ Fax: (312) 202-5001
Email: trussell@facs.org
Website: www.facs.org

AMERICAN COUNSELING ASSOCIATION

Tel: (800) 347-2329/ Fax: (703) 823-0252
Website: www.counseling.org

AMERICAN GERIATRICS SOCIETY

Tel: (212) 308-1414/ Fax: (212) 832-8646
Email: info@americangeriatrics.org
Website: www.americangeriatrics.org

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, INC.

Tel: (877) 668-2472/(212) 477-2677
Fax: (212) 979-6627
Email: info@agpa.org
Website: www.agpa.org

AMERICAN HOSPITAL ASSOCIATION

Tel: (800) 424-4301 or (202) 638-1100
Fax: (202) 626-2345
Email: ddavidson@aha.org
Website: www.aha.org

AMERICAN MANAGED BEHAVIORAL HEALTHCARE ASSOCIATION

Tel: (202) 756-7726/ Fax: (202) 756-7308
Website: www.ambha.org

AMERICAN MEDICAL ASSOCIATION

Tel: (800) 621-8335 or (312) 464-5000
Fax: (312) 464-4184
Website: www.ama-assn.org

AMERICAN MEDICAL STUDENT ASSOCIATION

Tel: (703) 620-6600 or (800) 767-2266
Fax: (703) 620-5873
Email: amsa@amsa.org
Website: www.amsa.org

**AMERICAN MEDICAL WOMEN'S
ASSOCIATION**

Tel: (703) 838-0500/ Fax: (703) 549-3864
Email: info@amwa-doc.org
Website: www.amwa-doc.org

**AMERICAN MUSIC THERAPY
ASSOCIATION**

Tel: (301) 589-3300/ Fax: (301) 589-5175
Email: info@musictherapy.org
Website: www.musictherapy.org

**AMERICAN NEUROLOGICAL
ASSOCIATION**

Tel: (952) 545-6284/ Fax: (952) 545-6073
Email: ana@llmsi.com
Website: www.aneuroa.org

**AMERICAN NEUROPSYCHIATRIC
ASSOCIATION**

Tel: (614) 447-2077/ Fax: (614) 263-4366
Email: anpa@osu.edu
Website: www.anpaonline.org

AMERICAN NURSES' ASSOCIATION

Tel: (800) 274-4262 or (301) 628-5000
Fax: (301) 628-5001
Email: convention@ana.org or
memberinfo@ana.org
Website: www.nursingworld.org

**AMERICAN OCCUPATIONAL THERAPY
ASSOCIATION**

Tel: (301) 652-2682/ Fax: (301) 652-7711
Website: www.aota.org

**AMERICAN ORTHOPSYCHIATRIC
ASSOCIATION**

Tel: (480) 727-7518/ Fax: (480) 965-8544
Email: americanortho@gmail.com
Website: www.amerortho.org

AMERICAN PAIN SOCIETY

Tel: (847) 375-4715/ Fax: (847) 734-8758
Email: info@ampainsoc.org
Website: www.ampainsoc.org

AMERICAN PEDIATRIC SOCIETY

Tel: (281) 419-0052/ Fax: (281) 419-0082
Email: info@aps-spr.org
Website: www.aps-spr.org

AMERICAN PSYCHIATRIC ASSOCIATION

Tel: (888) 357-7924 or (703) 907-7300

Fax: (703) 907-1085
Email: apa@psych.org
Website: www.psych.org

AMERICAN PSYCHIATRIC FOUNDATION

Tel: (888) 357-7924 or (703) 907-8512
Fax: (703) 907-7851
Email: apf@psych.org
Website: www.psychfoundation.org

**AMERICAN PSYCHIATRIC NURSES'
ASSOCIATION**

Tel: (703) 243-2443/ Fax: (703) 243-3390
Email: membership@apna.org
Website: www.apna.org

**AMERICAN PSYCHOANALYTIC
ASSOCIATION**

Tel: (212) 752-0450/ Fax: (212) 593-0571
Email: info@apsa.org
Website: www.apsa.org

**AMERICAN PSYCHOLOGICAL
ASSOCIATION**

Tel: (800) 374-2721 or (202) 336-5500
Email: membership@apa.org
Website: www.apa.org

AMERICAN PSYCHOLOGICAL SOCIETY

Tel: (202) 783-2077/ Fax: (202) 783-2083
Website: www.psychologicalscience.org

**AMERICAN PSYCHOPATHOLOGICAL
ASSOCIATION**

Email: gah13@columbia.edu
Website: www.appassn.org

AMERICAN PSYCHOSOMATIC SOCIETY, INC.

Tel: (703) 556-9222/ Fax: (703) 556-8729
Email: info@psychosomatic.org
Website: www.psychosomatic.org

**AMERICAN SOCIETY OF ADDICTION
MEDICINE**

Tel: (301) 656-3920/ Fax: (301) 656-3815
Email: email@asam.org
Website: www.asam.org

**AMERICAN SOCIETY FOR ADOLESCENT
PSYCHIATRY**

Tel: (972) 686-6166/ Fax: (972) 613-5532
Email: info@adolpsych.org
Website: www.adolpsych.org

AMERICAN SOCIETY OF CLINICAL HYPNOSIS

Tel: (630) 980-4740/ Fax: (630) 351-8490
Email: info@asch.net
Website: www.asch.net

**AMERICAN SOCIETY OF CLINICAL
PSYCHOPHARMACOLOGY, INC.**

Tel: (718) 470-4007/ Fax: (718) 343-7739
Website: www.ascpp.org

**AMERICAN SOCIETY OF LAW, MEDICINE
AND ETHICS**

Tel: (617) 262-4990/ Fax: (617) 437-7596
Email: info@aslme.org
Website: www.aslme.org

**AMERICAN SOCIOLOGICAL
ASSOCIATION**

Tel: (202) 383-9005/ Fax: (202) 638-0882
Email: executive.office@asanet.org
Website: www.asanet.org

THE ARC OF THE UNITED STATES

Tel: (301) 565-3842/ Fax: (301) 565-5342
Email: info@thearc.org
Website: www.thearc.org

**ASSOCIATED PROFESSIONAL SLEEP
SOCIETIES**

Tel: (708) 492-0930/ Fax: (708) 492-0943
Email: jmarkkanen@aasmnet.org
Website: www.apss.org

**ASSOCIATION FOR ACADEMIC
PSYCHIATRY**

Tel: (617) 661-3544/ Fax: (617) 499-5498
Email: cberney@mah.harvard.edu
Website: www.academicpsychiatry.org

**ASSOCIATION FOR THE ADVANCEMENT
OF PHILOSOPHY AND PSYCHIATRY**

Tel: (214) 648-4959/ Fax: (214) 648-4967
Email: linda.munch@utsouthwestern.edu
Website: www3.utsouthwestern.edu/aapp

**ASSOCIATION FOR AMBULATORY
BEHAVIORAL HEALTHCARE**

Tel: (703) 934-0160/ Fax: (703) 359-7562
Email: info@aabh.org
Website: www.aabh.org

**ASSOCIATION OF AMERICAN INDIAN
PHYSICIANS**

Tel: (405) 946-7072/ Fax: (405) 946-7651

Email: aaip@aaip.com
Website: www.aaip.com

**ASSOCIATION OF AMERICAN MEDICAL
COLLEGES**

Tel: (202) 828-0400/ Fax: (202) 828-1125
Email: aamcpresident@aamc.org
Website: www.aamc.org

**ASSOCIATION OF BEHAVIORAL
HEALTHCARE MANAGEMENT (ABHM)**

Tel: (301) 984-6200/ Fax: (301) 881-7159
Email: nolam@nccbh.org
Website: www.nccbh.org/abhm

**ASSOCIATION FOR CHILD
PSYCHOANALYSIS**

Tel: (505) 771-0372
Email: childanalysis@comcast.net
Website: www.childanalysis.org

**ASSOCIATION OF CHRISTIAN
THERAPISTS**

Tel: (703) 556-9222/ Fax: (703) 556-8729
Email: ACTheals@degnon.org
Web: www.actheals.org

**ASSOCIATION OF DIRECTORS OF
MEDICAL STUDENT EDUCATION IN
PSYCHIATRY (ADMSEP)**

Tel/Fax: (717) 270-1630
Email: admsep@verizon.net (or
tbfeldol@louisville.edu)
Website: www.admsep.org

**ASSOCIATION OF GAY AND LESBIAN
PSYCHIATRISTS**

Tel: (215) 222-2800/ Fax: (215) 222-3881
Email: aglp@aglp.org
Website: www.aglp.org

**ASSOCIATION FOR MEDICAL EDUCATION
AND RESEARCH IN SUBSTANCE ABUSE**

Tel: (401) 349-0000/ Fax: (877) 418-8769
Email: isabel@amersa.org
Website: www.amersa.org

**ASSOCIATION OF PROFESSIONAL
CHAPLAINS**

Tel: (847) 240-1014/ Fax: (847) 240-1015
Email: info@professionalchaplains.org
Website: www.professionalchaplains.org

**ASSOCIATION OF WOMEN
PSYCHIATRISTS**

Tel: (972) 686-6522/ Fax: (972) 613-5532
Email: womenpsych@aol.com
Website: www.womenpsychorg

**BAZELON CENTER FOR MENTAL HEALTH
LAW**

Tel: (202) 467-5730/ Fax: (202) 223-0409
Email: info@bazelon.org
Website: www.bazelon.org

BLACK PSYCHIATRISTS OF AMERICA

Website: ww.nmanet.org

CANADIAN MEDICAL ASSOCIATION

Tel: (800) 267-9703 or (613) 731-9331
Fax: (613) 731-7314
Email: William.tholl@cma.ca
Website: www.cma.ca

**CANADIAN MENTAL HEALTH
ASSOCIATION**

Tel: (416) 484-7750/ Fax: (416) 484-4617
Email: info@cmha.co
Website: www.cmha.ca

CANADIAN PSYCHIATRIC ASSOCIATION

Tel: (613) 234-2815, x 232
Fax: (613) 234-9857
Email: cpa@cpa-apc.org
Website: www.cpa-apc.org

CHILD WELFARE LEAGUE OF AMERICA

Tel: (202) 638-2952/ Fax: (202) 638-4004
Website: www.cwla.org

**CHRISTIAN MEDICAL ASSOCIATION,
PSYCHIATRY SECTION**

Tel: (404) 327-8366/ Fax: (404) 327-9323
Email: mbrship@cmda.org
Website: www.cmdahome.org

**COLLEGE ON PROBLEMS OF DRUG
DEPENDENCE, INC.**

Tel: (215) 707-3242/ Fax: (215) 707-1904
Email: baldeagl@temple.edu
Website: www.cpdd.org

**COUNCIL OF MEDICAL SPECIALTY
SOCIETIES**

Tel: (847) 295-3456/ Fax: (847) 295-3759
Email: mailbox@cmss.org

Website: www.cmss.org

**DEPRESSION AND BIPOLAR SUPPORT
ALLIANCE (DBSA)**

Tel: (800) 826-3632 or (312) 642-0049
Fax: (312) 642-7243
Website: www.dbsalliance.org

**EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES**

Tel: (215) 386-5900/ Fax: (215) 386-8151
Email: info@ecfmg.org
Website: www.ecfmg.org

**EPILEPSY FOUNDATION-NATIONAL
OFFICE**

Tel: (800) 332-1000 or (301) 459-3700
Fax: (301) 577-2684
Email: postmaster@efa.org
Website: www.epilepsyfoundation.org

**GROUP FOR THE ADVANCEMENT OF
PSYCHIATRY**

Tel: (972) 613-3044/ Fax: (972) 613-5532
Email: through website
Website: www.groupadpsych.org

**ICD-INTERNATIONAL CENTER FOR THE
DISABLED**

Tel: (212) 585-6009/ Fax: (212) 585-6262
Email: through website
Website: www.ICDrehab.org

**INDO-AMERICAN PSYCHIATRIC
ASSOCIATION**

Tel: (516) 292-9741
Email: shatti1@aol.com or
contactus@myiapa.org
Website: www.myiapa.org

**INSTITUTE OF MEDICINE & the NATIONAL
ACADEMY OF SCIENCES of the National
Acadamies**

Tel: (202) 334-3300/ Fax: (202) 334-3851
IOM: Tel: (202) 334-2352/ Fax: (202)
334-1412
Email IOM: iomwww@nas.edu
Email National Acad:
webmailbox@nas.edu
Website: www.nas.edu

INTERNATIONAL ACADEMY OF LAW AND MENTAL HEALTH (CANADA)

Tel: (514) 343-5938/ Fax: (514) 343-2452
Email: admin@ialmh.org
Website: www.ialmh.org

INTERNATIONAL ASSOCIATION OF GROUP PSYCHOTHERAPY (SINGAPORE)

Fax: +65 6 738 7466
Email: office@iagp.com
Website: http://www.iagp.com/

INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES/through USpra website

Tel: (410) 789-7054/ Fax: (410) 789-7675
Email: cpeterson@highlandscsb.org or
cjh.mts@sympatico.ca or via
info@uspra.org
Website: www.uspra.org or
http://www.uspra.org/i4a/pages/index.cfm?
pageid=3324

INTERNATIONAL COMMITTEE AGAINST MENTAL ILLNESS

Tel: (212) 263-6214/ Fax: (212) 263-8135

INTERNATIONAL FEDERATION OF PSYCHOANALYTIC SOCIETIES (MEXICO)

Tel: 52 55 5554 6383
Fax: 52 55 5554 0925
Email: sgojman@yahoo.com
Website: www.ifp-s.org

INTERNATIONAL FEDERATION FOR PSYCHOTHERAPY (SWITZERLAND)

Tel: 41-1-2554608
Email: uschnyd@psyp.unizh.ch
Website: www.psychotherapy.de (site
under construction Oct 2006)

INTERNATIONAL SOCIETY FOR THE STUDY OF DISSOCIATION

Tel: (703) 610-9037/ Fax: (703) 610 9005
Email: issd@issd.org
Website: www.issd.org

INTERNATIONAL TRANSACTIONAL ANALYSIS ASSOCIATION

Tel: (925) 600-8110 /Fax: (925) 600 8112
Website: www.itaa-net.org

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Tel: (630) 792-5000/ Fax: (630) 792-5005
Email: customerservice@jcaho.org
Website: www.jointcommission.org

MILTON H. ERICKSON FOUNDATION, INC.

Tel: (602) 956-6196/ Fax: (602) 956-0519
Email: office@erickson-foundation.org
Website: www.erickson-foundation.org

NATIONAL ALLIANCE FOR THE MENTALLY ILL

Tel: (703) 524-7600/ Fax: (703) 524-9094
Website: www.nami.org

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS

Tel: (212) 741-0515/ Fax: (212) 366-4347
Email: info@naap.org
Website: www.naap.org

NATIONAL ALLIANCE FOR RESEARCH ON SCHIZOPHRENIA & AFFECTIVE DISORDERS (NARSAD)

Tel: (516) 829-0091/ Fax: (516) 487-6930
Email: info@narsad.org
Website: www.narsad.org

NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

Tel: (202) 393-6700/ Fax: (202) 783-6041
Email: naphs@naphs.org
Website: www.naphs.org

NATIONAL ASSOCIATION OF SOCIAL WORKERS

Tel: (202) 336-8200/ Fax: (202) 336-8313
Email: membership@naswdc.org
Website: www.socialworkers.org

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Tel: (703) 739-9333/ Fax: (703) 548-9517
Email: webmaster@nasmhpd.org
Website: www.nasmhpd.org

NATIONAL BOARD OF MEDICAL EXAMINERS

Tel: (215) 590-9500/ Fax: (215) 590-9555
Email: webmail@mail.nbme.org
Website:
http://www.nbme.org/programs/usmle.asp

**NATIONAL COUNCIL ON ALCOHOLISM
AND DRUG DEPENDENCE, INC.**

Tel: (212) 269-7797/ Fax: (212) 269-7510
Email: national@ncadd.org
Website: www.ncadd.org

**NATIONAL COUNCIL FOR COMMUNITY
BEHAVIORAL HEALTHCARE**

Tel: (301) 984-6200/ Fax: (301) 881-7159
Email: lindar@nccbh.org
Website: www.nccbh.org

**THE NATIONAL FOUNDATION FOR
DEPRESSIVE ILLNESS**

Tel: (410) 268-0044/ Fax: (443) 782-0739
Email: info@ifred.org
Website: <http://www.ifred.org/>

NATIONAL INSTITUTE ON AGING

Tel: (800) 222-2225 or (301) 496-1762
Fax: (301) 496-1072
Email: through website
Website: <http://www.nia.nih.gov/>

**NATIONAL INSTITUTE ON ALCOHOL
ABUSE AND ALCOHOLISM (NIAA)**

Tel: (301) 443-3885/ Fax: (301) 443-7043
Email: through website
Website: <http://www.niaaa.nih.gov/>

NATIONAL INSTITUTE ON DRUG ABUSE

Tel: (301) 443-6480/ Fax: (301) 443-9127
Email: leshner@nih.gov
Website: <http://www.nida.nih.gov/>

**NATIONAL INSTITUTE OF MENTAL
HEALTH**

Tel: (301) 443-1124
Email: information@nida.nih.gov
Website: www.nimh.nih.gov

NATIONAL LEAGUE FOR NURSING

Tel: (800) 669-1656 or (212) 363-5555
Fax: (212) 812-0393
Email: customerhelp@nlh.org
Website: www.nln.org

NATIONAL MEDICAL ASSOCIATION

Tel: (202) 347-1895/ Fax: (202) 842-3293
Email: president@nmanet.org
Website: www.nmanet.org

**NATIONAL MENTAL HEALTH
ASSOCIATION**

Tel: (703) 684-7722/ Fax: (703) 684-5968
Email: infoctr@nmha.org
Website: www.nmha.org

**NATIONAL REHABILITATION
ASSOCIATION**

Tel: (703) 836-0850/ Fax: (703) 836-0848
Email: info@nationalrehab.org
Website: www.nationalrehab.org

**PROFESSIONAL RISK MANAGEMENT
SERVICES, INC.**

Tel: 800 245 3333
Email: theprogram@prms.com
Website: www.psychprogram.com

RECOVERY, INC.

Tel: (312) 337-5661/ Fax: (312) 337-5756
Email: inquiries@recovery-inc.com
Website: www.recovery-inc.com

**ROYAL AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS
(AUSTRALIA)**

Tel: 613 9640 0646/ Fax: 613 9642 5652
Email: ranzcp@ranzcp.org
Website: www.ranzcp.org

**ROYAL COLLEGE OF PHYSICIANS AND
SURGEONS OF CANADA**

Canada
Tel: (613) 730-6205/ Fax: (613) 730-8250
Email: ceo@rcpsc.edu
Website: www.rcpsc.medical.org

ROYAL COLLEGE OF PSYCHIATRISTS

England
Tel: 44 20 7235 2351
Fax: 44 20 7245 1231
Email: rcpsych@rcpsych.ac.uk
Website: www.rcpsych.ac.uk

THE ROYAL SOCIETY OF MEDICINE

England
Tel: 44 20 7290 2902
Fax: 44 20 7290 2909
Email: psychiatry@rsm.ac.uk
Website: www.roysocmed.ac.uk

**SEXUALITY INFORMATION AND
EDUCATION COUNCIL OF THE UNITED
STATES (SIECUS)**

Tel: (212) 819-9770/ Fax: (212) 819-9776
Email: siecus@siecus.org
Website: www.siecus.org

**SOCIETY OF BEHAVIORAL AND
COGNITIVE NEUROLOGY***

Email: sbcn@osu.edu

SOCIETY OF BEHAVIORAL MEDICINE

Tel: (414) 918-3156/ Fax: (414) 276-3349
Email: info@sbmweb.org
Website: www.sbm.org

SOCIETY OF BIOLOGICAL PSYCHIATRY

Tel: (904) 953-2842/ Fax: (904) 953-7117
Email: maggie@mayo.edu
Website: www.sobp.org

**SOCIETY FOR DEVELOPMENTAL AND
BEHAVIORAL PEDIATRICS**

Tel: 703) 556-9922/ Fax: (703) 556-8729
Email: info@sdbp.org
Website: www.sdbp.org

**SOCIETY OF IRANIAN PSYCHIATRISTS IN
NORTH AMERICA**

Tel: (713) 796-9992/ Fax: (713) 706-9419

SOCIETY FOR NEUROSCIENCE

Tel: (202) 962-4000/ Fax: (202) 962-4941
Email: info@sfn.org
Website: www.sfn.org

SOUTHERN MEDICAL ASSOCIATION

Tel: (800) 423-4992 or (205) 945-1840
Fax: (205) 945-1548
Email: through website
Website: www.sma.org

SOUTHERN PSYCHIATRIC ASSOCIATION

Tel: (410) 938-3403/ Fax: (410) 938-3450
Email: sproctor@sheppardpratt.org
Website: http://www.sopsych.org/

**STUDENT NATIONAL MEDICAL
ASSOCIATION**

Tel: (202) 882-2881/ Fax: (202) 882-2886
Email: snma@snma.org
Website: www.snma.org

**SUBSTANCE ABUSE AND MENTAL
HEALTH SERVICES ADMINISTRATION**

Email: info@samhsa.gov
Website: www.samhsa.gov

**U. S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

Tel: (877) 696-6775 or (202) 619-0257
Email: hhsmail@os.dhhs.gov
Website: www.hhs.gov

**U. S. DEPARTMENT OF VETERAN
AFFAIRS**

Tel: (202) 273-5400
Email: through website inquiry
Website: www.va.gov

U.S. PHARMACOPEIA

Tel: (800) 277-8722 or (301) 881-0666
(international 00 800 4875 5555)
Fax: (301) 816-8299
Email: rstech@usp.org
Website: www.usp.org

**WORLD ASSOCIATION FOR
PSYCHOSOCIAL REHABILITATION**

Email: taintz01@med.nyu.edu
Website: www.wapr.net

**WORLD ASSOCIATION FOR SOCIAL
PSYCHIATRY**

Tel: (202) 261-6586/ Fax: (202) 261-6587
Email: esorel@aol.com

**WORLD FEDERATION FOR MENTAL
HEALTH**

Tel: (703) 313-8680/ Fax: (703) 313-8683
Email: info@wfmh.com
Website: www.wfmh.org

WORLD HEALTH ORGANIZATION

Switzerland
Tel: 41 22 791 21 11
Fax: 44 22 791 3111
Email: saxenas@who.int
Website: www.who.int/mental_health

**WORLD MEDICAL ASSOCIATION
(FRANCE)**

Tel: 33 4 50 40 75 75
Fax: 33 4 50 40 59 37
Email: wma@wma.net
Website: www.wma.net

WORLD PSYCHIATRIC ASSOCIATION

Tel: (718) 334-3459/ Fax: (718) 505-6910

Email: through website

Website: www.wpanet.org

APPENDIX H INTERVIEW WORKSHEET

Date

Organization's Name:

Contact Person:

Address:

Telephone Number:

Organizational Information:

What is the history of the organization?

What is the size and make-up of the staff?

How many physicians are in the organization? Ask for some general information on them (approximate age range, training background, areas of expertise, Board Certification, etc.).

How long have the physicians been in the organization?

Reason for current opening:

If a new position, how have you determined the need for a psychiatrist?

How long have you been recruiting for this position?

How many doctors have left the organization in the past 5 years? Why did they leave?

How do the members of the organization get along with one another?

What is the volume of the practice, and what is the patient mix?

What is the current referral pattern? (Other MD's, other non-MD therapists, hospitals, provider panels, pharmacists, word-of mouth, phone book, etc.)

How does the organization market itself and what are the costs?

What is the organization's relationship, if any, to managed care entities? (In terms of peer review practices, as well as contractual relationships for clinical services, including capitated contracts?)

Who determines which managed care plans the organization contracts with?

Describe the treatment philosophy of the organization (and, if possible, get a feel for the ethical climate).

What is the organization's relationship to non-MD therapists in the area?

What are the organization's connections to the community (local boards, professional groups, or service organizations, etc.)?

What is the competition in the community?

What do you see for the future of the practice in 3, 5, or 10 years?

What are you looking for in an ideal candidate, both professionally and personally?

Responsibilities:

What will be my daily responsibilities?

How many patients will I be expected to see each day?

What is the call schedule?

How far is the hospital from the office?

How many beds does it have (total and psychiatric)?

What types of services does it offer?

What specialties are represented on the medical staff?

How is the nursing staff?

Is there a teaching appointment available?

Decision Making/Financial Information:

Who and how are the decisions made in the organization?

Are policies written down? If so, may I see a copy of the manual?

How are new patients distributed?

How are the fees determined?

What are the average earnings of the organization?

What is the organization's overhead?

What is the organization's billing practice? How is the billing done?

What is the overhead of the department/organization?

What is your collection ratio?

What does your benefits package include?

How is income divided among the organization's members?

If a group practice, what is the fee split? (60/40 practice/member, is typical)

What is your estimate of the new psychiatrist's first year income?

Are there "productivity" payments the first year?

If so, how will they be determined?

If so, when will they be received?

What will happen if my productivity exceeds my salary?

How might I share in gross profits? Is there a payback?

What is the route to partnership?

Are there buy-in requirements for partnership? If so, how will the buy-in value be determined?

When would you like to have a new psychiatrist start?

Community:

What is the average cost of living in the area?

What is the population and service area?

Is there employment for my spouse?

How is the school system?

How many colleges/universities are within an easy drive of the community?

What types of recreation are available?

What types of cultural activities are available?

Are transportation and airports nearby?

What is the economic condition of the area?

What is the growth potential?

Who are the major employers?

What type of real estate is available?

What are the local places of worship?

Other questions of specific interest to you:

APPENDIX I

STATE BOARDS OF MEDICAL LICENSURE

ALABAMA STATE BOARD OF MEDICAL EXAMINERS

Larry D. Dixon, Executive Administrator
P.O. Box 946
Montgomery, AL 36101-0946
(street address: 848 Washington Ave.)
(334) 242-4116 / Fax: (334) 242-4155
(800) 227-2606
www.albme.org

ALASKA STATE MEDICAL BOARD

Leslie A. Gallant, Executive Administrator
550 West Seventh Ave., Suite 1500
Anchorage, AK 99501
(907) 269-8163 / Fax: (907) 269-8196
<http://www.dced.state.ak.us/occ/pmed.htm>

ARIZONA MEDICAL BOARD

Timothy C. Miller, Executive Director
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258-5514
(480) 551-2700 / Fax: (480) 551-2704
www.azmd.gov

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY

Jack Confer, Executive Director
9535 East Doubletree Ranch Road
Scottsdale, AZ 85258-5539
(480) 657-7703 Fax (480) 657-7715
www.azosteoboard.org

ARKANSAS STATE MEDICAL BOARD

Peggy P. Cryer, Executive Secretary
2100 Riverfront Dr.
Little Rock, AR 72202-1793
(501) 296-1802 / Fax: (501) 603-3555
www.armedicalboard.org

MEDICAL BOARD OF CALIFORNIA

David T. Thornton, Executive Director
1426 Howe Ave., Suite 54
Sacramento, CA 95825-3236
(916) 263-2389 / Fax: (916) 263-2387
(800) 633-2322
www.caldocinfo.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Donald Krpan, DO, Executive Director
2720 Gateway Oaks Dr., Suite 350
Sacramento, CA 95833-3500
(916) 263-3100 / Fax: (916) 263-3117
www.dca.ca.gov/osteopathic

COLORADO BOARD OF MEDICAL EXAMINERS

Cheryl Hara, PA, JD, Program Director
1560 Broadway, Suite 1300
Denver, CO 80202-5140
(303) 894-7690 / Fax: (303) 894-7692
www.dora.state.co.us/medical

CONNECTICUT MEDICAL EXAMINING BOARD

Jeff Kardys, Board Liaison
P.O. Box 340308
Hartford, CT 06134-0308
(street address 410 Capitol Ave., MS #13PHO)
Licensing/Examinations, (860) 509-8374
Administrative (860) 509-7648 /
Fax: (860) 509-7553
www.dph.state.ct.us

DELAWARE BOARD OF MEDICAL PRACTICE

Gayle MacAfee, Executive Director
P.O. Box 1401
Dover, DE 19903
(street address: 861 Silver Lake Blvd., Cannon Building, Suite 203, 19904)
(302) 739-4522 / Fax: (302) 739-2711
www.dpr.delaware.gov

DISTRICT OF COLUMBIA BOARD OF MEDICINE

James R. Granger Jr., Executive

Director
717 14th Street, NW Suite 600
Washington D.C. 20005
(202) 724-4900/Fax: (202) 727-8471
dchealth.dc.gov

FLORIDA BOARD OF MEDICINE
Larry McPherson, Esq., Executive
Director
Department of Health
4052 Bald Cypress Way, BIN #C03
Tallahassee, FL 32399-3253
(850) 245-4131/ Fax:(850) 488-9325
www.doh.state.fl.us

**FLORIDA BOARD OF OSTEOPATHIC
MEDICINE**
Pamela King, Executive Director
4052 Bald Cypress Way, BIN C06
Tallahassee, FL 32399-1753
(850) 245-4161 / Fax:(850) 487-9874
www.doh.state.fl.us

**GEORGIA COMPOSITE STATE BOARD OF
MEDICAL EXAMINERS**
LaSharn Hughes, Executive Director
2 Peachtree Street, NW, 36th Floor
Atlanta, GA 30303
(404) 656-3913 / Fax:(404) 656-9723
www.medicalboard.state.ga.us

GUAM BOARD OF MEDICAL EXAMINERS
Chalsea Torres, Acting Administrator
Health Professionals Licensing Office
651 Legacy Square Commercial
Complex
South Route 10, Suite 9
Margilao, GU 96913
(011) 671-735-7406-8 / Fax:(011) 671-
735-7413

HAWAII BOARD OF MEDICAL EXAMINERS
Constance Cabral, Executive Officer
Department of Commerce and
Consumer Affairs
P.O. Box 3469
Honolulu, HI 96813
(street address: 335 Merchant St.,
Room 301, 96813)
(808) 586-3000 / Fax:(808) 586-2874
<http://www.hawaii.gov/dcca/pvl>

IDAHO STATE BOARD OF MEDICINE
Nancy Kerr, Executive Director
1755 Westgate Drive, Suite 140
Boise, ID 83704
(street address: 83704)
(208) 327-7000 / Fax:(208) 327-7005
www.bom.state.id.us

**ILLINOIS DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION**
Division of Professional Regulation,
Daniel E. Bluthardt
Chicago Office (disciplinary issues)
Doris Barnes, Disciplinary Board
Liaison
James R. Thompson Center
100 W. Randolph Street, Suite 9-300
Chicago, IL 60601
(312) 814-4500 / Fax: (312) 814-1837
www.ildfpr.com

**ILLINOIS DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION**
Division of Professional Regulation,
Daniel E. Bluthardt
Springfield Office (licensure issues)
Sandra Dunn, Licensure Manager
320 W. Washington St., 3rd Floor
Springfield, IL 62786
(217) 785-0800 / Fax:(217) 524-2169
www.ildfpr.com

INDIANA HEALTH PROFESSIONS BUREAU
Michael Rinebold, Board Director
402 W. Washington St., Room W072
Indianapolis, IN 46204
(317) 232-2960 / Fax:(317) 233-4236
www.in.gov/pla/bandc/mlbi

**IOWA STATE BOARD OF MEDICAL
EXAMINERS**
Ann Mowery, Ph.D., Executive Director
400 Southwest Eighth Street, Suite C
Des Moines, IA 50309-4686

(515) 281-5171 / Fax:(515) 242-5908
www.docboard.org/ia/ia_home.htm

KANSAS BOARD OF HEALING ARTS

Lawrence Buening Jr., J.D., Executive Director
235 South Topeka Blvd.
Topeka, KS 66603-3068
(785) 296-7413 / Fax:(785) 296-0852
www.ksbha.org

**KENTUCKY BOARD OF MEDICAL
LICENSURE**

C. William Schmidt, Executive Director
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222-4916
(502) 429-7150 / Fax:(502) 429-7158
kbml.ky.gov

**LOUISIANA STATE BOARD OF MEDICAL
EXAMINERS**

Robert Marier, M.D., M.H.A., Executive Director
P.O. Box 30250
New Orleans, LA 70190-0250
(street address: 630 Camp St., 70130)
(504) 568-6820 / Fax:(504) 568-8893
www.lsbme.louisiana.gov

MAINE BOARD OF LICENSURE IN MEDICINE

Randal C. Manning, Executive Director
137 State House Station (U.S. mail)
161 Capitol Street (delivery service)
Augusta, ME 04333
(207) 287-3601 / Fax:(207) 287-6590
www.docboard.org/me/me_home.htm

**MAINE BOARD OF OSTEOPATHIC
LICENSURE**

Susan E. Strout, Executive Secretary
142 State House Station
Augusta, ME 04333-0142
(207) 287-2480 (207) 287-3015
www.docboard.org/me-osteo

MARYLAND BOARD OF PHYSICIANS

C. Irving Pinder, Executive Director
P.O. Box 2571
Baltimore, MD 21215-0095
(street address: 4201 Patterson Ave.,

third floor, 21215)
(410) 764-4777 / Fax:(410) 358-2252
(800) 492-6836
www.mbp.state.md.us/

**MASSACHUSETTS BOARD OF
REGISTRATION IN MEDICINE**

Nancy Achin Audesse, Executive Director
560 Harrison Ave., Suite G-4
Boston, MA 02118
(617) 654-9800 / Fax:(617) 451-9568
(800) 377-0550
www.massmedboard.org

MICHIGAN BOARD OF MEDICINE

Rae Ramsdell, Licensing Director
P.O. Box 30670
Lansing, MI 48909-8170
(street address: 611 W. Ottawa St, 1st floor, 48933)
(517) 335-0918 / Fax:(517) 373-2179
www.michigan.gov/healthlicense

**MICHIGAN BOARD OF OSTEOPATHIC
MEDICINE AND SURGERY**

Rae Ramsdell, Licensing Director
P.O. Box 30670
Lansing, MI 48909-8170
(street address: 611 W. Ottawa St, 1st floor, 48933)
(517) 335-0918 / Fax:(517) 373-2179
www.michigan.gov/healthlicense

**MINNESOTA BOARD OF MEDICAL
PRACTICE**

Robert A. Leach, J.D., Executive Director
University Park Plaza
2829 University Ave. SE, Suite 500
Minneapolis, MN 55414-3246
(612) 617-2130 / Fax:(612) 617-2166
Hearing impaired 1-800-627-3529
www.bmp.state.mn.us

**MISSISSIPPI STATE BOARD OF MEDICAL
LICENSURE**

Dewitt G. Crawford, M.D., Interim Executive Director
1867 Crane Ridge Drive, Suite 200B

Jackson, MS 39216
(601) 987-3079 / Fax:(601) 987-4159
www.msbml.state.ms.us

**MISSOURI STATE BOARD OF
REGISTRATION FOR THE HEALING ARTS**
Tina M. Steinman, Executive Director
3605 Missouri Blvd.
Jefferson City, MO 65109
(street address: 3605 Missouri Blvd.,
65109)
(573) 751-0098 / Fax:(573) 751-3166
www.pr.mo.gov/healingarts.asp

**MONTANA BOARD OF MEDICAL
EXAMINERS**
Jeannie Worsech, Executive Director
P.O. Box 200513
Helena, MT 59620-0513
(406) 841-2300 / Fax: (406) 841-2363
[Discovering Montana](http://DiscoveringMontana)

**NEBRASKA BOARD OF MEDICINE AND
SURGERY**
Health and Human Services
Regulation and Licensure Credentialing
Division
Becky Wisell, Section Administrator
P.O. Box 94986
Lincoln, NE 68509-4986
(402) 471-2118 / Fax:(402) 471-3577
www.hhs.state.ne.us/

**NEVADA STATE BOARD OF MEDICAL
EXAMINERS**
Tony Clark, J.D., Executive Secretary
1105 Terminal Way, Suite 301
Reno, NV 89502
(775) 688-2559 / Fax:(775) 688-2321
www.medboard.nv.gov

**NEVADA STATE BOARD OF OSTEOPATHIC
MEDICINE**
Larry J. Tarno, D.O., Executive Director
860 E. Flamingo Rd., Suite G
Las Vegas, NV 89121
(702) 732-2147 / Fax:(702) 732-2079
www.osteo.state.nv.us

NEW HAMPSHIRE BOARD OF MEDICINE
Penny Taylor, Administrator
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520
(603) 271-1203 / Fax:(603) 271-6702
complaints (800) 780-4757
www.state.nh.us/medicine

**NEW JERSEY STATE BOARD OF MEDICAL
EXAMINERS**
William V. Roeder, Executive Director
P.O. Box 183
Trenton, NJ 08625-0183
(609) 826-7100 / Fax:(609) 826-7117
www.state.nj.us/lps/ca/medical.htm#bme5

NEW MEXICO MEDICAL BOARD
Lynn S. Hart, Executive Director
2055 S. Pacheco, Building 400
Santa Fe, NM 87505
(505)476-7220 / Fax:(505) 476-7237
www.nmmb.state.nm.us

**NEW MEXICO BOARD OF OSTEOPATHIC
MEDICAL EXAMINERS**
Liz King, Board Administrator
2550 Cerrillos Road
Santa Fe, NM 87501-5101
(505) 476-4695 / Fax:(505) 476-4665
www.rld.state.nm.us/b&c/Osteo

**NEW YORK STATE BOARD FOR MEDICINE
(LICENSURE)**
Thomas J. Monahan, Executive
Secretary
89 Washington Avenue, 2nd Floor,
West Wing
Albany, NY 12234
(518) 474-3817 Ext. 560 / Fax:(518)
486-4846
www.op.nysed.gov

**NEW YORK STATE BOARD FOR
PROFESSIONAL MEDICAL CONDUCT
(DISCIPLINE)**
Dennis J. Graziano, Executive Director
Department of Health
Office of Professional Medical Conduct

433 River St., Suite 303
Troy, NY 12180-2299
(518) 402-0855 / Fax:(518) 402-0866
www.health.state.ny.us/

NORTH CAROLINA MEDICAL BOARD

R. David Henderson, J.D., Executive
Director
P.O. Box 20007
Raleigh, NC 27619
(919) 326-1100 / Fax:(919) 326-1130
www.ncmedboard.org

**NORTH DAKOTA STATE BOARD OF
MEDICAL EXAMINERS**

Rolf P. Sletten, J.D., Executive
Secretary/Treasurer
City Center Plaza
418 E. Broadway, Suite 12
Bismarck, ND 58501
(701) 328-6500 / Fax:(701) 328-6505
www.ndbomex.com

NORTHERN MARIANA ISLANDS

Medical Professional Licensing Board
P.O. Box 501458, CK
Saipan, MP 96950
(670) 664-4811 / Fax:(670) 664-4813
www.cnmiqguide.com

STATE MEDICAL BOARD OF OHIO

Richard A. Whitehouse, Executive
Director
77 S. High St., 17th Floor
Columbus, OH 43215-6127
(614) 466-3934 / Fax:(614) 728-5946
(800) 554-7717
www.med.ohio.gov

**OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION**

Lyle Kelsey, C.A.E., Executive Director
P.O. Box 18256
Oklahoma City, OK 73118
(405) 848-6841 / Fax:(405) 848-8240
(800) 381-4519
www.okmedicalboard.org

**OKLAHOMA STATE BOARD OF
OSTEOPATHIC EXAMINERS**

Gary R. Clark, Executive Director
4848 N. Lincoln Blvd., Suite 100
Oklahoma City, OK 73105-3321
(405) 528-8625 / Fax:(405) 557-0653
www.docboard.org

OREGON BOARD OF MEDICAL EXAMINERS

Kathleen Haley, J.D., Executive
Director
1500 SW First Avenue, Suite 620
Portland, OR 97201-5826
(971) 673-2700 / Fax:(971) 673-2670
www.oregon.gov/BME

**PENNSYLVANIA STATE BOARD OF
MEDICINE**

Tammy Radel, Administrator
P.O. Box 2649
Harrisburg, PA 17105-2649
(717) 787-2381 / Fax:(717) 787-7769
www.dos.state.pa.us

**PENNSYLVANIA STATE BOARD OF
OSTEOPATHIC MEDICINE**

Gina K. Bittner, Administrator
P.O. Box 2649
Harrisburg, PA 17105-2649
(street address: 124 Pine St., 17101)
(717) 783-4858 / Fax:(717) 787-7769
www.dos.state.pa.us

**BOARD OF MEDICAL EXAMINERS OF
PUERTO RICO**

Pablo Valentin-Torres, Esq., Executive
Director
P.O. Box 13969
San Juan, PR 00908
(787) 782-8937 / Fax:(787) 706-0304

**RHODE ISLAND BOARD OF MEDICAL
LICENSURE AND DISCIPLINE**

Robert S. Crausman, M.D., Chief
Administrator
Department of Health
Cannon Building, Room 205
Three Capitol Hill
Providence, RI 02908-5097

(401) 222-3855 / Fax:(401) 222-2158
<http://www.health.ri.gov/hsr/bmld/>

SOUTH CAROLINA BOARD OF MEDICAL EXAMINERS

Department of Labor, Licensing and Regulation
Bruce F. Duke, Board Administrator
110 Centerview Drive, Suite 202
Columbia, SC 29210-1289
(803) 896-4500 / Fax:(803) 896-4515
www.llr.state.sc.us/pol/medical

SOUTH DAKOTA STATE BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Margaret B. Hansen, Executive Director
125 S. Main Ave.
Sioux Falls, SD 57104
(605) 367-7781 / Fax:(605) 367-7786
www.state.sd.us/doh/medical

TENNESSEE BOARD OF MEDICAL EXAMINERS

Rosemarie Otto, Executive Director
227 French Landing, Suite 300 Heritage Place MetroCenter
Nashville, TN 37243
(800) 778-4123 / Fax:(615) 253-4484
www.state.tn.us/health

TENNESSEE BOARD OF OSTEOPATHIC EXAMINERS

Rosemarie Otto, Executive Director
227 French Landing, Suite 300 Heritage Place MetroCenter
Nashville, TN 37243
(800) 778-4123 / Fax:(615) 253-4484
www.state.tn.us/health

TEXAS MEDICAL BOARD

Donald W. Patrick, M.D., J.D.,
Executive Director
P.O. Box 2018
Austin, TX 78768-2018
(512) 305-7010/Fax: (512) 305-7008
Disciplinary Hotline (800) 248-4062
Consumer Complaint Hotline (800) 201-9353
www.tmb.state.tx.us

UTAH DEPARTMENT OF COMMERCE

Division of Occupational and Professional Licensure
Physicians Licensing Board
Craig J. Jackson, R.Ph.
160 E. 300 South, 84102, Heber M. Wells Building, 4th Floor
Salt Lake City, UT 84114
(801) 530-6628 / Fax:(801) 530-6511
www.dopl.utah.gov

UTAH DEPARTMENT OF COMMERCE

Division of Occupational and Professional Licensure
Board of Osteopathic Medicine
Diana T. Baker, Bureau Manager
160 E. 300 South, 84102, Heber M. Wells Building, 4th Floor
Salt Lake City, UT 84114
(801) 530-6628 / Fax:(801) 530-6511
www.dopl.utah.gov

VERMONT BOARD OF MEDICAL PRACTICE

Paula DiStabile, Executive Director
108 Cherry Street
Burlington, VT 05402-0070
(802) 657-4220 / Fax:(802) 657-4227
www.healthyvermonters.info

VERMONT BOARD OF OSTEOPATHIC PHYSICIANS AND SURGEONS

Christopher D. Winters, Director
Office of Professional Regulation
26 Terrace Street, Drawer 09
Montpelier, VT 05609-1106
(802) 828-2373 / Fax:(802) 828-2465
vtprofessionals.org

VIRGIN ISLANDS BOARD OF MEDICAL EXAMINERS

Lydia Scott, Executive Assistant
Department of Health
48 Sugar Estate
St. Thomas, VI 00802
(340) 774-0117/ Fax:(340) 777-4001
MedicalLicensureRequirements

VIRGINIA BOARD OF MEDICINE

William L. Harp, M.D., Executive

Director
6603 W. Broad St., 5th Floor
Richmond, VA 23230-1717
(804) 662-9908 / Fax:(804) 662-9517
www.dhp.virginia.gov

**WASHINGTON MEDICAL QUALITY
ASSURANCE COMMISSION**

Blake T. Maresh, M.P.A., Executive
Director
Department of Health
310 Israel Road, SE
MS 47866
Tumwater, WA 98501
(360) 236-4788 / Fax:(360) 586-4573
www.doh.wa.gov

**WASHINGTON STATE BOARD OF
OSTEOPATHIC MEDICINE AND SURGERY**

Blake Maresh, Executive Director
Department of Health
P.O Box 47866
Olympia, WA 98504-7866
(360) 236-4945 / Fax:(360) 236-2406
www.doh.wa.gov

WEST VIRGINIA BOARD OF MEDICINE

Robert C. Knittle,
Executive Director
101 Dee Drive
Charleston, WV 25311
(304) 558-2921 / Fax:(304) 558-2084
www.wvdhhr.org/wvbom

WEST VIRGINIA BOARD OF OSTEOPATHY

Cheryl Schreiber, Executive Secretary
334 Penco Rd.
Weirton, WV 26062
(304) 723-4638 / Fax:(304) 723-2877
www.wvbdosteo.org

WISCONSIN MEDICAL EXAMINING BOARD

Department of Regulation and Licensing
Thomas Ryan, Bureau Director
1400 E. Washington Ave.
Madison, WI 53703
(608) 266-2112 / Fax:(608) 261-7083
www.drl.state.wi.us

WYOMING BOARD OF MEDICINE

Carole Shotwell, J.D., Executive
Secretary
211 W. 19th St., Colony Bldg., 2nd Floor
Cheyenne, WY 82002
(307) 778-7053 / Fax:(307) 778-2069
wyomedboard.state.wy.us
<http://badger.state.wi.us>

**Federation of State Medical
Board
Contact Information**

Phone: (817) 868-4000 [main]
Fax: (817) 868-4099 [main]
Email: Individual Department emails
provided on Contact webpage
Web address: <http://www.fsmb.org/>

APPENDIX J
SAMPLE DEA APPLICATION

Form-224

APPLICATION FOR REGISTRATION
Under the Controlled Substances Act

APPROVED OMB NO 1117-0014
FORM DEA-224 (9-05)
Previous editions are obsolete

INSTRUCTIONS

1. To apply by mail complete this application. Keep a copy for your records.
2. Print clearly, using black or blue ink, or use a typewriter.
3. Mail this form to the address provided in Section 7 or use enclosed envelope.
4. Include the correct payment amount. FEE IS NON-REFUNDABLE.
5. If you have any questions call 800-882-9539 prior to submitting your application.
6. Save time - **apply online at www.dea diversion.usdoj.gov**.

IMPORTANT: DO NOT SEND THIS APPLICATION AND APPLY ONLINE.

REGISTRATION INFORMATION :

\$390.00

FEE IS NON-REFUNDABLE

SECTION 1 **APPLICANT IDENTIFICATION**

Last Name (if registration is for individual) -OR- Business or Facility Name (if registration is for business entity)

First Name (if registration is for individual)

Middle
Initial

Business or Facility Name 2 ("doing business as", continuation of business name, or name of fee exempt institution)

Address Line 1 (street address)

Address Line 2

City

State Zip Code

Business Phone Number

Business Fax Number

DEBT COLLECTION INFORMATION

Mandatory pursuant to Debt Collection Improvements Act

Tax Identification Number (if registration is for business)

Social Security Number (if registration is for individual)

Provide SSN or TIN.
See note #3 on bottom of page 2

SECTION 2

BUSINESS ACTIVITY

Check one box only

See page 3 for additional instructions

Hospital/Clinic

Ambulance Service

Practitioner
(DDS, DMD, DO, DPM, DVM, MD or PHD)

PROFESSIONAL DEGREE

Nursing Home

Animal Shelter

Practitioner Military
(DDS, DMD, DO, DPM, DVM, MD or PHD)

Practitioners and MLPs :
Enter your professional degree from list

Central Fill Pharmacy

Teaching Institution

Mid-level Practitioner (MLP)
(DOM, HMD, MP, ND, NP, OD, PA, or RPH)

Retail Pharmacy

Automated Dispensing System

Euthanasia Technician

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

An ADS is automatically fee-exempt. Skip Section 6 and Section 7 on page 2. You must attach a notarized affidavit.

SECTION 3

DRUG SCHEDULES

Check all that apply

Schedule II Narcotic

Schedule III Narcotic

Schedule IV

Schedule II Non-Narcotic

Schedule III Non-Narcotic

Schedule V

Check this box if you require official order forms for purchase of schedule II narcotic/schedule II non-narcotic controlled substances

SECTION 4

Are you currently authorized to prescribe, distribute, dispense, conduct research, or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the state or jurisdiction in which you are operating or propose to operate?

STATE LICENSE(S)

YES PENDING NO

Be sure to include both state license numbers if applicable

State License Number

State Controlled Substance License Number (if required)

SECTION 5**LIABILITY****IMPORTANT**

All questions in this section must be answered.

1. Has the applicant ever been **convicted of a crime** in connection with controlled substance(s) under state or federal law? YES NO

2. Has the applicant ever surrendered (for cause) or had a **federal** controlled substance registration revoked, suspended, restricted, or denied?

3. Has the applicant ever surrendered (for cause) or had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation? **Is any such action pending?**

4. If the applicant is a **corporation** (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder, or proprietor been **convicted of a crime** in connection with controlled substance(s) under state or federal law, or ever surrendered, for cause, or had a **federal** controlled substance registration revoked, suspended, restricted, denied, or ever had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation?

EXPLANATION OF "YES" ANSWERS

Date(s) of incident: Location(s) of incident:

Applicants who have answered "YES" to any of the four questions above **must provide a statement to explain such answers**

Nature of incident:

Use this space or attach a separate sheet and return with application

Result of incident:

SECTION 6**CERTIFICATION OF EXEMPTION**
from application fee

Check this box if the applicant is a federal, state, or local government operated hospital, institution or official. **Be sure to enter the name and address of the exempt institution in Section 1.**

The undersigned hereby certifies that the applicant named hereon is a federal, state or local government-operated hospital, institution or official, and is exempt from payment of the application fee.

Provide the name and phone number of the certifying official

Signature of certifying official (other than applicant)

Date

Print or type name and title of certifying official

Telephone No. (required for verification)

SECTION 7**METHOD OF PAYMENT**

Check Make check payable to: **Drug Enforcement Administration**
See page 4 of instructions for important information.

American Express Discover Master Card Visa

Check one form of payment only

Credit Card Number

Expiration Date

Sign if paying by credit card

Signature of Card Holder

Printed Name of Card Holder

Mail this form with payment to:

U.S. Department of Justice
Drug Enforcement Administration
P.O. Box 28083
Washington, DC 20038-8083

FEE IS NON-REFUNDABLE**SECTION 8**

I certify that the foregoing information furnished on this application is true and correct.

APPLICANT'S SIGNATURE

Sign in ink

Signature of applicant

Date

Print or type name and title of applicant

WARNING: Section 843(a)(4)(A) of Title 21, United States Code states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to imprisonment for not more than four years, a fine of not more than \$30,000, or both.

1. No registration will be issued unless a completed application form has been received (21 CFR 1301.13).
2. In accordance with the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 1117-0014. Public reporting burden for this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.
3. The Debt Collection Improvements Act of 1996 (PL 104-134) requires that you furnish your Taxpayer Identifying Number and/or Social Security Number on this application. This number is required for debt collection procedures should your fee become uncollectable.
4. **PRIVACY ACT INFORMATION**

AUTHORITY:

Section 302 and 303 of the Controlled Substances Act of 1970 (PL 91-513) and Debt Collection Improvements Act of 1996 (PL 104-134) (for taxpayer identifying number and/or social security number).

PURPOSE:

To obtain information required to register applicants pursuant to the Controlled Substances Act of 1970.

ROUTINE USES:

The Controlled Substances Act Registration Records produces special reports as required for statistical analytical purposes. Disclosures of information from this system are made to the following categories of users for the purposes stated:

A. Other federal law enforcement and regulatory agencies for law enforcement and regulatory purposes.

B. State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes.

C. Persons registered under the Controlled Substances Act (PL 91-513) for the purpose of verifying the registration of customers.

EFFECT:

Failure to complete form will preclude processing of the application.

APPENDIX K STAFF APPLICATION FORM

This place of employment complies with all applicable state and federal laws governing employment opportunities. It does not discriminate in hiring or employment based on color, race, sex, age, religion, national origin, physical handicap, sexual orientation, or any other classifications that are irrelevant with consideration to position duties.

Desired Position: _____

PERSONAL INFORMATION

Name (Last Name First) _____

SS# _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone (If Possible) _____

Are you legally eligible for employment in this country? _____ Yes _____ No
(Proof of eligibility will be required prior to employment)

Have you ever been convicted of a felony? _____ Yes _____ No
(A felony conviction will not necessarily rule out the possibility for employment.)

If yes, please attach an explanation to this application.

When are you available for work? _____

Desired salary? _____

EDUCATION

Please list the last three schools that you have attended, starting with the most recent.

School and Address	Course of Study	Degree	Dates Attended

PREVIOUS EMPLOYMENT

Please list your last three places of employment, starting with the most recent.

Name of Employer #1	Dates of Employment	Job Title
Address	Phone	Duties
Supervisor's Name	Reason for Leaving	Salary

Name of Employer #1	Dates of Employment	Job Title
Address	Phone	Duties
Supervisor's Name	Reason for Leaving	Salary

Name of Employer #1	Dates of Employment	Job Title
Address	Phone	Duties
Supervisor's Name	Reason for Leaving	Salary

REFERENCES

Please list three references (who are not related to you).

Name and Address	Phone Number	Number of Years Known

ADDITIONAL SKILLS, EXPERIENCE, AND QUALIFICATIONS

Do you have licensure or certification in a healthcare profession? ____ Yes ____ No

If so, what?
(Please provide appropriate documentation.)

Are you familiar with basic computer and word processing applications? ____ Yes ____ No

If so, which ones?

If applicable, how many words do you type per minute? _____

Are you willing and able to work overtime as needed? ____ Yes ____ No

If no, please explain.

Please list any additional skills, experience, or qualifications that you would like us to consider.

Please Read Before Signing

I certify that all of the information presented in this application for employment is true to the best of my knowledge. I also authorize all persons, institutions, and former employers to furnish all pertinent work-related information known to them about me. Furthermore, I understand that, should I be employed by this medical practice, any statements found to be false will serve as grounds for my immediate dismissal.

Signature _____ Date _____

5 INCORPORATION OPTIONS

There are six types of business entities, or corporations, available to physicians: sole proprietorship, general partnership, limited partnership (LP), limited liability partnership (LLP), limited liability company (LLC), and professional corporation (PC).

To help you understand the differences between these six business structures, the Washington, DC, law firm of Crowell & Moring created the chart on the next page. The APA's Legal Information and Consultation Plan can help you with the decision of which entity might work best for you. You can get more information about the Plan by calling 888-357-7924 or 703-907-7300. Since the laws concerning incorporation differ from state to state, you will definitely want to consult with a lawyer before you decide which option to choose.

BUSINESS ENTITIES FOR PHYSICIANS: A COMPARISON

Form of Business	Liability of Members	Management of Business	Continuity of Operations	Transferability	Complexity & Cost of Formation & Operation	Tax Considerations
Sole Proprietorship	Proprietor personally liable for all debts/ judgments of the business	Autonomous decision making	Business disintegrates on death or incapacity of owner	Interest is not transferable	Very easy and inexpensive to form and operate	Single taxation; individual income tax only
General Partnership	Each partner personally liable for own acts, the acts of partners, & debts of the business	All partners have equal voice in management of business unless otherwise agreed	Unless otherwise specified partnership dissolves on death or withdrawal of one of the partners	Interest is not transferable	Easier to form and operate than a corporation	Single taxation; individual income tax only
Limited Partnership (LP)	General partners liable for own acts, acts of partners, & debts of business; limited partners only liable to extent of their capital investment	Limited unless otherwise specified. Partners prohibited from participating in business management; general partners have equal voices	Partnership terminates on death of general partner; death or withdrawal of limited partner does not dissolve partnership	Interest is not transferable	Fairly easy to form & operate. Unlike general partnership, LP forms must generally be filed with the state	Single taxation; individual income tax only; no additional taxation on business entity
Limited Liability Partnership (LLP)	Not liable for malpractice or negligence of peers or employees unless supervisory relationship exists; liable for some business debts	All partners have equal management rights	Partnership continues to exist despite dissociation of a particular partner	Generally, interests are not transferable	Higher degree of complexity in registration of entity than other forms of partnership	Single taxation; taxed similarly to other forms of partnership
Limited Liability Company (LLC)	Liability not as extensive as in sole proprietorship & partnership. Personal liability limited to own actions & actions of supervised employees	Management much like traditional company; hierarchical officer structure	In several states, death or resignation of a member dissolves the LLC	Generally, interests are not transferable	Expensive and highly complex; several forms to be filed; assistance of counsel necessary	Generally, single taxation; individual income tax only; some states require "entity" tax that's not too large
Professional Corporation (PC)	Not shielded from individual malpractice liability; generally not liable for nonprofessional obligations of PC	Board of directors elects officers to run corporation; officers handle daily operations & management	Perpetual existence of entity	Stock of employee shareholders is freely transferable; easy to enter & exist	Moderately expensive to form & operate; often complex regulations; assistance of counsel necessary	Double taxation; corporation taxed as are any dividend payments; (can be avoided with high salaries & few if any dividends)

APPENDIX L

STAFF PERFORMANCE REVIEW FORM

To help ensure that your employees are productive and satisfied, and that your practice runs as smoothly as possible, it is important to set up a system of employee performance checks. This system should ensure that position responsibilities and standards of quality are clearly defined; that periodic, standardized checks are made on employee performance; that incentives are provided for employee excellence; and that established avenues for dealing with problems and/or sub-par performance are made known to and followed by everyone in the practice.

The process of establishing a successful employee performance review program begins even before you hire an employee. In the interview, it is important that all key position responsibilities and expectations of quality are conveyed to the potential employee. Responsibilities should be explained to the candidate both in the interview and in a formal, written job description. By doing this, an individual to whom you offer a position will have a definite understanding of what will be expected of him should he take the job.

Once a position has been filled, the new employee should be placed on a pre-determined sixty or ninety day probationary period. At the conclusion of this period, the employee and her supervisor should meet to discuss the employee's progress. If performance is satisfactory, the probationary period should be lifted. If, however, performance is unsatisfactory, an established system for identifying problem areas and plans for correcting them must be utilized. Depending on the seriousness of problems, an extension of the probationary period may be necessary at this time. For optimum effectiveness, the employee should be made fully aware of any perceived problems with her performance and involved in developing solutions for them.

To keep formal records of an employee's performance, many employers administer yearly performance reviews. These are typically completed either at the end of the calendar year or on the anniversary of an employee's hire date. Annual performance evaluation reviews may vary greatly from one employer to another, depending on the type of practice and the management style of the group. Within a practice, however, similar positions should be assessed using the same standards to help maintain objectivity and fairness. Employers may or may not decide to devise a system in which responsibilities, work habits, and goals are weighted according to importance, allowing them to calculate a quantifiable, overall performance score.

In general, a performance review should include an evaluation of the employee's success in executing position responsibilities; highlight both areas of excellence and areas that need improvement, including a specific plan for improving these deficiencies; and assess the employee's general work habits, including, but not limited to, attention to detail, problem solving abilities, professionalism, reliability, and communication skills. The employer may also wish to include several goals designed to encourage the employee to excel at his or her job. The success of the employee in achieving these goals should then also be assessed in the review.

A quantitative system for evaluating these factors should be established to help ensure that employees are reviewed objectively. Space, however, should also be provided to further illuminate quantitative ratings. Many employers use a numbered rating system where, for example, "1" denotes a strong need for improvement and "4" indicates excellence, but this method is not set in stone. It is also common to hold mid-year reviews in which the employee and supervisor assess the employee's success to date, make appropriate adjustments, and note progress toward any predetermined goals.

Finally, it should be mentioned that these formal stages of the review process should be conducted in addition to, rather than in place of, frequent informal meetings to guide an employee in a productive and successful direction. In order to assist you in implementing this process, the following pages present the "skeleton" of a sample employee performance review form. It is designed to assist you in customizing your own staff review forms.

STAFF PERFORMANCE REVIEW

Employee Name:

Social Security Number:

Position:

Review Type (Annual, Mid-Year, Probationary, etc.):

Date of Review:

Instructions:

The employee's supervisor must fill out the following performance review, including supporting comments for all assessments deemed to be "marginally acceptable" (1) or "exceptional" (4) and suggestions for improvement for all assessments determined to be "marginally acceptable" (1) or "satisfactory" (2). The employee and supervisor should then discuss the review, allowing the employee both to voice his/her opinions and to write them down in the Employee Comments section at the end of the form. Finally, both individuals must sign and date the document.

Quantitative Values:

1. Performance level is only marginally acceptable; needs significant guidance.
 2. Satisfactory performance; quality of work is good; needs some guidance, but performs many tasks without assistance.
 3. Performance level is above average; work quality is always acceptable and sometimes exceptional; requires occasional guidance.
 4. Exceptional; work quality consistently exceeds expectations; needs minimal guidance.
-

Position Responsibilities:

Responsibility #1 _____

Quantitative Assessment: _____ Relative Weight: _____

Comments (required for all assessments deemed to be above or below average):

Responsibility #2 _____

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Responsibility #3 _____

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Responsibility #4 _____

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Responsibility #5 _____

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Responsibility #6 _____

Quantitative Assessment: _____ Relative Weight: _____

Comments:

General Work Habits:

Skill #1

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Skill #2

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Skill #3

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Skill #4

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Skill #5

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Skill #6

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Goals:

Goal #1

Completed: _____ Yes _____ No

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Goal #2

Completed: _____ Yes _____ No

Quantitative Assessment: _____ Relative Weight: _____

Comments:

Goal #3

Quantitative Assessment: _____

Relative Weight:

Completed: ____ Yes ____ No

Comments:

Goal #4

Completed: ____ Yes ____ No

Quantitative Assessment: _____

Relative Weight:

Comments:

Goal #5

Completed: ____ Yes ____ No

Quantitative Assessment: _____

Relative Weight:

Comments:

Goal #6

Completed: ____ Yes ____ No

Quantitative Assessment: _____

Relative Weight:

Comments:

Overall Performance:

Employee's overall performance is: _____

Total Weighted Score: _____

Overall Qualitative Assessment:

- _____ Outstanding
- _____ Above Average
- _____ Acceptable
- _____ Needs Improvement
- _____ Unacceptable

Overall Performance Comments and Suggestions for Improving Deficiencies (required):

Employee Comments:

Signatures:

I have been shown the contents of my employee performance review and have discussed it with my supervisor.

Employee's Signature

Date

I have objectively completed the preceding employee performance review to the best of my ability and have discussed its content with the employee with whom it concerns.

Supervisor's Signature

Date

APPENDIX M
THANK YOU LETTER FOR REFERRALS

Date

Referring Physician, M.D.

Address

Address

Re: Patient Name (Date of Birth)

Dear Dr. Physician:

Thank you for referring [PATIENT NAME] to me for a psychiatric evaluation. I evaluated [him/her] on [DATE]. [Mr./Ms NAME] reported experiencing [INSERT CHIEF COMPLAINT]. Based on this information and my evaluation, my diagnosis is [INSERT DIAGNOSIS]. I will be seeing [Mr./Ms. NAME] [XX] times per [week/month] for [psychotherapy/medication/other INSERT TREATMENT PLAN].

I will follow up with you if there are any major changes to this treatment plan. Please feel free to call me if you have any questions concerning this patient.

Sincerely,

John Doe, M.D.

APPENDIX N
CONFIDENTIALITY RELEASE FORM FOR PATIENTS

I, _____
(Patient's Name)

authorize _____ to release my
(Keeper of Patient's Psychiatric Records)

psychiatric medical records solely to:

(Name and Address of Party to Whom the Records Are to be Released)

This authorization is valid for _____
(Time Period)

and is strictly for the purpose of _____
(Purpose of Release)

Patient's or Guardian's Signature

Date

Witness's Signature

[This is a general release of information form. Some states have specific release forms mandated by law so be sure to check.]

APPENDIX O

PATIENT POLICIES

The following are sample patient policy statements that can be modified to meet your practice's needs. We recommend compiling all policies into one handout to be given to the patient at his or her first visit.

Payment Policies:

- Payment for services, including insurance copayments, is due at the time of service.
- If a check is returned due to insufficient funds, you will be charged an additional fee of \$20.
- Unless arrangements are made for a payment plan, all accounts that are outstanding for more than 90 days will be sent to our collections agency.

Appointment Cancellations:

- If an appointment is canceled with at least 48 hours notice, the patient will not be penalized.
- A first-time cancellation within 48 hours of the scheduled appointment will not be penalized.
- A second cancellation within 48 hours of the scheduled appointment will result in a fee equivalent to half the amount of the normal visit rate.
- A third cancellation within 48 hours of the scheduled appointment will result in a fee of the full normal visit rate.
- Exceptions will be dealt with on a case by case basis and are at the discretion of the doctor.

Emergencies/After Hours:

- Emergency psychiatric care is available 24 hours a day.
- In the event of an emergency, call the office's main number (999-999-9999). During normal business hours, the receptionist will set up an emergency appointment. If it is before or after normal business hours, a recording [or answering service] will provide instructions for reaching a psychiatrist [either by giving the number for an emergency room or pager].
- Provisions will be made for all emergency appointments to be conducted within 4 hours of the phone call.

APPENDIX P

SAMPLE BENEFITS VERIFICATION FORM

PLEASE FILL IN THE BLANKS BELOW, SO WE CAN KEEP THIS INFORMATION IN YOUR PATIENT FILE:

PATIENT'S NAME _____

ADDRESS _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

NAME OF INSURANCE PLAN _____

INSURANCE POLICY NUMBER _____

GROUP NUMBER _____

NAME OF EMPLOYER PROVIDING POLICY _____

INSURED'S NAME (IF DIFFERENT FROM PATIENT) _____

INSURED'S SOCIAL SECURITY NUMBER _____

INSURED'S DATE OF BIRTH _____

APPENDIX Q

CONFIDENTIALITY POLICY AND FORM FOR STAFF TO SIGN

As an employee of [INSERT PRACTICE NAME], you have access to confidential information concerning patients, physicians, other clinicians, and facilities. This information includes medical, as well as demographic (financial, marital, etc.), data contained in computerized and/or paper patient files or disclosed verbally by the patient.

You are responsible for maintaining the confidentiality of this information at all times. Under no circumstances will confidential information be disclosed without obtaining the appropriate release in writing from the patient. This extends to release of patient records, as well as discussion about specific patients not directly related to the provision of care.

Unauthorized disclosure of confidential information is grounds for dismissal and possible legal action.

Your signature on this form signifies that you understand and agree to abide by this policy.

Employee Signature

Date

Copies to: Employee
 Personnel File

APPENDIX R MEDICATION TREATMENT CONSENT FORM

Consent for Treatment With

(Name of Medication)

I, _____, am a patient of

Dr. _____. Dr. _____ has informed me that he/she recommends that I receive the medication _____ for the treatment of my illness. He/she has informed me of the nature of the treatment and has explained to me the risks of possible side effects, including _____.

[He/she specifically discussed the risk of tardive dyskinesia, which may cause involuntary tic-like movements in the face, tongue, neck, arms, and/or legs.]

I understand that although Dr. _____ has explained the most common side effects of this treatment to me, there may be other side effects, and that I should promptly inform Dr. _____ or another member of the staff if there are any unexpected changes in my condition.

I understand that I may not be compelled to take this medication and that I may decide to stop taking it at any time.

I also understand that although Dr. _____ believes that this medication will help me, there is no guarantee as to the results that may be expected.

On this basis I authorize Dr. _____ or anyone authorized by him/her to administer _____ at such intervals as he/she deems advisable.

Signed _____

Dated _____

APPENDIX S

SAMPLE PATIENT SATISFACTION SURVEY

What is your age? _____

How long have you been seeing Dr. _____? _____

	YES	NO	SOMETIMES
1. Do you feel confident that your doctor is providing you with care based on the latest medical information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When your doctor explains something to you, do you understand what it means for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel comfortable asking the doctor if there is something you don't understand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the doctor understand your problems and feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel the treatment is helping you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the office staff friendly and helpful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are the office hours convenient for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the office run efficiently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the office comfortable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are your calls handled promptly and courteously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the billing done correctly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Was the fee policy explained to your satisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Is there adequate parking near the office?

☐☐☐

14. Are you seen promptly when you arrive for an appointment?

☐☐☐

Please use this space to provide any comments you feel could help us provide you with better care:

APPENDIX T MANAGED BEHAVIORAL HEALTHCARE ORGANIZATIONS (MBHOS)

APS Healthcare, Inc.

6705 Rockledge Drive, Suite 200
Bethesda, MD 20817
Kenneth Kessler, M.D., Chairman and CEO
Phone: (301) 571-0633 / Fax: (301) 493-0776

Behavioral Health Services Employee Assistance Programs

2021 E. Hennepin Avenue, Suite 450
Minneapolis MN 55403
David Miller, Chief Executive Officer
John Scanlan, M.D., Chief Medical Officer
Phone: (800) 432-5155 / Fax: (651) 662-0852

CIGNA Behavioral Health (formerly MCC Behavioral Care)

11095 Viking Drive, #350
Eden Prairie, MN 55344
Keith Dixon, President and CEO
Phone: (952) 996-2000 / Fax: (952) 996-2659

CMG Health (see Magellan)

CNR Health, Inc. (see Innovative Resource Group)

Comp Care

1111 Bayside Drive, Suite 100
Corona Del Mar CA 92625
Robert Landis, President
Phone: (949) 644-9425 / Fax: (949) 719-9797

Comprehensive Behavioral Care

200 South Hoover Boulevard
Bldg 219, Suite 200
Tampa, FL 33609
Mary Jane Johnson, President and CEO
Phone: (813) 288-4808 / Fax: (813) 288-4844

ComPsych Corporation

NBC Tower
455 North Cityfront Plaza Drive 24th Floor
Chicago IL 60611-5322
Richard Chaifetz, CEO
Phone: (312) 595-4000 / (312) 595-4029

FEI Behavioral Health

11700 West Lake Park Drive
Milwaukee, WI 53224
Joseph DesPlaines, President and CEO
Paul Todd, M.D., Medical Director
Phone: (414) 359-1055 / Fax: (414) 359-1973

First Health Services

501 Great Circle Road, #300
Nashville, TN 37228
Pate McCartney, D.S.W., Vice President of Business Development
Olivia Garland, Ph.D., Vice President of Operations
Gilmore Sanes, M.D., Corporate Medical Director
Phone: (615) 256-3400 / Fax: (615) 256-0786

Green Spring Health Services (see Magellan)**Horizon Behavioral Services**

1500 Waters Ridge Drive
Lewisville TX 75057
Linda A. Laitner, President
Dorothy Harrison, Ph.D., VP EAP/Employer Division
Phone: (970) 420-8200 / Fax: (972) 420-8247

Human Affairs International (see Magellan)**Innovative Resource Group (formerly CNR Health)**

2514 S. 102nd Street
Milwaukee, WI 53227
James Hartert, M.D., M.S., President and COO
Phone: (414) 327-5197 / Fax: (414) 327-0886

Integra, Inc.

1060 First Avenue, Suite 400
King of Prussia PA 19406
Stuart S. Piltch, President & CEO
Suja Mathew, M.D., Medical Director
Phone: (610) 992-5484 / Fax: (610) 992-7046

Magellan Behavioral Health (MBH), [division of Magellan Health Services (MHS)]

6950 Columbia Gateway Drive
Columbia, MD 21046
Dan Messina, Chairman & President, MHS
Jonathan Book, M.D., Chief Medical Officer, Executive Vice President, MBH
Phone: (800) 458-2740 / Fax: (410) 953-5200

Merit Behavioral Care (see Magellan)

MHN, Inc.

1600 Los Gatos Drive, Suite 300
San Rafael, CA 94903
Matt Lonsdale, President and COO
(415) 491-6955
Robert Fusco, M.D., Medical Director
Phone: (415) 491-7200 / Fax: (415) 446-1835

Oxford Health Plans, Inc.

48 Monroe Turnpike
Trumbull, CT 06611
Norman C. Payson, M.D., Chairman and CEO
Charles G. Berg, President and COO
Alan M. Muney, EVP, CMO
Satwant Ahlawalia, Director, Behavioral Health
Phone: (800) 201-6991 or (203) 459-6000 / Fax: (203) 459-6464

PacifiCare Behavioral Health, Inc.

23046 Avenida De La Carlota, Suite 700
Laguna Hills, CA 92653
Jerome Vaccaro, M.D., President and CEO
Phone: (818) 623-5600 or (949) 348-5287 / Fax: (949) 855-4836

PRO Behavioral Health, Inc.

7600 E. Eastman Avenue
Suite 500, Tamarac Plaza III
Denver CO 80231
Theodore Wirecki, M.D., President and CFO
Martha Wirecki, LCSW, CEO
Phone: (303) 695-8007 / Fax: (303) 695-0100

Sheppard Pratt Health System

6501 North Charles Street
Towson, MD 21204
P.O. Box 6815
Baltimore, MD 21285-6815
Steven S. Sharfstein, M.D., President and CEO
Phone: (410) 938-3000 / Fax: (410) 938-4532

United Behavioral Health

425 Market Street, 27th Floor
San Francisco, CA 94105
Saul Feldman, D.P.A., Chairman and CEO
William Goldman, M.D., Senior V.P., Behavioral Health Science
David K. Nace, M.D., Corporate Medical Director (215) 557-6030
Phone: (415) 547-5000 / Fax: (415) 547-5200

Value Behavioral Health (see ValueOptions)

ValueOptions (parent company FHC Health Systems)

3110 Fairview Park Drive

Falls Church, VA 22042

Ronald I. Dozoretz, M.D., Chairman, FHC Health Systems
and ValueOptions

Phone: (800) 451-3581 / Fax: (757)459-5402

Don Fowls, M.D., Executive V.P. of Development and CMO for FHC Health Systems

Phone: (703) 205 8640

WellPoint Behavioral Health, Inc.

9655 Granite Ridge Drive 6th Floor

San Diego CA 92123

Leonard D. Schaeffer, Chairman and CEO

Michael Brase, M.D., Staff Vice President; Medical Director, Behavioral Health Quality
Management

Phone: (858) 571-8174 / Fax: (858) 571-8214

APPENDIX U

GENERAL PRINCIPLES FOR THE OPERATION OF MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE ORGANIZATIONS*

As in all of medicine, effective care is the most economical care. Many are concerned that the manner in which healthcare services are administered not impede effective treatment. There are presently no clinically sufficient principles for evaluating the operation of managed mental health and substance abuse organizations. In response, the American Psychiatric Association proposes and advocates for the following principles:

- A. Overall priority must be given to protecting the ability of the psychiatrist to provide a treatment setting and service that is optimum for the provision of psychiatric care, including psychotherapy.
- B. In providing oversight of a patient's evaluation and treatment, the privacy of the psychiatrist-patient relationship shall be protected and be in strict conformity with state and national laws, medical ethics, and specialty and subspecialty standards.
- C. Medical necessity of psychiatric treatment shall be determined by applying generally accepted medical standards. Third-party reviews must not mandate specific goals and treatment to the exclusion of treatment deemed most appropriate by the treating psychiatrist and the patient and his/her family.
- D. The patient, in collaboration with the psychiatrist, should make choices among psychiatric treatments that meet generally accepted medical standards. These decisions should not be made by representatives of managed care organizations.
- E. Decisions regarding coverage for psychiatric treatment shall be made in a timely manner and according to ERISA regulations and applicable state laws. These decisions and reviews shall not be excessively frequent and/or interfere with ongoing treatment.
- F. Patients and psychiatrists shall have available to them procedures for appealing, and these procedures shall include an independent third-party reviewer. Such appeals must be conducted in a timely manner, and treatment and funding shall continue pending the outcome of the appeal.

* Approved by the APA Board of Trustees September 1997

- G. To ensure that the processes of handling appeals of denials of coverage are fair and valid, an independent psychiatrist reviewer with similar training and experience to the treating psychiatrist shall conduct reviews of patients' appeals for psychiatric treatment. The reviewer must be licensed in the same geographic area in which the treatment is being provided.
- H. Release of material from medical records must be limited to only that information that is required to determine medical necessity, as determined by generally accepted medical standards and state laws.
- I. Interactions between the psychiatrist-reviewer and the psychiatrist shall be supportive of the treatment and shall not create barriers to discourage treatment. Patients who wish to voice their opinions to reviewers or the Medical Director shall have the opportunity to do so during the utilization review process
- J. The treating psychiatrist should be allowed sufficient time for adequate evaluation and treatment planning prior to definitive review.
- K. The diversity of therapeutic approaches supported by the APA's practice guidelines and the preference of patients to choose their own psychiatrists, including psychiatrists of a specific gender or ethnicity, shall be respected whenever possible and appropriate.
- L. Patients and psychiatrists shall be fully informed of the benefits provided by the managed care organization before the initiation of treatment. Such information regarding benefits shall include medical necessity criteria, data that will be sought for utilization review, and the guidelines for their interpretation. Patients and psychiatrists shall also be informed of the process for appeals, confidentiality policies, and financial incentives that could influence treatment.
- M. Organizations conducting utilization review are responsible for adverse outcomes resulting from denial of care authorizations.

BUYING OR LEASING OFFICE SPACE AND EQUIPMENT

If you go into private practice or establish a new group practice, you'll have to make decisions about where to locate and whether it will serve you better to lease or buy office space and equipment.

CONSIDERATIONS IN CHOOSING AN OFFICE LOCATION

Selecting a primary office location is one of the first decisions that must be made in establishing a practice. Once you have settled on the particular locale where you want to practice, you'll want to choose a favorable location in that city or town. Many clinicians are now setting up both primary and secondary offices as a survival strategy. When determining where to locate, keep the following factors in mind:

- **Accessibility:** Obviously you will want your office to be easily accessible to patients. One way to accomplish this is to set up office in or near an existing medical building or mental health providers' complex. This should facilitate referrals and will be convenient for many patients since they already travel to this part of town for healthcare services. In addition, you might consider setting up practice near a heavily traveled area, such as a shopping center or in the business district. Locations on bus and subway routes are also convenient. Unless you're in the center of a city, be sure that there is ample parking for your patients.
- **The area's capacity to support another psychiatrist:** Another option is to open an office in an area that is underserved by psychiatry. By doing some investigative and marketing work--looking in the phone book, calling the Chamber of Commerce, asking colleagues, consulting local psychiatric and other medical associations--it may be possible to find an area in which there are few or no psychiatrists or other mental health providers. Again, however, this area needs to be easily accessible to patients.
- **Patient privacy:** Keep in mind that patients may not want their trip to the psychiatrist to be public knowledge. This can be particularly problematic in a rural area. To avoid embarrassment, you may want to select a discrete location, such as a medical building that houses other medical professionals or a building that is a block or two away from the main drag.

TYPES OF OFFICE SPACE

There are some common factors to keep in mind when looking at potential office space. A single psychiatrist needs a minimum of four to five hundred square feet. This space can be divided into a waiting room, consultation room, and an administrative area. Given the importance of confidentiality, it is vital that the walls be reasonably soundproof, and don't overlook the space needed for the secure storage of medical records and other office files. You may also want to have separate entrance and exit doors for patients to use. With these common factors in mind, you'll need to determine what type of office space to use for your practice:

- **Home office:** If you are thinking about working out of your home, be sure to carefully weigh the advantages and disadvantages. It is certainly more convenient for you and probably will save you money. However, it may be difficult to keep your personal and professional lives separate when you're working out of your house; your home may be in a poor location for an office; and some patients and colleagues may view a home office as less professional. Be sure to check your neighborhood's zoning rules and consult your accountant regarding Internal Revenue Service codes before you commit to a home office.
- **Purchased office space:** In assessing the benefits of purchasing office space, you'll probably want to consult with an accountant, realtors, bankers, and a lawyer. Shop around to find the best mortgage deal, and be sure that you plan to practice in the area for a minimum of five years. Buying office space may not be advisable for psychiatrists who are just starting out or who may want to expand in the near future.

Medical condominiums are an option that can be attractive to the psychiatrist who wants to be near other healthcare professionals. Keep in mind, however, that you will pay maintenance fees for servicing common areas and will have to abide by rules set by the condominium governing board.

- **Leased space:** For psychiatrists who choose to lease office space, there are several key points to remember. First, landlords are often willing to negotiate. This can include reducing rent, waiving the security deposit, or making renovations prior to occupancy. Also, make sure that you feel comfortable with the length of the lease. If you lock into a five- or ten-year lease and decide to move after two, you may have trouble getting out of the agreement. Finally, do not assume anything. It is extremely important that all the details

of the lease, including the location of the property and the starting and ending dates of the agreement, are clearly and thoroughly stated. Remember, a lease is a contract, and like all contracts should be reviewed by an attorney before it is signed.

A good lease should clearly state, but not necessarily be limited to:

- Square footage of the office;
- Storage space;
- Parking spaces;
- Snow removal;
- Utilities;
- Furniture;
- Cleaning services;
- Twenty-four-hour access to the office;
- Insurance coverage;
- Policies for remodeling and redecorating;
- Increases in rental fees at the end of each year;
- Sublet policies;
- An escape clause for certain unforeseen incidents that would require you to leave your practice; and
- Language giving you first rights to new space that becomes available, should you decide to expand.

COMPUTER SYSTEMS AND SOFTWARE

To stay efficient and competitive in today's healthcare marketplace, it is essential that a psychiatric practice be supported by an up-to-date, comprehensive computer system. Whether working in a large practice or alone, there are innumerable tasks that a psychiatrist must tackle that can be handled far more efficiently and cost-effectively if done by computer. Some of the more common areas in which computer software packages can assist you are:

- Billing;
- Scheduling;
- Maintaining patient records;
- Electronic claims;
- Accounting;
- Accessing national data banks; and
- Working in a managed care environment.

With the large number of software companies and, thus, competition in the business, you should be able to find a package that fits your specific needs. For

more details on information systems and what they can do, please see Chapters 9 and 17.

TELEPHONE SYSTEMS

As is the case with home telephone service, you will use your local telephone company for local phone service and can choose among several long distance providers for long distance service. When purchasing equipment, you will have to choose between the local telephone carrier and private, independent vendors in your area. In comparing services and settling on a purchase contract, make sure that you know exactly what is included, such as:

- Service;
- Cost (initial and monthly);
- Maintenance;
- Warranties; and
- Installation.

In purchasing or leasing a telephone system, make sure that you have enough lines to fulfill your needs. Even a small, solo practice could require a minimum of three lines: one for the phone, a second for a fax machine, and a third for a computer modem, if you don't have a broadband connection for your modem such as DSL or cable. For a small practice without a receptionist, an answering machine is probably adequate or you can generally get individual voice mail services through your local phone company for a small monthly fee.

As the size of the practice increases, it will be necessary to add more lines. In addition, a voice-mail system may begin to make sense if your office employs more than eight people. If you are in a small practice that you think may expand, be sure your telephone system is designed to easily accommodate added features such as additional lines, an intercom, and a "local service only" reception-room phone.

To begin telephone service with five lines, initial costs for local phone service should be around \$200, depending on where the office is. With some companies if you sign an agreement for several years the installation charges are waived. Thereafter there will be a monthly charge that is approximately \$20 per line, again, depending on where you are. To receive hardware, telephones, installation, training, and warranties from a vendor, you can expect to pay a one-time fee of \$3,000 to \$4,000 for a basic system unless installation fees are waived. Vendors will also lease telephone equipment. Lease agreements generally run from one to five years. Consult your accountant to determine if leasing makes sense for you.

You may also want to consider hiring an answering service to cover your calls during nonbusiness hours. If so, hire a service that answers calls twenty-four hours a day. The answering service employees should know basic information about your practice and schedule, should consistently take accurate messages, and must understand the need for complete confidentiality. You may wish to supplement your in-office phone system with pagers and cellular phones so that you can be reached no matter where you are. The important thing to remember with both pagers and cell phones is that you want to be selective about who gets these numbers and be certain those people understand what circumstances warrant a call.

COPY MACHINES

In thinking about a copier, you must decide how much copying you plan to do. A single psychiatrist with little paperwork may decide that purchasing a machine doesn't make sense. A printer/scanner combination, which can be purchased very cheaply these days might well be all you need, and any big jobs could be taken to the nearest copy center. On the other hand, a large practice might copy thousands of pages a day and require a machine with high-speed copying and advanced features.

If you determine that you do need a copier, you have to decide how to obtain a machine. There are three main options: you can buy a new machine, buy a used one, or lease one. Tax deductions may vary depending on which option you choose. Consult your accountant to determine which choice is best for you.

It is also important to remember that, despite the temptation, it may not be wise to try to save money by purchasing the smallest machine you think you can get away with. This is because copiers that are overused wear out quickly and need frequent repairs. Ask your sales representative about warranties and service contracts. Many companies include these benefits in their leasing and sales packages.

You will need to replace the toner cartridge on a regular basis, so it is important to keep in mind that some machines require more expensive cartridges than others. This price variation will add up over time if you copy frequently and, thus, should be factored into overall cost when comparing different models.

FAX MACHINES

Fax machines can also be purchased relatively cheaply these days and can prove to be very valuable. Options to look for when investing in a fax machine include:

-
- Auto redial;
 - Speed of transmission;
 - Memory capacity;
 - Resolution; and
 - Capability to automatically switch between voice calls and fax document reception.

If saving money is a priority, sending documents in the evening is cheaper than during regular business hours. Ask about warranties and service contracts and remember, like copiers, fax machines require periodic replacement of the toner cartridge.

GENERAL OFFICE SUPPLIES

As an APA member, you are entitled to special savings at Penny Wise Office Supplies. Discounts of up to 36 percent are offered to APA members on over 18,000 products and delivery is nationwide. For more information, call (800) 942-3311.

APPENDIX W

PATIENT PAMPHLET ON MANAGED CARE *

What You Need to Know About Your Managed Mental Illness Insurance Benefits

Your Benefits

Don't assume that because you or your family member does not now have a mental illness that you don't need good mental health coverage. One in four adults will suffer from a mental illness or substance use disorder in any year. The best plans provide the same coverage for mental illness as for any other medical illness such as cancer or arthritis, subject to the same deductibles, copay amount, annual limits, and lifetime maximums. Unfortunately, most health plans discriminate by providing less care for mental illness and by requiring you to pay more out-of-pocket for the care you do receive. Make sure the plan offers emergency care, including psychiatric emergencies, and will allow you to go to the nearest emergency facility.

Exclusions

Read the "fine print" in your own benefit plan and ask to see the contract between the plan and the employer. If you can't understand its legalese, have your employee benefits manager or an attorney explain it in straightforward language. Some plans will discriminate by strictly limiting the number of psychotherapy visits and days in the hospital and may limit the type of medications they will provide or pay for. If you are joining the plan for the first time, make sure it will cover illnesses you suffered in the past or are currently being treated for. Many plans require a waiting period for preexisting illnesses.

Choosing Your Psychiatrist

The American Psychiatric Association believes that all health plans should allow you to choose your own psychiatrist, even one outside the plan, although you may be required to pay a larger portion of the cost yourself. If your psychiatrist is not a "participating physician," a second choice is to ask whether he or she would be allowed (or would be willing) to join the plan's panel of physicians. The third choice, and least desirable, is to negotiate a transition period with the plan in which you remain in treatment with your current psychiatrist, but eventually transfer to the care of a "participating psychiatrist." If you must switch to a plan psychiatrist, ask your treating psychiatrist to recommend one from the plan roster. Note: Not all may be accepting new patients or be convenient to you.

Gatekeepers

Many plans will not allow you to make an appointment directly with a psychiatrist. They require that you first be evaluated by a "gatekeeper" – usually a family physician, social worker, or plan service representative – to determine whether specialist care is needed. Unfortunately, gatekeepers may not be adequately trained in the diagnosis of mental illness and may miss symptoms indicating the need for care by a psychiatrist. George Anders, in his book *"Health Against Wealth"* quotes the mother of a seriously ill child who was mistreated by a well-known managed care plan: "We don't need a gatekeeper if the child is in an emergency, we need all the doors to be wide open."

Confidentiality

Your trust that confidential information discussed with your psychiatrist will not be shared with others is crucial to effective treatment. Ask how confidential information is protected and don't sign blanket medical record release forms; only sign time-limited requests for specific informa-

* This document was approved by the APA Board of Trustees in 1997 for psychiatrists to give to their patients.

tion. If the plan cannot assure you that information that would identify you will not be shared without your permission, investigate another plan or consider contracting privately for care from a professional outside the plan who will protect your confidences.

Quality of Care

It is nearly impossible for a consumer to judge the quality of care provided by a managed health plan, and the National Commission of Quality Assurance (NCQA) – created by the managed care industry to accredit HMOs and other organizations – at present offers limited help. The NCQA measures such things as the percentage of plan physicians who are “board certified.” It does not measure many indicators of quality—for example, the number of participants treated for depression who resume normal functioning. To determine overall member satisfaction with the plan, request the plan’s “patient satisfaction data” from your benefits manager. However, this survey data is unreliable without knowing how the questions were asked, cannot be compared with other plans, and may not give you an indication of how seriously ill patients rate the plan. Also, ask how many member appeals were filed and how many were denied. A high denial rate may mean the plan is rationing care to save money.

User Friendliness

Plan hospitals, clinics, and physicians should be conveniently located near your home or work place, with flexible hours of service. You should be able to get an appointment to see a psychiatrist or other professional within a reasonable period of time, and your waiting time to see the clinician once you have arrived should not be excessive. If you travel extensively, make certain you are covered for care in other cities or countries

Open Communication

Patients should be able to have a free and open conversation with their psychiatrist or other physician about their care. The psychiatrist should be free to tell you about all treatments that may help you, even those not covered by the plan. The physician should also be allowed to tell you about his or her financial arrangement plan – whether he or she benefits financially by limiting treatments and tests according to goals set by the plan. Over 95% of people responding to a recent survey said they wanted more information about financial incentives HMOs offer their physicians to reduce costs. Managed care plans can dismiss physicians who order more tests or hospital days beyond the plan’s “norm.” Some plans have “gag rules” prohibiting full communication between doctor and patient, or “antidisparagement” rules prohibiting any comments critical of the plan. (So far, ten states have passed laws barring these practices.)

When You Are Dissatisfied

With the Plan Offered You – Call the plan’s customer service department, and talk to your employer’s benefits manager or your union representative about your concerns. Remember, you don’t have to have mental illness in your family to be worried about the adequacy of the mental health benefit.

With the Services Provided – First talk to your psychiatrist or other physician and ask him or her to appeal on your behalf. If you have been denied treatment in what you consider a life threatening situation, do not hesitate to get the care you need from outside the system, even if you have to pay the entire bill yourself. Otherwise, use the plan’s appeal process. File a formal written complaint with the plan, with a copy to your employer’s health benefits manager and to the state insurance commissioner. Write to your state and federal legislators. Seek advice from your local psychiatric society. If you have a very strong case, consider taking it to the local news media. Consider talking with an attorney about your rights. In all cases, do everything in writing, and make as much noise as you can. In managed care, the squeaky wheel does get attention.

APPENDIX X

CONCEPTS FOR CREATING A BETTER MANAGED CARE SYSTEM

Passed by the APA Board of Trustees, December 1998

The Assembly and the Board voted to adopt the following as actions which, if implemented, will create a more consumer and doctor friendly managed care system.

- (a) Public accountability – That MCOs should be treated as are the public utilities.
- (b) A maximum choice of clinician – As close to an “any willing physician” policy as possible. As a compromise, a patient should be able to see any physician credentialed by any managed care organization in that state who agrees to the patient’s managed care company’s fee schedule.
- (c) A minimum “medical loss” ratio below which the MCO would be sanctioned.
- (d) “Community rating” in the setting of premiums.
- (e) Enrollment opened to all consumers regardless of health status or history.
- (f) A definition of “medical necessity” which reflects professional/community standards of care.
- (g) One submission of credentials satisfies all MCOs to which the physician wishes to apply.
- (h) All MCOs are incorporated as nonprofit corporations or, as a compromise, corporations whose profit is fixed (capped) and tied to the efficiency of administration, not to denial of cares, e.g., the rules under which the Medicare fiscal intermediaries operate.
- (i) All specialty services are “carved-In” services – Carving out mental health and other services leads to fragmented treatment.
- (j) Clinicians have a mechanism to negotiate fees, i.e., collective bargaining.
- (k) Financial books are opened for public inspection.

- (l) The medical directors are liable for the undesirable consequences of decisions to deny payment for care.
- (m) MCOs are liable for damages resulting from such denials as well.
- (n) Clinicians will be able to practice to the full extent of their licenses, i.e., MCOs are not allowed to prevent ophthalmologists from prescribing glasses or psychiatrists from doing psychotherapy.
- (o) An “open formulary” which permits both FDA-approved and off-label uses.
- (p) parity for mental health benefits and parity for utilization management – Mental health has been excessively cut via the utilization management process, spending has dropped over 25% for the treatment of mental illness as compared to 3% for medical and surgical procedures.
- (q) No micromanagement – For example, referrals to specialists should be for more than one visit, initially.
- (r) “Point of services” option will be offered by MCOs and will be offered at a reasonable additional cost.
- (s) Maintenance of confidentiality (based on a requirement that the patient grant informed consent for the release of records and that this consent not be a condition of payment).
- (t) MCOs will be required to request only that information needed for preauthorization, utilization management, etc.
- (u) Emergency admissions not require preauthorization.
- (v) No financial incentive should be given to the treating physicians for the denial of care, e.g., “bonuses” should be capped in capitated systems.
- (w) Internal and external independent, grievance procedures – External review done by a government agency or subject to government oversight.
- (x) Coverage for emergency room visits should be governed by prudent laymen standards.

- (y) Equal prescription benefits for patients using local pharmacies or mail order pharmacies.
- (z) Access to experimental procedures.
- (aa) Allowing specialists to have authority to serve as primary care doctors under certain circumstances, such as oncologists who must treat persons with cancer, nephrologists who treat renal failure, rheumatologists who treat severe autoimmune disease, neurologists who treat advanced multiple sclerosis, and psychiatrists who treat chronic and persistent mental illness.
- (bb) Specialists allowed to be admitting physicians in certain clinical conditions, e.g., cardiologists for persons with myocardial infarction, neurologists for patients with strokes, and psychiatrists for patients with acute mental illness, etc.
- (cc) Hospitalist's role is defined as that which best serves the interest of patient, and which does not interfere with primary or specialists care.
- (dd) No gag rules.
- (ee) Deselection occurs via due process and only "for cause. For cause deselections which do not reflect clinical incompetence or neglect should not need to be reported to the National Practitioner Data Bank.
- (ff) Clinicians should be able to withdraw from MCOs, i.e., "take a sabbatical," and return without prejudice. For example, if fees are too low, clinicians will be allowed to request inactive status, and thereby create a condition that truly reflects the market.
- (gg) Fees should not be set lower than the Medicare fees, which are based on a RBRVS – resource based relative value scale.
- (hh) Clinicians are involved in establishing standards for medical necessity.

APPENDIX Y

TERMINATION OF PSYCHIATRIST-PATIENT RELATIONSHIP

[Date]

Dear [Name of Patient]:

This is to inform you that I believe it is necessary to terminate our professional relationship. [Psychiatrist may, but is not required to, specify reason.]

I have been serving as your psychiatrist since [specify date], and am currently treating you for [indicate diagnosis] with a program of [specify treatment mode, including any drugs]. In my view, you [would/would not] benefit from continued treatment.

If you wish to continue to receive treatment, you are, of course, free to contact any psychiatrist of your choice. However, you may wish to contact one of the following [psychiatrists/facilities], [who/which] may be willing to accept you as a patient: [indicate specific referrals here]. If you find that none of these choices is acceptable, please contact me; I will make every effort to suggest additional alternatives. If you do decide to obtain treatment from one of these psychiatrists or facilities, or from any other psychiatrist or facility of your choice, I will be happy to forward your clinical records to your new doctor on your written authorization.

Finally, be assured that I will be available to treat you until [specify date]. [The following factors, among others, may be used to determine what is “reasonable” in a particular situation: condition of the patient, length of the psychiatrist-patient relationship, availability of other psychiatric services in the community, reason for termination, and amount of money owed, if any.]

Sincerely,

[Psychiatrist's Signature]

[Psychiatrist's Name]

Note: it is advisable to send termination letters via certified mail, return receipt requested.

APPENDIX Z

(1) MEDICARE PRIVATE CONTRACT

This agreement is entered into by and between _____
(hereinafter called "Physician"), whose principal medical office is located at _____
and _____
(a beneficiary enrolled in Medicare Part B, hereinafter called "Beneficiary"), who
resides at _____
_____.

A. Background

A change in the Social Security Act, effective January 1, 1998, permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician was not permitted to charge a beneficiary more than a certain percentage in excess of the Medicare fee schedule amount (limiting charge). The law now permits physicians and beneficiaries to enter into private arrangements through a written contract under which the Beneficiary may agree to pay the Physician more than that which would be paid under the Medicare program.

However, beneficiaries and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare. The Physician has certain other obligations, such as filing an affidavit with the appropriate Medicare carrier(s), a copy of which is attached to this contract. The purpose of this contract is to permit the Beneficiary and the Physician to take advantage of this change in the Medicare law, and it sets forth the rights and obligations of each. Furthermore, this agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

B. Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.
2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.

3. Physician acknowledges that (s)he will not execute this contract at a time when the Beneficiary is facing an emergency or urgent healthcare situation.
4. Physician agrees to provide the beneficiary or his/her legal representative with a copy of this document before items or services are furnished to the beneficiary under its terms.
5. Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS), upon the request of the CMS.

C. Obligations of Beneficiary

1. Beneficiary or his/her legal representative agrees to be fully responsible for payment of all items or services furnished by Physician and understand that no reimbursement will be provided under the Medicare program for such items or services.
2. Beneficiary or his/her legal representative acknowledges and understands that no limits under the Medicare program (including the limits under section 1848 (g) of the Social Security Act) apply to amounts that may be charged by Physician for such items or services.
3. Beneficiary or his/her legal representative agrees not to submit a claim to Medicare and further agrees not to ask Physician to submit a claim to Medicare.
4. Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
5. Beneficiary or his/her legal representative enters into this contract with the knowledge and understanding that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.
6. Beneficiary or his/her legal representative understands that Medigap plans (under section 1882 of the Social Security Act) do NOT, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.

7. Beneficiary or his/her legal representative acknowledges that the Centers for Medicare and Medicaid Services (CMS) has the right to obtain copies of this contract upon request.

D. Physician's Status

Beneficiary or his/her legal representative further acknowledges his/her understanding that Physician [has/has not] been excluded from participation under the Medicare program under section 1128, 1156, 1892 or any other section of the Social Security Act.

E. Term and Termination

This agreement shall become effective on _____ and shall continue in effect until _____. Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary or his/her legal representative agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract shall survive this contract.

F. Successors and Assigns

The parties agree that this agreement shall be fully binding on their heirs, successors, and assigns.

The parties hereto, intending to be legally bound by signing this agreement below, have caused this agreement to be executed on the date written below.

Name of Physician (printed)

Name of Beneficiary (printed) or
his/her Legal Representative

Signature of Physician

Signature of Beneficiary or his/her
Legal Representative

Date of Signature

Date of Signature

(2) MEDICARE OPT-OUT AFFIDAVIT

TWO COPIES OF THIS AFFIDAVIT SHOULD BE COMPLETED—ONE MUST BE FILED WITH YOUR MEDICARE CARRIER (SENT BY REGISTERED MAIL, RETURN RECEIPT REQUESTED) AND THE OTHER SHOULD BE KEPT ON FILE IN YOUR OFFICE.

I, _____, being duly sworn,

Full Name of Physician

depose and say:

1. I promise that, except for emergency or urgent care services (as specified in 42 C.F.R. §405.440), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of 42 C.F.R. §405.415 for services that, but for their provision under a private contract, would have been Medicare-covered services.
2. I promise that I will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the 2-year period beginning on the following effective date: _____; nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in 42 C.F.R. §405.440.
3. I understand that, during the opt-out period, I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare + Choice plan.
4. I acknowledge that, during the opt-out period, my services are not covered under Medicare and no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
5. I promise that during the opt-out period I will be bound by the terms of both this affidavit and the private contracts that I enter into with Medicare beneficiaries.
6. I acknowledge that the terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by me during the opt-out period (except for emergency or urgent care services furnished to

the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

7. I understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of 42 C.F.R. §405.440 apply if I furnish such services.
8. *[Section 8 should be used only for those physicians who have signed a Part B participation agreement.]* I acknowledge that my Part B participation agreement terminates on the effective date of the affidavit.

Signature of Physician

Principal Office Address

Telephone Number

National Provider Identifier (NPI)

Uniform Provider Identification Number (UPIN), if one has been assigned

Sworn to and subscribed before me

this _____ day of _____

Notary Public

APPENDIX BB
Medicare Carrier Advisory Committee Psychiatry Representatives

Alabama	James F. Hooper, M.D. Taylor Hardin Secure Medical Facility 1301 River Road NE Tuscaloosa, AL 35401 tel: 205-556-7060 fax: unknown jhooper@bama.ua.edu
Alaska	Wandal Winn, M.D. 4300 B Street, Ste.202 Anchorage, AK 99503 tel: 907-562-0794 fax: 907-561-4036 wwwinn@gci.net
Arizona	Paul R. Butzine, M.D. 14506 W. Granite Valley Dr., Ste. 108 Sun City West, AZ 85375 tel: 602-214-1141 fax: 602-214-8903 pbutzine@medscape.com
Arkansas	Raymond Remmel, M.D. 11219 Financial Center Pkwy #303 Little Rock, AR 72211 tel: 501-223-2622 fax: 501-223-2622 rremmel@aol.com
California (Northern)	Mark Fettman, M.D. 3139 Mission Street San Francisco, CA 94110 tel: 415-920-3812 fax: 415-920-9153 mfet600000@aol.com
California (Southern)	Barry Friedman, M.D. 200 N. Robertson Blvd. #300 Beverly Hills, CA 90211-1772 tel: 310-274-4372 fax: 310-274-5146 bfriedman@ucla.edu
Colorado	Vincent (Ben) Marshall, M.D. 165 Cook Street, #100 Denver, CO 80206 tel: 303-321-0326 fax: unknown no e-mail

Connecticut	<p>Alan Siegal, M.D. 60 Washington Street, Ste. 203 Hamden, CT 06518 tel: 203-288-0414 fax: 203-288-3655 asiegalmd2000@yahoo.com</p>
Connecticut (Alt.)	<p>Harry Morgan, M.D. 55 Nye Road Glastonbury, CT 06033 tel: 860-657-3056 fax: 860-633-3517 sandmorg@aol.com</p>
Delaware	<p>Peter Zorach, M.D. 1601 Concord Pike, #92-100 Wilmington, DE 19803 tel: 302-573-5112 fax: 302-655-4027 pzorach@comcast.net</p>
District of Columbia	<p>Catherine May, M.D. 1301 20th St., NW #913 Washington, DC 20036 tel: 202-466-3455 fax: 202-965-3301 csmaymd.aol.com</p>
Florida	<p>S.Reddy Pasem, M.D. 2801 SW College Road #4 Ocala, FL 34474-4430 tel: 352-237-0550 fax: 352-237-0749 reddymd@msn.com</p>
Florida (alt)	<p>David Tobolowsky, M.D. 7400 N. Kendall Drive #310 Miami, FL 33156 tel: 305-670-1167 fax: unknown dtobolowsk@aol.com</p>
Georgia	<p>William Thorneloe, M.D. 4015 S. Cobb Drive, Ste.130 Smyrna, GA 30080-6315 tel: 770-434-0677 fax: 770-434-3911 thornel@attglobal.net</p>

Hawaii	Stephen Kemble, M.D. 600 Kapiolani Blvd. Honolulu, HI 96813-5147 tel: 808-357-2665 fax: unknown sbkemble@hawaii.rr.com
Idaho	Stephen T. Bushi, M.D. 331 N. Allumbaugh Street Boise, Idaho 83704 tel: 208-658-0800 steveboise@earthlink.net
Illinois	Shastri Swaminathan, M.D. 36 Kingston Drive Oak Brook, IL 65021-1772 tel: 773-883-0200 fax: 773-883-0090 docshrink1@aol.com
Illinois (Alt.)	Bruce Gober, M.D. 2800 N. Sheridan Rd. #206 Chicago, IL 60657-6156 tel: 773-472-5424 fax: 773-472-8903 no e-mail
Indiana	John Wernert, M.D. 1776 Summerlakes Court Carmel, IN 46032 tel: 317-639-3406 fax: unknown jwernert@juno.com
Iowa	Robert Smith, M.D. VA Medical Center Psychiatry Service (116A) Iowa City, IA 52240 tel: 319-338-0581 x5445 robert.smith29e29c@med.va.gov
Kansas	Donald R. Brada, M.D. 1010 N. Kansas Street Wichita, KS 67214-3124 tel: 316-293-2647 fax: 316-293-1863 dbrada@kumc.edu

Kentucky	Nat H. Sandler, M.D. 1401 Harrodsburg Road #425 Lexington, KY 40504-3751 tel: 859-233-0444 fax: 859-233-0144 nhsandler@pol.net
Louisiana	Victor D. Gonzalez, M.D. 855 Berlanger St. #202 Houma, LA 70360-4463 tel: 504-868-1621 fax: 504-873-5904 no e-mail
Maine	Ronald Bailyn, M.D. Department of Psychiatry Maine Medical Center 22 Bramhall St. Portland, ME 04102-3134 tel: 207-871-2889 fax: 207-871-6783 bailyr@mmc.org
Maryland	Robert Roca, M.D. Sheppard Pratt Health System P.O. Box 6815 Baltimore, MD 21285 tel: 410-938-4320 fax: unknown rroca@sheppardpratt.org
Maryland (Alt.)	Allan Anderson, M.D. Dorchester General Hospital 300 Bryn Street Cambridge, MD 21613-1908 tel: 410-228-6800 fax: 410-228-3491 shrink@dmv.com
Massachusetts	Gary Moak, M.D. 21 Longmeadow Road Westboro, MA 01581 tel: 508-831-0045 fax: 508-870-9793 gerosike@aol.com
Michigan	Seymour Baxter, M.D. 999 Hayes Street Birmingham, MI 48009-6775 tel: 248-642-4820 fax: 248-642-6601 sbaxter@baxtermed.com

Minnesota	Eric Larson, M.D. Department of Mental Health Park Nicollet Health Services 3800 Park Nicollet Blvd St. Louis Park, MN 55416 tel: 952-993-3307 fax: 952-993-1762 larsoew@parknicollet.com
Minnesota (Alt.)	Deane C. Manolis, M.D. 4010 W. 65th Street, Ste. 218 Edina, MN 55435-1726 tel: 612-920-7203 fax: 612-920-0989 dmanolis@aol.com
Mississippi	David Richardson, M.D. 4500 I-55 North, Suite 234 Highland Village Jackson, MS 39211 tel: 601-982-8531 fax: 601-982-1115 no e-mail
Missouri	No current psychiatry representative
Montana	James L. Day, M.D. 162 Highland Road Great Falls, MT 59405-8118 tel: 406-761-0554 jldaymd@aol.com
Nebraska	No current psychiatry representative
Nevada	William Stone, M.D. P.O. Box 12477 Las Vegas, NV 89112-0477 tel: 702-877-6000 fax: 702-877-6000 nvapa@aol.com
New Hampshire	Christine Barney, M.D. 6 S. Park Street Lebanon, NH 03766 tel: 603-448-4831 fax: 603-448-2182 christine.barney@dartmouth.edu
New Jersey	Istvan Boksay, M.D. 7 North Crescent Maplewood, NJ 07040-2701 tel: 212-263-7634 fax: 212-263-6991 no e-mail

New Mexico	Jo Lynn Muraida, M.D. 9426 Oakmont Rd. Albuquerque, NM 87111 tel: 505-342-8412 fax: 505-342-8447 joly4u@aol.com
New York	Edward Gordon, M.D. 388 Hardscrabble Road N. Salem, NY 10560 tel: 914-669-5526 fax: 914-669-9428 nypsych@attglobal.net
New York (Alt.)	Mark Russakoff, M.D. Phelps Memorial Hospital 701 North Broadway Sleepy Hollow, NY 10591 tel: 914-366-3604 fax: 914-366-1302 mrussakoff@stellarishealth.org
North Carolina	James S. Williford, M.D. 600 Greenvally Road, #204 Greensboro, NC 27408 tel: 336-292-1510 fax: 336-292-0679 strat74@pol.net
North Dakota	Ronald M. Burd, M.D. MeritCare Clinic Neuroscience 700 1 st Avenue South Fargo, ND 58103-1899 tel: 701-234-4131 fax: 701-234-4024 ronaldburd@meritcare.com
Ohio	R. Gregory Rohs, M.D. 310 Chenora Court Cincinnati, OH 45215-4107 tel: 513-872-2692 rgregory_rohs@trihealth.com
Oklahoma	No current psychiatry representative
Oregon	Candace McKanna, M.D. 9155 SW Barnes Road, Ste. 435 Portland, OR 97225-6631 tel: 503-297-6656 fax: 503-297-4006 ckmck@aol.com

Pennsylvania	Marc H. Zisselman, M.D. 6 Tohopeka Lane Philadelphia, PA 19118-3825 tel: 215-456-2029 fax: 214-456-2883 zisselmanm@einstein.edu
Pennsylvania (Alt.)	David Buch, M.D. 306 Wyncote Road Jenkintown, PA 19046-3121 tel: 215-629-0195 fax: 215-629-0341 dbuchmd@telocity.com
Puerto Rico	Maria Sanchez-Bonilla, M.D. Avenida de Diego #150 Santurce, PR 00907-2318 tel: 787-724-8667 fax: 787-722-1950 sanchez@coqui.net
Rhode Island	Stanley Gale, M.D. 6 Irving Avenue Providence, RI 02906 tel: 401-831-7756 fax: unknown stanley_gale@brown.edu
South Carolina	Jim Bouknight, M.D., Ph.D 1530 Richland Street Columbia, SC 29201-2611 tel: 803-252-4042 fax: 803-252-7440 jbouk@aol.com
South Carolina (Alt.)	Charles Ham, M.D. Lexington County Mental Health 301 Palmetto Park Blvd Lexington, SC 29072-7872 tel: 803-739-8600 x 10 fax: 803-739-8606 no e-mail
South Dakota	William Fuller, M.D. 1000 E. 21st Sioux Falls, SD 57105 tel: 605-322-5700 fax: 605-322-5704 wfuller@usd.edu

South Dakota (Alt.)	Richard Renka, M.D. P.O. Box 288 Rapid City, SD 57701-0288 tel: 605-348-5401 fax: 605-348-7319 renka@hills.net
Tennessee	No current psychiatry representative
Texas	Leslie H. Secrest, M.D. 8200 Walnut Hill Lane Dallas, TX 75231 tel: 214-345-7355 fax: 214-345-2682 no e-mail
Texas (Alt.)	Larry E. Tripp, M.D. 3707 Gaston #418 Dallas, TX 75246 tel: 214-824-2273 fax: 214-826-9340 ltripp@flash.net
Utah	Michael Kalm, M.D. 3191 S. Valley Street, #152 Salt Lake City, UT 84109 tel: 801-468-1248 mikalm@alumni.duke.edu
Vermont	Alban Coghlan, M.D. 90 Mahoney Avenue Rutland, VT 05701 tel: 802-775-2581 fax: 802-775-3395 no e-mail
Virginia	Page Moss Fletcher, M.D. 224 Cornwall St., NW Leesburg, VA 20176 tel: 703-779-5222 fax: 703-549-5240 manningfletcher@aol.com
Washington	Robert B. Olsen, M.D. 1101 Madison St. #1290 Seattle, WA 98104 tel: 206-622-5455 fax: 206-622-2008 orobert@aol.com

West Virginia	Sidney Lerfald, M.D. 415 Morris Street #306 Charleston, WV 25301 tel: 304-343-1022 fax: unknown slerfald@firstphysician.com
Wisconsin	Harold Harsch, M.D. FMLH-E/Psychiatry 9200 West Wisconsin Ave. Milwaukee, WI 53226 tel: 414-257-5373 fax: 414-257-5241 hharsch@mcw.edu
Wyoming	No current psychiatry representative

APPENDIX CC

DOCUMENTATION OF PSYCHOTHERAPY BY PSYCHIATRISTS ¹

I. Conflicting Principles and Priorities

The issues considered in the following paragraphs highlight an irreconcilable conflict between two important principles. On the one hand, medical-legal principles indicate that the medical record should be complete, factual, and accurate. On the other, the growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical record lest this expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in every individual clinical situation must be free to use their judgment in facing this dilemma. What follows is a consideration of the issues involved; it is not a standard and is not binding on members of the APA.

Documentation of any medical procedure serves multiple purposes and is generally required by state statute, case law, and/or the bylaws of health care organizations. Documentation is a medical and legal record of assessment, decision-making, general management, and specific medical treatment. It should be factual, legible and accurate. The record traditionally serves to provide clinical care, supporting continuity in the care of the patient by the treating psychiatrist or successors. Secondly, with the patient's specific, delimited, written, informed consent, the medical record can also be referenced to verify that services actually took place or to evaluate "medical necessity" of services rendered for purposes of claiming third party payment. (This usage of a record of psychotherapy is, however, considered by many practitioners to be incompatible with the practice of psychotherapy; it is illegal in the District of Columbia.) Furthermore, the medical record may become evidence in litigation for a variety of purposes, including professional liability, where documentation may make a significant difference in the exposure of the treating psychiatrist to risk (Psychiatrists' Purchasing Group, 1994).

Despite ethical standards and varying degrees of legal protection of confidentiality of the doctor-patient relationship, medical records may be open to disclosure in unanticipated ways that are beyond the control of the patient or the psychiatrist, as in the case of mandated reporting laws or other statutory exceptions to confidentiality. Such potential intrusions present risks to the integrity of psychotherapeutic treatments. The psychiatrist should use all available legal means to protect the confidentiality of any record of psychotherapy.

Psychiatric treatment, and especially psychotherapy, involves sensitive, personal information about the patient and other people in the patient's life. The patient

reveals this information to the psychiatrist in the faith and trust that it will be used to advance the treatment and that no information from that treatment will be revealed to any other person without informed consent for disclosure. In a landmark ruling pertaining to the admissibility of evidence in Federal courts, the U.S. Supreme Court has explicitly acknowledged the absolute privilege of any information pertaining to a psychotherapy (*Jaffee vs. Redmond*, 1996) as being essential to effective treatment.

Data regarding the diagnosis and treatment of substance abuse are also protected at a higher standard than other medical records by Federal law; this protection comes through a different legal pathway and thus cannot be quantitatively compared with the protection of psychotherapy by the Supreme Court. The American Psychiatric Association is committed to seeking maximum protection of the confidentiality of psychiatric records.

The fact that it is now technically feasible to computerize medical records and transmit them electronically presents a greatly increased vulnerability to unauthorized access that may compromise confidentiality and could significantly harm the patient. There is no consensus that any security system exists that absolutely protects electronic records in data banks from human error or malice. Although the same risks pertain to paper records, access to electronic records may be easier to accomplish and more difficult to detect. Recording psychotherapy content or process in electronic systems beyond the direct control of the practitioner (and professionals in an organized setting who are collaborating in the patient's care) would place a patient's private thoughts and acts at such grave risk of unauthorized disclosure as to make treatment impossible.

Psychotherapy is a crucial part of the training of psychiatric residents. As a part of this training, residents must learn how to document psychotherapy in the medical record while maintaining confidentiality. They need to understand those instances when documentation conflicts with and potentially jeopardizes the confidentiality upon which the effectiveness of the psychotherapy is based. The same emphasis on maintaining confidentiality in documentation should also be addressed in the continuing education of practicing psychiatrists.

What follows is a suggested format, not a standard of practice, for documentation of psychotherapy by psychiatrists. It does not address issues involved in the process of releasing information to third parties², but it considers how the possibility of such release may affect documentation procedures. This discussion does not necessarily reflect current practice of documentation of psychotherapy throughout the profession. Variations occur because of state law and the requirements of individual clinical situations. The extent of documentation may vary from session to session and depends on the treatment method and intensity. A patient and/or a psychotherapist may prefer that there be no documentation, although this can pose significant risks to the practitioner

because of the absence of contemporaneous documentation that can serve as evidence to support the standard of care provided. It is not unethical for the psychiatrist to refrain from keeping a written record of the psychotherapy, and this may be regarded as the clinically appropriate course of action. In some states, however, documentation is explicitly required under law.

APA's ethical principles state that "Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient." And, "Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact." The psychiatrist should be mindful of the cautions stated in these principles when writing medical records in general, considering how likely it is that the records might be viewed by others and thus become a vehicle for disclosure. Entering any notation of psychotherapy process or content requires even greater circumspection.

II. Suggested format for documentation of psychotherapy by psychiatrists

1. ***Clinical judgment.*** The growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical record in order not to expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in each individual clinical situation must be free to use their judgment in coming to terms with this dilemma.
2. ***Variation in documentation procedures.*** Variations in documentation procedures may necessarily occur because of state law or the requirements of individual clinical situations. The latter may include a patient's request or the clinician's judgment that there be no identifiable documentation. It is not considered to be a violation of professional ethics to keep only administrative records and no therapy notes. Possible legal ramifications may vary based on geographic location.
3. ***Initial evaluation.*** The record of the patient's initial evaluation should accord with generally accepted procedures for conducting and documenting an initial psychiatric evaluation, which are beyond the scope of these recommendations. It is important that the individual clinician use judgment in regard to what information is included in the evaluation report so as not to jeopardize the patient's privacy or confidentiality. An initial evaluation may be done and documented by another psychiatrist.
4. ***Concise, factual documentation of psychotherapy while respecting the privacy of the patient's mental life.*** Characteristically, psychotherapy notes should concisely record only factual, administrative material regarding the psychotherapy itself, such as the date, duration of the session (some

Medicare carriers want documentation of the clock time of starting and ending the session), procedure code, and/or category of psychotherapeutic intervention (e.g., psychodynamic therapy, supportive therapy, cognitive restructuring, relaxation or behavioral modification techniques, etc.). Depending on the security of the patient record in the particular treatment setting, some practitioners may also include a brief listing of major themes or topic(s) addressed, whereas others would consider this an unacceptable risk to the confidentiality of privileged communications.

5. **Documentation of psychiatric management.** Records may include other descriptive and factual information, not related to the process or content of psychotherapy, which may provide a record of responsible, diligent psychiatric management and be valuable both to patient care and to the psychiatrist in case of untoward developments. Examples of such information are: notable events in the treatment setting or the patient's life, clinical observations of the patient's mental and physical status, documentation of the psychiatrist's efforts to obtain relevant information from other sources, psychological test findings, notation that a patient has been fully informed and indicated an understanding of the risks and benefits of a new medication or therapeutic procedure, or other pertinent data. Reporting requirements may necessitate factual documentation in cases involving activities dangerous to the patient's self or others, such as suicidal ideation with intention to act, child abuse, credible threats of harm to others, etc. Collaboration with other clinicians should also be noted. The record would generally include basic management information that could enable other clinicians to maintain continuity of care if necessary. However, a responsible professional approach in today's world is to consider and justify the necessity of recording each item.
6. **Exclusion of mental content from the formal record.** Intimate personal content, details of fantasies and dreams, process interactions, sensitive information about other individuals in the patient's life, or the psychiatrist's personal reactions, hypotheses, or speculations are not necessary in a formal medical record. Before charting such material the clinician should carefully consider the potential vulnerability of the record to disclosure and misinterpretation.
7. **Information systems considerations.** Information entered into a computerized system that goes beyond the direct and immediate control of the treating psychiatrist (and, in an organized treatment setting, of the professionals who are collaborating in the patient's care) should be stringently restricted to protect patient privacy and confidentiality. It must be limited to the minimum requirements of the system for administrative and basic clinical data and not jeopardize the essential privacy of psychotherapy material. As with any disclosure of medical records, paper or electronic, transmission of clinical data to information systems outside the treatment setting must not occur without the awareness and specific, voluntary, delimited, written consent of

the patient; such consent must not be mandated as a precondition for third party payment for treatment. Psychiatrists, along with their patients, should have the right to decide together to keep information from psychotherapy out of any computerized system.

8. ***Psychotherapy with Medical Evaluation and Management.*** The APA and the Commission of Psychotherapy by Psychiatrists affirm that psychiatrists' medical training, experience, and assessment and management skills are integral to their ongoing psychotherapeutic work. However, certain CPT codes in the 908xx series specifying "Psychotherapy with Medical Evaluation and Management (E&M)" have been interpreted by APA's experts on coding to require specific documentation that in each session thus coded the physician 1) ***assessed*** the patient's condition through ***history-taking and examination*** and/or 2) carried out ***medical decision-making*** and/or 3) provided ***management services***. The medical E&M service(s) may optionally be described under a separate heading from the psychotherapy service. Writing a prescription is only one of many possible actions fulfilling this requirement. Documentation may include mental status or physical observations or findings, laboratory test results, prescriptions written (dates, dosages, quantities, refills, phone number of pharmacy, etc.), side effects or rationale for changes of medication, notation that a patient has been fully informed and indicated an understanding of the risks and benefits of a new medication or therapeutic procedure, compliance with medication regimen and clinical response, etc. A minimal number of E&M activities may suffice. At this time, it appears that the medical evaluation and management service (as distinct from the psychotherapy service) rendered under the "Psychotherapy with Medical E&M" codes is comparable to a Level One service under the general E&M codes (992xx) available for use by all physicians. Level One assessment could consist of one element of the mental status examination, a vital sign, or an observation of musculoskeletal status.

Documentation requirements for the general E&M (992xx) codes are still in flux. Third parties, such as Medicare, insurance companies, and HMO's are still in the process of developing policies on the kind of documentation they may require to reimburse patients and/or pay practitioners for CPT codes for "Psychotherapy with Medical E&M" (908xx). The APA will work hard to ensure that these new standards conform with APA recommendations for documentation of psychotherapy by psychiatrists³.

9. ***Consideration of patient access to records.*** Psychiatrists should be cognizant of and sensitive to the fact that patients have access to their medical records in many jurisdictions. State law may require release of the record to another physician or healthcare professional caring for the patient or to the patient's attorney, pursuant to valid written authorization by the patient.

- 10. Psychiatrist's personal working notes: an unresolved dilemma.** In keeping with the APA Guidelines on Confidentiality (1987) and some authorities on psychiatry and the law (Appelbaum and Gutheil, 1991), the psychiatrist may make personal working notes, kept physically apart from the medical record, containing intimate details of the patient's mental phenomena, observations of other people in the patient's life, the psychiatrist's reflections and self-observations, hypotheses, predictions, etc. Such personal working notes are often used as a memory aid; as a guide to future work; for training, supervision or consultation; or for scientific research that would not identify the patient. Many psychiatrists consider such uses to be crucial to the clinical care they provide. *If such notes are written, every effort should be made to exclude information that would reveal the identity of the patient to anyone but the treating psychiatrist.* If there is any risk of disclosure, patients should be informed in a general way about the use of notes for teaching and research and the ways in which identifiable disclosures will be avoided, and the patient's consent should be obtained for such uses.

Except for a few jurisdictions there is no statutory assurance that such notes are exempt from discovery in litigation, and even in protective jurisdictions the definition of personal working notes may be challenged and the notes subject to judicial review. It is possible for a psychiatrist to resist a subpoena of such material, but the likely outcome is that the judge would review it *in camera* and select what is relevant to the case at hand. *Destroying such notes after a subpoena arrives opens the psychiatrist to extreme legal risk and should never be done. Personal working notes should be destroyed as soon as their purpose has been served, and this should be done in a systematic, routine way for all cases that clearly is not designed to avoid discovery in a specific case.* Psychiatrists should acquaint themselves with the prevailing law on personal working notes in their state. The absence of notes does not assure that a psychiatrist would not be required to testify from memory regarding the content of treatment.

- 11. Final clinical note.** A final clinical note at the end of treatment may summarize the psychotherapy concisely from a technical standpoint without divulging intimate personal information, and document the patient's status and prognosis, reasons for termination, and any recommendations made to the patient regarding further treatment and/or follow-up. It is important that the individual clinician use judgment in regard to what information is included in the final report so as not to jeopardize the patient's privacy or confidentiality. An exit evaluation may be done and documented by another psychiatrist.
- 12. Special situations.** Special documentation requirements established by reputable professional organizations for use by members of those organizations may apply to specified treatment methods or clinical situations. An example is The American Psychoanalytic Association's Practice Bulletin on "Charting Psychoanalysis" (American Psychoanalytic Association, 1997.)

Footnotes

¹. This resource document incorporates valuable comments and suggestions made by members of many components of the APA. These include the Commission on Psychotherapy by Psychiatrists, the Council on Psychiatry and the Law and its Committee on Confidentiality, the Consortium on Treatment Issues of the Council on Psychiatric Services, the Council on Health Care Systems and Financing and its Committee on Private Practice, the Work Group on Codes and Reimbursements, the Joint Commission on Government Relations, the Committee on Ethics, JoAnn E. Macbeth, J.D. (APA's legal counsel), and APA's liability insurance carrier. As the primary author, Norman A. Clemens, M.D., chair of the Commission on Psychotherapy by Psychiatrists, integrated the contributions of the above components with the assistance of members of the Commission. The Commission is most grateful for the thoughtful work that went into these contributions.

². Recommendations for actual third-party review procedures and the individual psychiatrist's response to a request for review or disclosure are beyond the scope of this paper. Psychiatrists should be alert to APA statements on these important and complex matters.

³. Individual psychiatrists and their patients should be able to exercise the right, if they believe that it is essential to the integrity of psychotherapy, to insist that any review of the psychotherapy (beyond administrative review of such matters as date and duration of service, CPT code, charge, etc.) be conducted in a professional, confidential setting. All personal data, including the content of psychotherapy, must remain confidential, and only the medical opinion (as to whether the treatment in question is or is not medically indicated) would be sent to a third party.

References

American Psychiatric Association (1987). Guidelines on Confidentiality, *American Journal of Psychiatry* 144:11.

Reprint available on request from the APA.

American Psychoanalytic Association (1997). "Charting Psychoanalysis", *Journal of the American Psychoanalytic Association*, 45:656-672. Available on request from the American Psychoanalytic Association.

Appelbaum, P., and Gutheil, T. (1991). *Clinical Handbook of Psychiatry and the Law*, 2nd Ed., Williams and Wilkins

Melonas, J. (1999). "Confidentiality in the Era of Managed Care", *Psychiatric Practice and Managed Care*, 5(1, Jan./Feb.):6-8,12, American Psychiatric Association Office of Healthcare Systems and Financing

Psychiatrists' Purchasing Group, Inc. (1994). "Psychiatric Records" in *Legal and Risk Management Issues in the Practice of Psychiatry*, Chapter 7, pp. 1-7.

THIS RESOURCE DOCUMENT DOES **NOT** REPRESENT OFFICIAL POLICY OF THE AMERICAN PSYCHIATRIC ASSOCIATION. It was produced by the Commission on Psychotherapy by Psychiatrists and approved by the Board of Trustees in July, 1999. This document has been reviewed by various components throughout the Association.

APPENDIX DD

FUTURE MEETINGS AND EVALUATIONS

APA ANNUAL MEETINGS

For Information: (703) 907- 7822

YEAR	DATES	LOCATION
2011	May 14-19	Honolulu, HI
2012	May 5-9	Philadelphia, PA

INSTITUTE ON PSYCHIATRIC SERVICES

For Information: (703) 907- 7815

YEAR	DATES	LOCATION
2010	October 14-17	Boston, MA
2011	October 27-30	San Francisco, CA
2012	October 4-7	New York, NY
2013	October 10-13	Philadelphia, PA
2014	October 30-November 2	San Francisco, CA
2015	October 8-11	New York, NY

EXAMINATIONS

The American Board of Psychiatry and Neurology (ABPN) conducts regular examinations for certification in psychiatry, neurology, and subspecialties, as well as for maintenance of certification. For complete information about deadlines and when and where examinations are scheduled, go to the ABPN website at <http://www.abpn.com/> or call them at (847) 229-6500.

APPENDIX EE PSYCHOTHERAPY CONSENT FORM

Consent for Psychotherapy Treatment

I, _____, am a patient of

Dr. _____. Dr. _____ has informed me that he/she recommends that I receive psychotherapy for the treatment of my illness or problems. He/she has informed me of the nature of the treatment and has explained to me the benefits and risks as well as alternative approaches for care (including psychotropic medication, if clinically appropriate).

I understand that although Dr. _____ has explained the treatment to me, there may be problems that develop. I understand that it is my responsibility to inform Dr. _____ (or a member of his/her staff if s/he is unavailable) if there are any unexpected changes in my condition or if any problems arise relating to my treatment.

I understand that I am not compelled to engage in psychotherapy and that I may decide to stop it at any time. It is my responsibility to notify Dr. _____ if I do decide to terminate treatment.

I also understand that, although Dr. _____ believes that psychotherapy will help me, there is no guarantee that my condition will improve.

On this basis, I authorize Dr. _____ to provide psychotherapy at such intervals as he/she deems advisable.

Signed _____

Dated _____

MEDICAL PROFESSIONAL LIABILITY INSURANCE

OVERVIEW

Medical professional liability insurance, usually referred to as malpractice insurance, covers damages and defense costs for claims a psychiatrist becomes legally obligated to pay arising out of either the rendering of or failure to render psychiatric services.

Most states, although not all, require physicians to carry malpractice insurance. Even in states that don't require malpractice coverage, physicians must have this coverage to obtain hospital privileges. If the physician does not obtain medical professional liability insurance, the state will usually require that a bond be posted from the personal funds of the psychiatrist. There are also some states that have enacted legislation regulating the coverage that physicians have to carry ("primary limits"), and these states provide limits in excess of the primary limits for a surcharge assessed to the physician. These programs are referred to as patient compensation fund programs. They vary from state to state and may or may not require mandatory participation by a physician. To learn if your state has specific requirements regarding malpractice insurance, you can contact the state licensing board or the department of insurance. Additionally, many managed care organizations, hospitals, and medical group practices specify how much insurance (the limits of liability) a psychiatrist must carry.

SELECTING LIABILITY INSURANCE COVERAGE

When choosing a malpractice policy you should compare the coverages and benefits offered by each program to ensure that your interests are adequately protected. Knowing the difference between the basic coverages and the "bells and whistles" is critical when considering malpractice insurance. To adequately compare carriers, you should obtain a specimen copy of the policy contract from each carrier. If they are unwilling to provide you with a specimen copy, you may want to seriously consider looking elsewhere.

The American Professional Agency, Inc. provides malpractice coverage exclusively for APA members. If you'd like to inquire about the coverage they offer, their toll-free number is 800-421-6694.

In the past, psychiatrists have listed the following elements as being important in their coverage.

Competence of Counsel

Insurance companies should use attorneys who have an in-depth knowledge of state malpractice laws and who have a record of outstanding performance. Specific knowledge of psychiatric malpractice is important since the allegations tend to be more subjective than in other areas of medicine.

Access to Attorneys for Pre-Suit Advice

Psychiatrists should be able to discuss risk management situations and events so that a suit may be averted or damages mitigated.

Consent to Settle

Since every settlement or judgment must be registered with the National Practitioner Data Bank (see Chapter 44), it is important to purchase a malpractice policy with provisions that allow the psychiatrist to participate in the decision of whether to settle a claim or suit.

Company Reputation and Financial Strength

The insurance company's reputation for service and financial stability should be unparalleled. Companies such as A.M. Best and Standard & Poor's rate the financial stability of various corporations that provide liability coverage. A.M. Best has two books of ratings that you should be able to find in libraries, *Best Insurance Reports* and *Key Rating Guide*. In addition, if you would like an updated rating, you can go to their website, <http://www.ambest.com/sales/BIR/>, and purchase updated ratings. For further understanding of the rating system, you can go to Standard & Poor's website at <http://www.standardandpoors.com/ratings/insurance/en/us>. You may also ask the insurance company you are interested in purchasing coverage from to provide you with written information regarding their A.M. Best or Standard & Poor's rating.

Understandable Policy Language

The policy you choose should be written in an easy-to-read and understandable format. Terms and conditions should be defined and exclusions specifically outlined.

Coverage Designed for Psychiatrists

The insurance company should understand and provide coverage and services that meet the unique needs of the psychiatric profession.

The malpractice insurance policy should define psychiatric/medical services. It should be designed and written specifically for psychiatrists.

High Quality Customer Service

The insurance company should have underwriting, risk management, and claim staff knowledgeable about the unique needs of the psychiatric profession. They should be accessible by mail, fax, phone, and e-mail to respond to coverage inquiries, claims, and risk management questions in a timely and effective manner.

OTHER IMPORTANT ISSUES TO CONSIDER WHEN YOU PURCHASE INSURANCE

Coverage Options

There are two fundamental types of malpractice policies; occurrence policies and claims-made policies. Occurrence insurance protects you against lawsuits no matter when they are made, even after you have stopped your coverage. Claims-made insurance only protects you if a suit is brought while the insurance is current. However, this limitation of claims-made policies can be eliminated by purchasing a prepaid “tail” (officially, an Extended Claim Reporting Endorsement) at the end of coverage. The tail, in essence, turns a claims-made insurance policy into an occurrence policy. It is important, however, to find out how quickly you must purchase the tail after coverage ends. Insurance companies often have a deadline, sometimes regulated by the state. After this deadline, the company may no longer be required to provide you with tail coverage.

Costs Involved

Before deciding on the type of insurance you want to buy, evaluate the costs involved. Claims-made premiums are typically based on a five-year maturation scale. This means that the premium begins at a reduced rate and gradually increases over the next five years. At the fifth year, it levels off and can be slightly lower than the occurrence premium. However, at the time of cancellation, the Extended Reporting Claim Endorsement will be offered at an additional premium cost. Insurance policies written on a claims-made basis should provide a death, disability, and retirement waiver of the premium for tail coverage.

Many malpractice insurance programs will offer discounts (more properly called premium credits) based on a variety of factors. Be sure to look into what discounts you are eligible for before you choose an insurance carrier.

Coverage Limits

A malpractice policy usually has two limits:

- **Per occurrence:** the maximum amount that will be paid for damages in a single case.

- **Aggregate:** the maximum amount paid for damages in all cases against the insured that are filed for the policy year.

The most common policy for psychiatrists has limits of \$1 million (per occurrence) and \$3 million (aggregate).

It is very important to determine if defense costs are paid outside the limits of liability. If the defense costs are included in the limits of liability, this may cause your limits to be eroded faster and further reduce the funds available to pay settlements or judgments.

Portability of Coverage

If you move to another state, it is important that your insurance carrier is licensed and approved to write business in that state. If it is not, you will be required to cancel your policy and purchase a new one with another carrier.

Payment Flexibility

Some insurance carriers allow you to pay your insurance premiums in installments with no finance charge. This option can be very helpful.

Additional Coverages

In addition to standard coverages, you may have the option to receive coverage for premises liability and vicarious liability.

- **Premises liability:** A psychiatrist who rents or owns an office in which patients are seen will probably want insurance against the normal hazards of running an office. For example, a claim would be covered by this policy if a patient slips and falls on the stairs or has something stolen from the waiting room.

Some policies include this coverage with the malpractice policy. Any policy, that includes this coverage at no additional cost, is highly recommended. The limits of liability are written on a shared basis with the malpractice limit of liability. This coverage does not replace the need for a broad-range general liability policy but may sufficiently meet the needs of the individual practitioner.

- **Vicarious liability:** Under most state laws, a psychiatrist can be sued for liability for the acts of his employees or contractors, or on a count of negligent supervision. If you have any employees or contractors who have professional contact with patients, make sure that your policy covers such vicarious liability.

If the policy provides vicarious liability coverage, however, it probably will not cover accusations of malpractice made directly against the employee. You need to determine whether employees or contractors such as social workers and nurses should have their own professional liability coverage, or will receive such coverage through a policy purchased by the employing organization.

- **Defense Expenses for Proceedings:** This is the most frequently used feature in malpractice policies that offer this valuable coverage. Essentially, this coverage feature provides reimbursement for defense expenses associated with licensing board hearings and similar regulatory actions. Protecting your license is of paramount importance. Proper legal representation can be the difference between a dismissal and suspension or revocation of your license. The APA program includes \$5,000 of this coverage at no additional premium with the ability to purchase up to \$50,000. This is a defense reimbursement feature only and does not cover fines and penalties.

Exclusions

It is very important to know what is excluded from coverage in a policy. You will want to know about any exclusions before you accept an insurance contract. The following are typical exclusions in a malpractice policy:

- Undue familiarity (when a psychiatrist allegedly becomes sexually involved with a patient or former patient).
- Contractual liability assumed for third parties. Each party to the contract should carry medical professional liability insurance to protect their legal liability. Transfer of liability by contract is typically not acceptable to insurance carriers.
- Liability arising from a psychiatrist's ownership, financial interest, or involvement in any business enterprise.

Most exclusions are standard with any malpractice policy because state insurance laws restrict the type of risks allowed in a malpractice policy. Typically, the exclusions can be covered through other types of insurance policies such as Directors and Officers Liability, General Commercial Liability, Property, or Worker's Compensation policies. In some cases the risk is not insurable, such as criminal or malicious acts or practicing medicine without a valid medical license.

MANAGED CARE GLOSSARY

Accessibility — Degree to which the healthcare delivery system inhibits or facilitates the ability of an individual to gain entry and to receive services (includes geographic, transportation, social, time, and financial considerations).

Actuary — A person trained in the insurance field, who determines policy rates, reserves, and dividends, and conducts various other statistical studies.

Adjustable Premium — Usually used in connection with guaranteed renewable health policies in which the premium is subject to change based on classes of insured.

Administrative Services Only (ASO) — An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits, and other administrative functions for a self-insured group.

Adverse Selection — When a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with subpopulations with higher-than-average costs are said to be adversely selected. Plans with subpopulations with lower-than-average costs are favorably selected.

Aftercare — The process of providing continuous contact that will support and increase the gains made to date in a health treatment process.

Age/Sex Rating — A method of structuring capitation payments based on health plan enrollee age and sex.

All-Payer Contract — An arrangement allowing for payment of health services delivered by a contracted clinician regardless of product type (e.g., HMO, PPO, indemnity) or revenue source (e.g., premium or self-funded).

Alliances — Purchasing pools responsible for negotiating health insurance arrangements for employers and/or employees. Alliances use their leverage to negotiate contracts that ensure care is delivered in economical and equitable ways (also referred to as health insurance purchasing cooperatives or health plan purchasing cooperative.) (See also **Community Health Purchasing Alliance**.)

Allowable Costs — A Medicare term (sometimes used by third-party payers) that refers to charges for services rendered or supplies furnished by a clinician that qualify as covered expenses.

Alternative Care — Medical care received in lieu of inpatient hospitalization. Examples include outpatient treatment, psychiatric home healthcare, and partial hospitalization.

Alternative Delivery System (ADS) — A structure for providing healthcare benefits that departs from traditional indemnity methods and explicitly integrates the financial and service delivery components. An HMO, for example can be said to be an alternative delivery system.

Ambulatory Setting — Any setting in which organized services are provided on an outpatient basis. Ambulatory care settings also may be mobile units of service.

Ancillary Charge — The fee associated with an additional service performed prior to and/or secondary to a significant procedure. Examples include lab work, x-rays, and pharmacy.

Annual Maximum — The total dollar benefit available during the course of the plan year.

Any Willing Provider Laws — State laws that challenge and establish policy governing managed care organizations. They require the granting of network enrollment to any provider who is willing to join, as long as he or she meets provisions outlined in the plan. The central issue is the fairness of physician deselection by a plan, and conversely, the plan's ability to reduce medical costs by eliminating overusing physicians.

Average Length of Stay (ALOS) — Average number of patient days of service rendered to each inpatient (excluding newborns) during a given period. Varies for patients by diagnosis, age, hospital efficiency, etc. One measure of use of health facilities.

Balance Billing — Billing a patient for charges above the amount reimbursed by the health plan, (i.e., the difference between billed charges and the amount paid). This may or may not be appropriate, depending upon the contractual arrangements between the parties and/or requirements of state and federal law.

Base Capitation — A stipulated dollar amount to cover the cost of healthcare per covered person, less mental health/substance abuse services, pharmacy, and administrative charges.

Basic Health Services — Benefits that all federally qualified HMOs must offer. As far as mental health care is concerned, these include: medically necessary emergency health services; short-term (not to exceed twenty visits) outpatient evaluative and crisis intervention services; and medical treatment and referral services for alcohol and drug abuse and addiction.

Benchmarking — An ongoing measurement and analysis process that compares administrative and clinical practices, processes or methodologies of an organization or an individual with others. The goal is to discover the best practices of others in order to improve one's own. Terms often used are administrative bench-marking and clinical bench-marking.

Beneficiary — The person designated or provided for by the policy terms to receive benefits under the insurance contract.

Benefit Package — A collection of specific services or benefits that are covered by insurance plan.

Benefit Year — A twelve-month period that a group uses to administer its employee fringe benefits program. Most use a January through December benefit year. The benefit year, however, may not match the fiscal year used by a group.

Capitation — A stipulated dollar amount established to cover the cost of healthcare services delivered for a person. The term usually refers to a per capita rate to be paid periodically, usually monthly, for the delivery of all health services required by the covered person under the condition of the contract. The payment to the practitioner is the same regardless of the amount of service needed or rendered. (See also **Base Capitation**.)

Carve-Out — A separate financing and delivery structure established for a particular healthcare benefit package. Example: A mental health benefit may be carved out and separated from other medical benefits covered by an indemnity or HMO plan, and a specialized vendor selected to supply these services on a stand-alone basis. These arrangements are usually provided for a fixed fee per subscriber or per member per month (e.g., capitation). Also sometimes referred to as single service plans (SSPs). (See also **Capitation**.)

Case Management — A process whereby covered persons with specific healthcare needs are identified and a plan is developed and managed whereby all available healthcare resources (and sometimes social services) are utilized to achieve the optimum patient outcome in the most efficient, cost-effective manner. It typically integrates care provided by all the entities involved -- the MCO, the physician or other type of clinician(s), the patient, and the family -- in an effort to find the most appropriate treatment for the patient.

Case Manager — An experienced clinician (e.g., physician, nurse, or social worker) who works with patients, treating clinicians, and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriated healthcare.

Case Mix — The frequency and intensity of hospital admissions or services reflecting different needs and uses of hospital resources. Case mix can be measured based on patients' diagnoses or the severity of their illness, the utilization of services, and the characteristics of a hospital.

Case Rate — A reimbursement model used by hospitals to establish a flat rate per admission based on an assumed average length of stay per admission. The HMO is charged this rate for each member admitted; unique rates may be set or grouped by diagnosis type or categories of medical/surgical, obstetrical, critical care, etc. Other elements may include sliding scale volume, ALOS by type, volume of ancillary per patient, and contribution margin. Also sometimes used for episodes of post-hospital care.

Cash Indemnity Benefits — Sums that are paid to the insured for covered services and that require submission of a filed claim. The insured may assign such payments directly to clinical providers of services (hospitals, physicians, etc.). Payments may or may not fully reimburse the insured for costs incurred.

Certificate of Need — A certificate required by a governmental authority of an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service.

Claim — A demand to the insurer for the payment of benefits under the insurance contract.

Claims Completion — A measure used to evaluate the performance of the claims payment function, usually calculated by subtracting the date of receipt of the claim from the date the claim is adjudicated as paid by the payer. A common industry standard is a fourteen-day claims turnaround.

Claims Lag — An analysis, usually performed by an actuary, that allocates the actual dollars paid to the months in which the services are performed. Claims lag analyses are

used to determine completion rates for claims payment performance and are integral in the calculation and projection of claims expenses for a given period.

Claims Procedure — Under ERISA each plan is required to provide a claims procedure, which must be explained to plan beneficiaries. The denial of a claim made under the claims procedure must be in writing, with an explanation of the reasons for the denial. Note, however, that **despite** the essential requirements, there may be considerable variations in these procedures.

Claims-Made Insurance — A type of insurance that covers the policyholder only if the claim is made during the time the policy is held. For example, if you have claims-made insurance coverage in 1998 and a claim is made against you during that year, you are covered. If a claim for malpractice allegedly occurring in 1998 is made in 1999 and you have discontinued paying the insurance premium, you are not covered. (See also **Tail Coverage**.)

Coinsurance — The portion of covered healthcare costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

Community Health Management Information System (CHMIS) — A system to electronically link clinicians, payers, employers, and consumers in communities to improve healthcare quality and promote community wellness.

Community Health Purchasing Alliance (CHPA) — A purchaser of healthcare benefits on behalf of employer groups

Community Rating — A method of determining a premium structure that is not influenced by the expected level of benefit utilization by specific groups, but by expected utilization by the population as a whole. Everyone in a specified community would pay the same premium for the same package of benefits, regardless of age, sex, medical history, lifestyle, or place of residence. An adjusted community rating is a community rating that is influenced by group-specific demographics.

Concurrent Review — A routine review of the medical necessity for continued treatment, by an internal or external utilization reviewer, during the course of a patient's treatment. This usually occurs for inpatient, residential, and partial hospitalization treatment, though it is becoming more frequent for outpatient treatment as well.

Consolidated Omnibus Budget Reconciliation Act (COBRA) — A federal law that, among other things, requires employers to offer continued health insurance coverage for a certain length of time to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

Continuum of Care — A range of clinical services provided to an individual or group that may reflect treatment rendered during a single patient hospitalization or may include care for multiple conditions during a lifetime. The continuum provides a basis for analyzing quality, cost, and utilization in the long term.

Contract — An agreement executed between a payer and a purchaser to provide healthcare benefits. Also used to designate an enrollee's coverage.

Contract Mix — The distribution of enrollees according to contracts classified by dependency categories. For example, the number or percentage of individuals, couples, or families. Contract mix is used to determine average contact size.

Contracted for Liability — This liability refers to the exposure a clinician may assume by agreeing to an indemnification clause in her/his contract with an MCO.

Coordination of Benefits (COB) — Established procedures to be followed in the event of duplicate coverage, thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient.

Copayment — A cost-sharing arrangement in which a covered patient pays a specific charge for a specified service, such as \$10 for an office visit. The covered patient is usually responsible for payment at the time the healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions, or hospital services. Often copayments are referred to as coinsurance, with the distinguishing characteristic that copayments are flat dollar amounts and coinsurance is a defined percentage of the charges for services rendered. Also called copay.

Cost Sharing — A general set of financing arrangements via deductibles, copays, and/or coinsurance in which a person covered by the health plan must pay some of the costs to receive care. See also copayment and coinsurance.

Cost Shifting — The practice by some clinicians of recovering the difference between normal charges and amounts actually received from certain payers by increasing charges made to other payers.

Cost-Effectiveness — The degree to which a service or a medical treatment meets a specified goal at an acceptable cost and level of quality.

Covered Expenses — Hospital, medical, and miscellaneous healthcare expenses incurred by the insured for which she/he is entitled to payment of benefits under a health insurance policy. The term defines, by either description, reasonableness, or necessity the type and amount of expense which will be considered in the calculation of benefits.

Credentialing — A process of review to approve a clinician who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan. Decredentialing is the removal of the clinician as a participant in the plan.

Critical Pathways — Charts (often algorithms) showing the key events that typically lead to the successful treatment of patients in a certain homogeneous population. They organize, sequence, and time the major interventions of nursing staff, physicians, and other departments for a particular case type (such as asthma), subset, or condition.

Deductible — Annual expenses a subscriber has to pay before an insurance plan covers healthcare costs. These often apply to a subscriber and his or her family in total.

Dependent — Any member of a subscriber's family who meets the applicable eligibility requirements of the health plan and who has enrolled in the plan in accordance with its enrollment requirements.

Diagnosis Independent Outcome — Outcomes adjusted for severity of illness, based primarily on clinical indicators, independent of the ultimate discharge diagnosis. Thus, there is no direct correlation between the diagnosis and the treatment interventions and outcomes. Examples are MedisGroups and APACHE.

Diagnosis Related Groups: (DRG) — A system of patient classification used by Medicare to reimburse hospitals. Classification under DRGs is based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications.

Direct Contracting — Individual employers or business coalitions contract directly with clinicians for healthcare services with no third-party intermediary.

Discounted Fee-for-Service — An agreed upon rate for service between the clinician and payer that is less than the clinician's full fee. This may be a fixed amount per service or a percentage discount.

Drug Formulary — A listing of prescription medications that are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an open, or voluntary, formulary allows coverage for both formulary and nonformulary medications. A plan that has adopted a closed, select, or mandatory formulary limits coverage to those drugs in the formulary.

Dual Choice — A health benefit offered by an employment group permitting eligibles of the group a voluntary choice of health plan; usually the employer's primary insurer and an HMO.

Duplication of Benefits — Overlapping or identical coverage of an insured person under two or more health plans, usually the result of contracts with different insurance companies, service organizations or prepayment plans. (See also **Coordination of Benefits**.)

Effective Date — The date on which the insurance under a policy begins.

Electronic Data Interchange (EDI) — The computer-to-computer exchange of information between organizations. The data may be either a standardized or proprietary format.

Eligibility Date — The date on which an individual becomes eligible to apply for insurance.

Eligibility Period — A specified length of time, frequently thirty-one days, following the eligibility date, during which an individual member of a particular group will remain eligible to apply for insurance under a group health or life insurance policy without evidence of insurability.

Employee Assistance Program (EAP) — Services designed to assist employees, their family members, and employers in finding solutions for workplace and personal problems. Services may include assistance for family/marital concerns, legal or financial problems, elder care, child care, substance abuse, emotional/stress issues, violence in the workplace, sexual harassment, dealing with troubled employees, transition in the workplace, and other events that increase the rate of absenteeism or employee turnover, lower productivity and other issues that impact an employer's financial success or employee relations management. EAPs also can provide the voluntary or mandatory access to mental health benefits through an integrated mental health program.

Encounter — Face-to-face meetings between a covered person and a clinician where services are provided or rendered. The number of encounters per member per year is

calculated as the total number of encounters per year, divided by the total number of members per that year.

Enrolled Group — Persons with the same employer or with membership in an organization in common, who are enrolled in a health plan. Usually there are stipulations regarding the minimum size of the group and the minimum percentage of the group that must enroll before the coverage is available.

Enrollee — Any person eligible as either a subscriber or a dependent in accordance with an employee benefit plan. (Synonyms: beneficiary, eligible individual, member, participant).

Enrollment — The total number of covered persons in a health plan. The term also refers to the process by which a health plan signs up groups and individuals for membership or the number of enrollees who sign up in any one group.

Episode of Care — Treatment rendered in a defined time frame for a specific disease. Episodes provide a useful basis for analyzing quality, cost, and utilization patterns.

ERISA (Employee Retirement Income Security Act) — A federal law enacted in 1974 that allows self-funded plans to avoid paying premium taxes and exempts them from complying with state-mandated benefits even though insurance companies and managed care plans must do so. Another provision requires that plans and insurance companies provide an explanation of benefits (EOB) statement to a member or covered insured in the event of a denial of a claim explaining why the claim was denied and informing the individual of the rights of appeal.

Exclusions — Charges, services, or supplies that are not covered by a health insurance plan.

Exclusive Provider Organization (EPO) — A managed care organization that provides coverage only if care is provided by contracted clinicians. Technically, many staff-model HMOs also can be described as EPOs.

Experience — The relationship, usually expressed as a percentage or ratio, of premiums collected to claims paid, coverage or benefits, during a slated period of time.

Experience Rating — The process of setting rates based partially or entirely on previous claims experience and projected required revenues for a future policy year for a specific group or pool of groups.

Family Deductible — A deductible that is satisfied by the combined expenses of all covered family members. For example, a program with a \$25 deductible may limit its application to a maximum of three deductibles (\$75) for the family, regardless of the number of family members. See Deductible.

Fee Maximum — The maximum amount a participating clinician may be paid for a specific healthcare service provided to patients under a specific contract. A comprehensive listing of fee maximums used to reimburse a physicians and/or other clinicians on a fee-for-service basis is called a fee schedule.

Fee Schedule — A listing of fees or allowances for specific medical procedures, which usually represents the maximum amounts the program will pay for specific procedures.

Fee-for-Service — A traditional means of billing for each service performed, referring to payment in specific amounts for specific services rendered (as opposed to capitation, salary, or other contract arrangements).

First-Dollar Coverage — Feature of a healthcare plan in which the plan does not require its participants to pay any deductibles or copayments before benefits are received.

Flat Fee per Case — Flat fee paid for treatment based on the diagnosis and/or presenting problem. For this fee, the psychiatrist or other clinician covers all of the services the patient requires for a specific period of time. (See **Case Rate**)

Functionality — A quality of life indicator that relates to whether a patient has the potential to respond to treatment options and, as a result, be able to function in a normal life.

Gatekeeper — A primary care physician who serves as the patient's initial contact for medical care and who makes referrals to specialists. The gatekeeper function is to coordinate care and control access to other healthcare resources.

Global Budgets — Pre-set limits on the total amount of expenditures in a healthcare system.

Grace Period — A specified period after premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Insurance — A policy protecting a specified minimum number of persons usually having the same employer or connected to each other through some other entity through which the insurance is purchased.

Group Model HMO — A healthcare model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of its patients.

Group Practice Without Walls — A range of physician-created practice arrangements that link doctors through the sharing of central services for contracting purposes, and yet the physicians maintain autonomy by keeping their own offices. Also known as clinics without walls.

Health Alliance — Also called a health purchasing cooperative. A state or regional body that combines consumers' purchasing power in order to negotiate prices with competing health plans.

Health Care Financing Administration (HCFA) — The federal agency responsible for the administration of Medicaid and Medicare programs.

Health Maintenance Organization (HMO) — An organization that provides comprehensive medical care for a fixed annual fee. Physicians and other clinicians often are on salary or on contract with the HMO to provide services. Patients are assigned a primary care doctor or nurse as a gatekeeper, who decides what health services are needed and when. There are four basic models of HMOs: group model, individual practice association, network model, and staff model.

Health Plan Employer Data and Information Set (HEDIS) — A core set of performance measures to assist employers and other health purchasers in understanding the value of healthcare purchases and evaluating health plan performance. Used by the National Center for Quality Assurance (NCQA) to accredit HMOs.

Health Status — An overall evaluation of an individual's degree of wellness or illness, with a number of indicators, including quality of life, and functionality (see **SF36**).

Hospital Affiliation — A contractual relationship between a health plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the health plan.

Indemnity — An insurance program in which the insured person is reimbursed for covered expenses. It is a traditional health insurance plan with little or no benefit management, a fee-for-service reimbursement model, and few, if any, restrictions in selection of clinicians.

Independent Practice Association (IPA) — A healthcare model that contracts with an entity, which in turn contracts with physicians, to provide healthcare services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

Individual Mandate — Requirement that all individuals purchase health insurance, much the same as is done in auto insurance. This proposal is usually combined with some strategy for aiding low-income workers and the unemployed with the costs of such coverage.

Integrated Delivery System — A generic term referring to a combination of clinicians, programs, and facilities, delivering healthcare in an integrated way. Some models of integration include the **physician-hospital organization**, **management service organization**, **group practice without walls**, integrated provider organization, and medical foundation.

International Classification of Diseases, 9th Edition (Clinical Modification) (ICD-9-CM) — A listing of diagnosis and identifying codes used by physicians for reporting diagnoses of healthcare plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communications on claim forms.

Legal Reserve — The minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code. The reserve amount is usually determined by an actuary.

Length of Stay (LOS) — The number of days that covered patients stay in an inpatient facility.

Lifetime Maximum — Under a health insurance plan, the total benefit dollar available to an individual during the course of a lifetime.

Managed Care — A system that manages or controls what it spends on healthcare by closely monitoring how physicians and other clinicians treat patients. Various techniques for keeping costs down include limiting coverage to care provided by specially selected physicians and hospitals, and requiring preauthorization for hospital care and other services.

Managed Competition — A proposed policy approach whereby health plans would compete on the basis of cost and other factors. Purchasers would join cooperatives and be given the ability to compare plans across several dimensions of performance. The principle behind this approach is improvement of the health economy through increased health plan competition.

Managed Mental Health Program (MMHP) — An organization that assumes responsibility for managing the mental health benefit for an employer or MCO. The management may range from utilization management services to the actual provision of the services through its own organization or clinician network. Reimbursement may be on a fee-for-service, shared risk, or full-risk basis.

Management Service Organization(MSO) — A legal entity that provides practice management, administrative, and support services to individual physicians or group practices. An MSO may be a direct subsidiary of a hospital or may be owned by investors.

Maximum Benefits — The maximum annual or lifetime benefits to which a covered individual is entitled.

Maximum Limits — The maximum amount payable under a health plan for each cause for each year or for a lifetime.

Medicaid — A nationwide program, adopted in 1965, of health insurance for eligible disabled and low-income persons, administered by the federal government and participating states. The program's costs are shared by the federal and state governments and paid for by general tax revenue.

Medical Necessity — Generally defined as treatment that is appropriate and necessary to the symptoms, diagnoses, or manifestations of a medical disorder; the treatment falls within standards of good practice for the service modality; and the most appropriate level or supply of service is safely provided to the individual.

Medicare — A nationwide, federally administered health insurance program that covers the costs of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts. Part A covers inpatient costs. Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in outpatient settings. Part B covers outpatient costs for Medicare patients.

Medicare Supplement Policy — A policy guaranteeing that a health plan will pay coinsurance, deductible, and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit (the portion of the cost of services not covered by Medicare). Also called Medigap or Medicare wrap.

Morbidity — An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Mortality — An actuarial determination of the death rate at each age as determined from proper experience. A mortality study (table) shows the probability of death and survival at each age for a unit of population.

Network Model HMO — An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multispecialty groups. The physician works out of his or her own office and may share in utilization savings, but does not necessarily provide care exclusively for HMO beneficiaries.

Occupancy Rate — The ratio of actual patient days to the maximum patient days, as determined by bed capacity, during a given period.

Occurrence Coverage — Coverage that extends beyond the term of the policy and protects the psychiatrist for all malpractice claims related to services during the term of the policy, regardless of when the claims are made. For example, if you purchased occurrence insurance in 1998 you would be covered for all acts in 1998, even if the claim is filed years later. This type of insurance is more expensive than **claims-made insurance**.

Office of Health Maintenance Organizations (OHMO) — A division of the U.S. Department of Health and Human Services, with headquarters in Rockville, Maryland, that is responsible for administering federal law respecting HMOs.

Open Access — A self-referral arrangement allowing patients to see participating clinicians for open panel specialty care without a referral from a doctor.

Outcome Measures — Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of functional status, as well as measures of mortality, morbidity, cost, quality of life, and patient satisfaction.

Outcomes Management — Definitions vary, but this generally involves collection and analysis of results of medical processes and performances according to agreed-on specifications and the use of that information to optimize healthcare provisions through the collaborative efforts of patients, payers, and clinicians.

Outlier — A patient who varies significantly from other patients with the same diagnosis, such as a longer or shorter length of stay, death, or leaving against medical advice.

Out-of-Area Benefits — Benefits that a managed care plan supplies to its subscribers outside of its geographical area.

Paid Claims — The dollar value of all claims paid (i.e., hospital medical, surgical, etc., during the plan year) regardless of the date that the services were performed.

Participating Provider — A clinician, program, or facility who has contracted with the health plan to provide medical services to covered persons.

Payer — Any individual or organization that pays for healthcare services, including insurance companies and various government programs such as Medicare and Medicaid.

Per Diem — An agreed upon dollar rate per inpatient, residential, or partial hospitalization day that is usually all-inclusive.

Per Incident — The maximum amount of money the insurance company will pay per claim.

Percentage of Occupancy — The ratio of actual patient days to the maximum possible patient days as designated by bed capacity during any given period.

Physician-Hospital Organization — A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and further mutual interests.

Plan Administrator — Under ERISA the person designated as such by the instrument under which the plan is operated. If the administrator is not so designated, *administrator* means the plan sponsor. If the administrator is not designated and the plan sponsor cannot be identified, the administrator may be such person as is prescribed by regulation of the Secretary of Labor.

Point-of-Service (POS) — A provision that allows patients to seek treatment outside of the network, typically with a higher copayment.

Portability — Insurance benefit plans moveable from one job to another or from one state to another so as to provide continuous coverage for the individual and his or her family.

Practice Guidelines — Systematically developed statements on medical practice that assist physicians in decisions about appropriate healthcare for specific medical conditions. Terms used synonymously include practice parameters, standard treatment protocols, and clinical practice guidelines.

Preexisting Condition (PEC) — Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage.

Preferred Provider Organization (PPO) — An organized network of healthcare providers, typically reimbursed on a discounted fee-for-service basis. Coverage may or may not be available outside of the network for a higher copayment.

Primary Data — Information obtained from medical records or other primary sources of clinical findings such as diagnostic tests and physical examination results.

Prospective Reimbursement — Any method of paying hospitals, programs, or clinicians for a defined period (usually one year) according to amounts or rates of payment established in advance.

Provider Profiling — Statistical techniques used to identify clinicians who over- or under-utilize services.

Quality — The features of a product or service that bear on its ability to satisfy the stated or implied needs of the user, or patient. Quality assessment should include patients' evaluations of how well a product or service meets their needs and expectations with respect to process, outcomes, and perceived value.

Reinsurance — A type of protection purchased from insurance companies specializing in underwriting specific risks for a stipulated premium. Typical reinsurance risk coverages include (1) individual stop-loss, (2) aggregate stop-loss, (3) out-of-area, and (4) insolvency protection.

Resource Based Relative Value Scale (RBRVS) — A fee schedule introduced by HCFA to reimburse physicians' Medicare fees based on the amount of time, resources, and expertise expended in selected specific medical procedures.

Retrospective Review — Determination of medical necessity and/or appropriate billing practice for services already rendered.

Risk Analysis — The process of evaluating expected medical care costs for a prospective group — and determining what product, benefit level, and price to offer under a risk arrangement.

Risk Sharing — A method by which premiums and costs of medical protection are shared by plan sponsors and clinicians.

Self-Funded Health Plans — Plans that provide for the reimbursement of medical expenses incurred by an employee and/or his/her dependents where reimbursements are not provided under an accident or health insurance policy; that is, all or some of the risk is borne directly by the plan. It is possible to insure some benefits and self-insure others; to self-insure or self-fund all benefits up to a certain aggregate claim level; or to set certain individual claim limits for self-funding and insure above that level. Reimbursements to highly compensated individuals must be included in their income unless the self-insured plan satisfies certain requirements relating principally to nondiscrimination in plan benefits and eligibility of expenses.

Self-Insurance — An entity itself assumes the risk of coverage and makes appropriate financial arrangements rather than purchasing insurance from a third party and paying a premium for this coverage.

SF36 — Medical Outcomes Study Short Form with thirty-six questions. A psychometrically strong health status questionnaire designed to measure overall functional status and well-being for adult patients, including physical, social, and mental status.

Single-Payer System — A healthcare financing arrangement in which money, usually from a variety of taxes, is funneled to a single entity (usually the government) that is responsible for the financing and administration of the health system. The controlling entity typically imposes various forms of price controls and rate settings. Single-payer systems can be regional, statewide, or nationwide.

Staff Model HMO — A healthcare model that employs physicians to provide healthcare to its patients. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

Standard Benefit Package — A specified set of minimum medical benefits available to all persons.

Stop-Loss Insurance — Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (see **Reinsurance**).

Tail Coverage — Extension of insurance coverage for acts occurring during the life of the policy for claims filed after the policy expires.

Tax Equity and Fiscal Responsibility Act of 1982(TEFRA) — The federal law that created the current risk and cost contract provisions under which health plans contract with HCFA, and which defined the primary and secondary coverage responsibilities of the Medicare program and the system of payment for psychiatric inpatient care under Medicare.

Third-Party Administrator(TPA) — An independent person or corporate entity (third party) that administers group benefits, claims, and administration for a self-insured company/group. A TPA does not underwrite the risk.

Third-Party Payer — The insurer who pays for the services provided to a patient.

Total Quality Management (TQM) — An organization-wide process of improving the quality of products and services in any organization. It is also often referred as continuous quality improvement (CQI).

Triple Option — Multiple option plans that typically include indemnity, PPO, and HMO plans through one insurer. Triple option plans, in theory, prevent "adverse selection" by placing all employees in a single risk pool.

Unbundling — Separating packaged units that might otherwise be packaged together. For claims processing, this includes clinicians billing separately for healthcare services that might be combined according to industry standards or commonly accepted coding practices.

Underwriter — The term generally used applies either to 1) a company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; 2) the company employee who decides whether or not the company should assume a particular risk; or 3) the agent who sells the policy.

Usual, Customary, and Reasonable Fee — The fee usually charged for a given service by an individual clinician to his or her private patient; that is, the clinician's own usual fee.

Utilization — The extent to which the beneficiaries within a covered group use a program or obtain a particular service, or category of procedures, during a given period of time. Usually expressed as the number of services used per year or per one thousand persons covered.

Utilization Criteria — The guidelines used to establish the medical necessity and appropriateness of a course of treatment.

Utilization Management — The management of patient utilization of healthcare services by a managed healthcare program.

Utilization Review — A formal assessment by an independent third party of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans on a prospective, concurrent, or retrospective basis.

Withhold — A percentage of payment held back from a practitioner until the total cost of his or her referral or hospital services has been determined. Physicians exceeding the amount determined as appropriate lose the amount held back.

Workers Compensation — A state-governed system designed to address work-related injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from an employee's job related injury or disease, regardless of who is at fault. In return, employees give up the right to sue employers, even if injuries stem from employer negligence.

ACRONYMS

The following are acronyms that are frequently used when discussing psychiatric practice issues:

AA: Alcoholics Anonymous

AAAP: American Academy of Addiction Psychiatry

AABH: Association for Ambulatory Behavioral Healthcare

AACAP: American Academy of Child and Adolescent Psychiatry

AAHP: American Association of Health Plans

AAP: American Academy of Psychoanalysis

AAPHO: American Association of Physician-Hospital Organizations

AAPPP: American Association of Private Practice Psychiatrists

AAPPO: American Association of Preferred Provider Organizations

ACP: American College of Physicians

ACR: Adjusted community rate

ACSW: Academy of Certified Social Workers

ADA: Americans with Disabilities Act

ADS: Alternative delivery system

AFDC: Aid to Families with Dependent Children

AHA: American Hospital Association

AHCPR: Agency for Health Care Policy and Research

ALOC: Alternative level of care

ALOS: Average length of stay

AMA: American Medical Association

AMBHA: American Managed Behavioral Healthcare Association

AMCRA: American Managed Care and Review Association

AMPRA: American Medical Peer Review Association

APA: American Psychiatric Association

APG: Ambulatory patient group

ASO: Administrative services only

AWP: Any willing provider

CAC: Certified addictions counselor

CD: Chemical dependence

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services

CMHS: Center for Mental Health Services

CMI: Case-mix index

COA: Certificate of authority
COB: Coordination of benefits
COBRA: Consolidated Omnibus Budget Reconciliation Act
COC: Certificate of coverage
CON: Certificate of need
CPI: Consumer Price Index
CPT: Current procedural terminology
CRC: Certified rehabilitation counselor
CQI: Continuous quality improvement
CSO: Claims services only
DAW: Dispense as written
DCI: Duplicate coverage inquiry
DFFS: Discounted fee-for-service
DME: Durable medical equipment
DOH: Department of Health
DOS: Date of service
DRG: Diagnosis-related groups
DSM-IV: Diagnostic and Statistical Manual (fourth edition)
DUE: Drug use evaluation
DUR: Drug utilization review
Dx: Diagnosis
EAP: Employee assistance program
EOB: Explanation of benefits
EOI: Evidence of insurance
EPO: Exclusive provider organization
ERISA: Employee Retirement Income Security Act of 1974
FFS: Fee-for-service
FSA: Flexible spending account
FTE: Full-time equivalent
GHAA: Group Health Association of America
HCFA: Health Care Financing Administration
HCPCS: HCFA common procedural coding system
HEDIS: Health Plan Employer Data and Information Set
HHA: Home health agency
HHS: Department of Health and Human Services
HIAA: Health Insurance Association of America
HMO: Health maintenance organization
HPA: Health purchasing alliance

IBH: Institute for Behavioral Healthcare
IBNR: Incurred but not reported
ICD: International classification of diseases
IOM: Institute of Medicine
IPA: Independent provider/practitioner association
JCAHO: Joint Commission on Accreditation of Healthcare Organizations
LCSW: Licensed clinical social worker
MAC: Maximum allowable charge
MCO: Managed care organization
MDC: Major diagnostic category
MH: Mental health
MIS: Management information system
MOB: Maintenance of benefits
MOE: Maintenance of effort
MSA: Medical savings account
MSO: Management services organization
NA: Narcotics Anonymous
NAEHCA: National Association of Employers on Health Care Action
NAHMOR: National Association of HMO Regulators
NAIC: National Association of Insurance Commissioners
NAMI: National Alliance for the Mentally Ill
NAPHS: National Association of Psychiatric Health Systems
NASW: National Association for Social Workers
NAPDP: National Association of Prescription Drug Programs
NCQA: National Committee on Quality Assurance
NDMDA: National Depressive and Manic Depressive Association
NIH: National Institutes for Health
NIMH: National Institute for Mental Health
NMHA: National Mental Health Association
NPDB: National Practitioner Data Bank
OSHA: Occupational Safety and Health Administration
PCCM: Primary care case management
PCN: Primary care network
PCP: Primary care physician
PEPM: Per employee per month
PHO: Physician-hospital organization
PMPM: Per member per month
POS: Point of service

PPO: Preferred provider organization
PPRC: Physician Payment Review Commission
PPS: Prospective payment system
PRO: Peer review organization
ProPAC: Prospective Payment Assessment Commission
PSRO: Professional Standards Review Organization
QA: Quality assurance
QI: Quality improvement
RBRVS: Resource-based relative value scale
R&C: Reasonable and customary
Rx: Prescription
SA: Substance abuse
SAMHSA: Substance Abuse and Mental Health Services Administration
TPA: Third-party administrator
TQM: Total quality management
Tx: Treatment
UM: Utilization management
UCR: Usual, customary, and reasonable
UR: Utilization review
URAC: Utilization Review Accreditation Commission
VA: Veterans Administration

BIBLIOGRAPHY

BOOKS AND MONOGRAPHS*

Allies and Adversaries: The Impact of Managed Care on Mental Health Services.

RK Schreter, SS Sharfstein, CA Schreter, editors. American Psychiatric Press, Washington, DC. 1994. \$36.

American Psychiatric Association Capitation Handbook: Actuarially Determined Capitation Rates for Mental Health Benefits. SP Melek, BS Pyenson. American Psychiatric Press, Washington, DC. 1995. \$35.

American Psychiatric Association Practice Guidelines. American Psychiatric Press, Washington, DC. Single copies, \$22.50.

Practice Guideline for Eating Disorders. 1993.

Practice Guideline for Depressive Disorder in Adults. 1993.

Practice Guideline for the Treatment of Patients With Bipolar Disorder. 1994.

Practice Guideline for the Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids. 1995.

Practice Guideline for Psychiatric Evaluation of Adults. 1995.

Practice Guideline for the Treatment of Patients With Nicotine Dependence. 1995.

Practice Guideline for the Treatment of Patients With Schizophrenia. 1997.

Practice Guideline for the Treatment of Patients With Alzheimer's and Other Dementias of Late Life. 1997.

Practice Guideline for the Treatment of Patients With Panic Disorder. 1998.

Practice Guideline for the Treatment of Patients With Delirium. 1999.

Best Insurance Reports. A.M. Best, Oldwick, NJ. \$695 (book), \$1,295 (book and diskette). (908) 439-2200.

Career Planning for Psychiatrists. KM Mogul, LJ Dickstein, editors. American Psychiatric Press, Washington DC. 1995. \$19.95.

Code of Medical Ethics, Current Opinions with Annotations. American Medical Association, Chicago. \$39.95. (800) 621-8335.

The Complete Capitation Handbook: How to Design & Implement At-Risk Contracts for Behavioral Healthcare. GL Ziemann, editor. CentraLink Publications / Jossey-Bass, Tiburon, CA. 1995. \$58. (800) 956-7739.

Controversies in Managed Mental Health Care. A Lazarus, editor. American Psychiatric Press, Washington, DC. 1996. \$58.50.

* Most of the books listed here can be purchased from the Health Source Bookstore by calling (800) 713-7122. APA members receive a 10% discount.

“Compliance Program Guidance for Third Party Medical Billing Companies.”

(press release) U.S. Department of Health and Human Services, Office of Inspector General. Can be downloaded off the Web:
<http://www.dhhs.gov/progorg/oig/modcomp/thirdparty.htm> or call (202) 619-1142.

CPT Handbook for Psychiatrists, 2nd ed. CW Schmidt, M.D. American Psychiatric Press, Washington, DC. \$25.

Current Opinions on Ethical and Judicial Affairs. Ethics Committee, American Psychiatric Association, Washington, DC. 1995. \$3.

Effective Use of Group Therapy in Managed Care. KR MacKenzie, editor. American Psychiatric Press, Washington, DC. 1995. \$30.

Electronic Data Interchange: The Physician's Guide. K DeFavero, J Hill. American Medical Association, Chicago. 1996. \$19.95 members, \$29.95 nonmembers. (800) 621-8335.

Essentials of Managed Health Care. PR Kongstvedt. Aspen Publishers, Gaithersburg, MD. 1995. \$47. (800) 638-8437.

Fundamentals of Psychiatric Treatment Planning. JA Kennedy. American Psychiatric Press, Washington, DC. 1992. \$37.50

“Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists”. *American Journal of Psychiatry*, American Psychiatric Association, Washington, DC. November, 1980. \$22.50. members; (202) 682-6090, nonmembers; (202) 682-6158.

Key Rating Guide. A.M. Best, Oldwick, NJ. 1998. \$95 (book) \$225 (book and diskette). (908) 439-2200.

Legal Answer Book for Managed Care. P Younger, C Conner, KK Cartwright, SM Kole. Aspen Publishers, Gaithersburg, MD. 1995. \$69. (800) 638-8437.

Legal and Risk Management Issues in the Practice of Psychiatry. JE Macbeth, AM Wheeler, JW Sither, NJ Onek. Psychiatrists' Purchasing Group / American Psychiatric Press, Washington, DC. 1994. \$42.

Managed Care Answer Book. ST Dacso, CC Dacso. Aspen Publishers, Gaithersburg, MD. 1995. \$125. (800) 638-8437.

Managed Care Monographs. APA Office of Economic Affairs and Practice Management. American Psychiatric Press, Washington, DC. 1996. Five-volume set, \$100.

The Psychiatrist's Managed Care Primer, \$25.

The Psychiatrist's Guide to Managed Care Contracting, \$25.

The Psychiatrists's Guide to Capitation and Risk, \$25.

The Psychiatrist's Guide to Practice Management, \$25.

Public Mental Health: A Changing System in an Era of Managed Care, \$25.

- Managed Health Care Handbook***, 3rd ed. PR Kongstvedt. Aspen Publishers, Gaithersburg, MD. 1996. \$99. (800) 638-8437.
- Managed Mental Health Care: Administrative and Clinical Issues***. JL Feldman, RJ Fitzpatrick, editors. American Psychiatric Press, Washington, DC. 1992. \$49.95.
- Managing Care, Not Dollars: The Continuum of Mental Health Services***. RK Schreter, SS Sharfstein, CA Schreter, editors. American Psychiatric Press, Washington, DC. 1997. \$55.
- Managing Managed Care II: A Handbook for Mental Health Professionals***, 2nd ed. M. Goodman, JA Brown, PM Deitz. American Psychiatric Association, Washington, DC. 1996. \$35.
- Maneuvering the Maze of Managed Care: Skills for Mental Health Practitioners***. K Corcoran, V Vandiver. The Free Press, New York. 1996. \$35; \$20 (paper). (800) 223-2348.
- Mental Illness and Managed Care: A Primer for Families and Consumers***. M Malloy. The National Alliance for the Mentally Ill, Arlington, VA. 1995. Available upon request. (703) 524-7600.
- Outcomes Assessment in Clinical Practice***. LI Sederer, B Dickey. Williams & Wilkins, Baltimore. 1996. \$45. (410)-528-4000.
- Physician Characteristics and Distribution in the United States***. American Medical Association, Chicago. 1999. \$149.95. (800) 621-8335.
- Physician Compensation and Production Survey***. Medical Group Management Association, Englewood, CO. 1998. \$300. (303) 799-1111.
- Physicians' Current Procedural Terminology Manual***. American Medical Association, Chicago. 1999. \$47.95 members, \$72.95 nonmembers. (800) 621-8335.
- Places Rated Almanac: Your Electronic Guide to Finding the Best Places to Live in North America***. 5th ed. Macmillan, Indianapolis. 1996. \$24.95 (includes disk). (800) 428-5331.
- Practical Psychiatric Practice: Forms and Protocol for Clinical Use***. RJ Wyatt. American Psychiatric Press, Washington, DC. 1994. \$29.95.
- Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry***. American Psychiatric Association, Washington, DC. 1998. \$3. (202) 682-6240.
- Statements of Antitrust Enforcement Policy in Healthcare***. U.S. Department of Justice, Washington, DC. Can be downloaded off the Web, <http://www.usdoj.gov>
- Time-Managed Group Psychotherapy: Effective Clinical Applications***. KR MacKenzie. American Psychiatric Press, Washington, DC. 1997. \$67.50.

JOURNALS AND OTHER PERIODICALS

- The Academic Physician and Scientist***. Association of American Medical Colleges, Washington, DC. Free upon request. (202) 828-0416.

- Behavioral Health Outcomes.** Manisses Communication Group, Providence, RI. \$149. (800) 333-7771
- Healthcare Trends Report.** Summaries of over one hundred periodicals. \$239. (301) 652-8937.
- Managed Care Week.** Atlantic Publications Services. \$409. (800) 521-4323.
- Medical Economics.** Richard F. Kiernan, publisher. Montvale, NJ. \$99. (201) 358-7330.
- Mental Health Weekly.** Manisses Communication Group, Providence, RI. \$499 (800) 333-7771.
- Modern Healthcare.** Crain Communications, Inc., Chicago. \$110. (800) 678-9595.
- New England Journal of Medicine.** Massachusetts Medical Society, Waltham, MA. \$129. (781) 893-4610.
- Psychiatric Practice & Managed Care.** American Psychiatric Association, Washington, DC. \$55, members; \$125, nonmembers.
- Practical Psychiatry and Behavioral Health.** Williams & Wilkins. Baltimore, \$79, individual; \$49 in-training staff. (410) 528-4000.
- Psychiatric News.** American Psychiatric Association, Washington, DC. Free to APA members. (202) 682-6240 or (800) 368-5777.
- Psychiatric Services.** American Psychiatric Association, Washington, DC. \$45, individual; \$22.50, student. (202) 682-6240.
- Psychiatric Times.** CME, Inc., Irvine. CA. \$120. (949) 250-1008.
- Psychotherapy Finances.** Ridgewood Financial Institute, Jupiter, FL. \$68. (561) 747-1460.
- State Update.** Division of Government Relations, American Psychiatric Association, Washington, DC. Free to APA members. (202) 682-6060.
- Unique Opportunities: The Magazine for Physician Recruitment.** Louisville, KY. \$30. (502) 589-8250.

HIRING AND MANAGING ADMINISTRATIVE STAFF

An enthusiastic and productive staff can make the difference between a successful, fulfilling practice and a sluggish, unsatisfying one. In order to ensure the former, it is critical that the physician be a strong and effective leader and be knowledgeable about employment laws, successful hiring techniques, and how to maintain an orderly yet open office in which communication is a high priority.

EMPLOYMENT LAWS AND REGULATIONS

Before you hire and manage administrative staff, it is important that you understand the laws that govern this kind of employer-employee relationship. As far as hiring is concerned, a general rule to follow is that only the skills and work experience that directly influence a candidate's ability to effectively perform the duties of the position should affect his likelihood of obtaining the job. Factors such as age, sex, race, marital status, religion, and sexual orientation cannot be considerations in the hiring process. Even in situations where laws only apply to businesses with more than a certain number of employees, often fifteen or twenty, it is highly advisable to adhere to them regardless of the size of your office.

The following are seven of the key federal laws that psychiatrists, and all employers, must keep in mind when hiring staff:

1. **Fair Labor Standards Act of 1938 (FLSA), as Amended** - sets requirements for a minimum wage, overtime pay, child labor regulations, and prohibits wage discrimination based on sex.
2. **Equal Pay Act of 1963** - prohibits wage discrimination based on sex.
3. **Title VII of the Civil Rights Act of 1964** - prohibits discrimination based on religion, national origin, race, sex, etc. and created the Equal Employment Opportunity Commission (EEOC) for enforcement. Acts of harassment, including sexual harassment, are also prohibited under this law.
4. **Age Discrimination in Employment Act of 1967 (ADEA)** - prohibits discrimination based on age.
5. **Pregnancy Discrimination Act of 1978** - prohibits discrimination based on pregnancy.
6. **Immigration Reform and Control Act of 1986 (IRCA)** - requires employers to maintain proof of employees' citizenship.

7. Americans With Disabilities Act of 1990 (ADA) - prohibits discrimination against a “qualified individual with a disability.”

Employers must also comply with employee safety and health standards as set forth by the Occupational Safety and Health Administration (OSHA). These regulations are designed to ensure that employees have a safe work environment. For compliance information, contact your local OSHA office or access its website at www.osha.gov.

Additional laws and regulations that must be adhered to include, but are not limited to:

- Workers’ compensation laws (mostly state mandated);
- Federal record-keeping requirements;
- Wage deductions;
- Unemployment compensation;
- Social security;
- Employee safety and rights poster requirements (mandated by the Department of Labor and the Equal Employment Opportunity Commission);
- Employee Retirement Income Security Act of 1974 (ERISA) (see Chapter 42);
- Consolidated Omnibus Budget Reconciliation Act (COBRA); and
- Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For more complete information on complying with federal employment laws, contact your regional office of the Department of Labor. This address, along with an abundance of additional helpful information, including the contents of many pertinent federal regulations can be found on the Department of Labor’s website at www.dol.gov. Of particular interest is the link entitled “Small Business Resources.” The Department also maintains a National Toll-Free Contact Center. Assistance is available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time by calling 1-866-487-2365, TTY: 1-877-889-5627. In addition, you should always seek guidance from a lawyer or other consultant familiar with federal and state employment laws and regulations when dealing with these compliance issues.

HIRING AND EXPECTATIONS

You cannot expect your office to function well unless you are willing to take considerable time and effort to hire the right staff members. First you must conduct a thorough search. Consider people you work with at the hospital, put

advertisements on Craig's List and in the local paper, and work with employment agencies. Once you have reviewed several promising resumes, schedule interviews with those candidates.

Make the interview really count. If you want to, you can have the candidate fill out a standard job application form (see Appendix K, Staff Application Form). To put the candidate at ease, and thus get the most accurate impression of him or her, begin the interview with casual conversation. Gradually move to more compelling questions that clarify the applicant's skills, interests, and job-related experience. On this note, be sure that you do not ask unacceptable (and possibly illegal) questions, such as questions about an applicant's family background or age. As a general rule, only ask questions that are relevant to the duties of the position. If you have any doubt about a particular question, do not ask it until you have consulted an attorney knowledgeable in this area or a representative at the Department of Labor.

Be straightforward and honest about the job's responsibilities and your expectations. Give a general overview of both the office and the position and then explain the specifics of the job's day-to-day duties. This will encourage candidates who are appropriately suited for the job and discourage those who are not, saving both you and the candidates valuable time. It also prevents disappointing surprises and possible problems once an individual is hired and begins working.

In addition to a verbal description of the position, a candidate should also be given a detailed written job description that covers all major responsibilities. This helps to ensure that an employee knows precisely what is expected. An employee handbook that covers general employee issues should also be available upon hire. For more information on enhancing staff performance, see Appendix L, Staff Performance Review Form .

References, particularly former-employer references, are a good way to confirm and supplement information from the interview and resume. In some instances, you may want to check public records to further illuminate an employee's background. Ensuring that your employees are competent and trustworthy is particularly important for a psychiatrist's office, since staff may be in contact with your patients and their confidential medical records. As always, consult your lawyer prior to engaging in any activities that may have legal ramifications for you or your practice.

Finally, make sure that the salaries and compensation package you offer are competitive. High turnover and mediocre employees are not worth the money that you might save by offering below-market salaries.

TECHNIQUES FOR FOSTERING A PRODUCTIVE WORK ENVIRONMENT

Once you have your staff in place, it is important to do your part to create and maintain a productive work environment. Most would agree that a friendly, energized atmosphere in which teamwork is stressed and supervisors take an active role in promoting this environment is the key to an efficient and productive office.

Several management suggestions to encourage such a work setting were offered by the periodical *Unique Opportunities: The Physician's Resource* back in 1997. They still apply.

- **Express your appreciation** - thank employees for a job well-done;
- **Adapt your management style** - provide detailed guidance for new employees and ease up as they become accustomed to their jobs;
- **Encourage initiative** - if an employee has a good idea, let him or her act on it;
- **Involve staff in decisions** - this will increase your understanding of the situation at hand and encourage employees to actively pursue a solution;
- **Be a “gentle enforcer”** - hold employees accountable for mistakes and poor performance, but help them learn from their mistakes, rather than punishing them;
- **Consider financial rewards for the group** - this will encourage teamwork and office efficiency;
- **Be open** - encourage face-to-face interaction and discourage rumors or hearsay; and
- **Be flexible** - if you bend for your employees, they will tend to bend for you.

As a physician, you are an office leader to the administrative staff. Take it upon yourself to institute these practices in your office. Your office will be more efficient and rewarding for you, your employees, and your patients.

STATE MEDICARE ADMINISTRATIVE CONTRACTORS

The Medicare program is in the process of making a transition from Medicare Carriers to Medicare Administrative Contractors. Medicare Carriers still oversee Part B for a few states. Medicare Administrative Contractors (MACs) will eventually oversee both Parts A and B for all of the 15 jurisdictions CMS has designated.

ALABAMA- Jurisdiction 10

Greg McKinney, M.D.
Cahaba GBA - Alabama
P.O. Box 13384
Birmingham, AL 35205-3384
Provider Enrollment:
Cahaba GBA
Attn: Provider Enrollment
P.O. Box 830170
Birmingham, AL 35283-0170
(866) 801-5301
<https://www.cahabagba.com/>

ALASKA

William Mangold, M.D.
Noridian Administrative Services, LLC
900 42nd Street S
P.O. Box 6740
Fargo, ND 58108- 6740
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816 (option 1 for Part B)
Provider Reopenings: 8(00) 279-5331
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6703
Fargo, ND 58108-6703
www.noridianmedicare.com

ARIZONA—Jurisdiction 3

William Mangold, M.D. JD
Noridian Administrative Services, LLC
8920 N 23rd Ave. Suite 1
Phoenix, AZ 85021
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816 (option 1 for Part B)
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6704
Fargo, ND 58108-6704
www.noridianmedicare.com

ARKANSAS

Sidney P. Hayes, M.D.
Pinnacle Medicare Services
P.O. Box 8150
Little Rock, AK 72203
(866) 567-8419
www.pinnaclemedicare.com

CALIFORNIA—Jurisdiction 1

Arthur Lurvey, MD
Palmetto GBA
P.O. Box 1476
Augusta, GA 30943-1476
Claims Issues address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1051
Augusta, GA 30903-1051
(866) 669-5543

Provider Enrollment address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508
Provider/Enrollment line: (866) 895-1520
<http://palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>

COLORADO—Jurisdiction 4

Debra Patterson, MD
Trailblazer Health Enterprises, LLC
8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
IVR J-4: (877) 567-9230
Provider Contact Center 866.280.6520
Send enrollment, claims, & appeals to:
TrailBlazer Health Enterprises, LLC
PO Box 650710
Dallas, TX 75265-0710
866.539.5596
<http://www.trailblazerhealth.com/>

CONNECTICUT—Jurisdiction 13

Paul Deutsch, MD

National Government Services, Inc.

By phone:

IVR: (877) 869-6504

Provider Contact Center: 866 837-0241

Appeals: (888) 812- 8905, press 1

In writing:

Enrollment:

National Government Services, Inc.

P. O. Box 6229

Indianapolis, IN 46206-6229

Claims:

National Government Services, Inc.

Medicare Part B Claims

PO Box 6185

Indianapolis, IN 46206-6185

Appeals:

National Government Services, Inc.

P.O. Box 7111

Indianapolis, IN 46207-7111

<http://www.ngsmedicare.com/ngsmedicare/HomePage.aspx>

DELAWARE—Jurisdiction 12

Robert Muscalus, MD

Novitas Solutions

1800 Center Street

Camp Hill, PA 17089

Part B:

Provider Inquiries: (877) 235-8073

Enrollment: (866) 488-0549, option 1

IVR/Fax: (877) 235-8073

Phone Claims/Appeals: (866) 488-0551

Enrollment:

Provider Enrollment Services

Novitas Solutions

PO Box 890408

Camp Hill, PA 17089-0408

Initial Paper Claims:

PO Box 890397

Camp Hill, PA 17089-0397

Appeals:

PO Box 890400

Camp Hill, PA 17089-0400

<https://www.novitas-solutions.com>

DISTRICT OF COLUMBIA Metropolitan Area [includes Northern Virginia]—Jurisdiction 12

Robert Muscalus, MD

Novitas Solutions

1800 Center Street

Camp Hill, PA 17089

Part B:

Provider Inquiries: 877 235 8073

Enrollment: 866 488 0549, option 1

IVR/Fax: 877 235 8073

Phone Claims/Appeals: 866 488 0551

Enrollment:

Provider Enrollment Services:

PO Box 890407

Camp Hill, PA 17089-0407

Initial Paper Claims:

PO Box 890396

Camp Hill, PA 17089-0396

Appeals:

PO Box 890399

Camp Hill, PA 17089-0399

<https://www.novitas-solutions.com>

FLORIDA- Jurisdiction 9

James Corcoran, M.D.

First Coast Service Options

532 Riverside Avenue 20T

Jacksonville, FL 32202

To enroll or opt out:

Provider Enrollment

P. O. Box 44021

Jacksonville, FL 32231

(877) 847-4992

(877) 454-9007

<http://medicare.fcso.com/>

GEORGIA- Jurisdiction 10

Greg McKinney, M.D.

Cahaba Medicare

P.O. Box 13384

Birmingham, AL 35205-3384

(877) 567-7271

Provider Enrollment:

Cahaba GBA

Provider Enrollment

P.O. Box 830170

Birmingham, AL 35283-0170

(877) 567-7271

www.cahabagba.com

HAWAII—Jurisdiction 1

Arthur Lurvey, MD

Palmetto GBA

P.O. Box 1476

Augusta, GA 30943-1476

Claims Issues address & phone:

J1 MAC – Palmetto GBA
P.O. Box 1051
Augusta, GA 30903-1051
(866) 669-5543
Provider Enrollment:
J1 MAC – Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508
Provider/Enrollment line: (866) 895-1520
<http://palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>

IDAHO

Gary Oakes, M.D.
CGS Medicare
Two Vantage Way RTG 576
Nashville, TN 37228
(866) 824-8593
www.cignamedicare.com

ILLINOIS

Stephen D. Boren, M.D.
Medicare B/Wisconsin Physician Services
111 East Wacker Drive, #950
Chicago, IL 60601
(877) 908-9499
(877) 867-3418 to appeal
(877) 908-8476 to enroll
Send Opt Out to:
Medicare Part B Enrollment Unit
PO Box 8248
Madison WI 53708-8248
www.wpsmedicare.com

INDIANA

Carolyn Cunningham, M.D.
AdminaStar Federal
8115 Knue Road
Indianapolis, IN 46250
(866) 250-5665
www.adminastar.com

IOWA—Jurisdiction 5

Kenneth Bussan, MD
Wisconsin Physicians Service
1717 W. Broadway
Madison, WI 53713
IVR: (866) 590-6702 24 hrs, 7 days a week
Contact Center: (866) 503-3807 8:00 am to 5:00 pm CST M-F
Enrollment:
WPS Medicare Part B

Provider Enrollment
P.O. Box 8248
Madison, WI 53708-8248
(866) 503-7664 8:00 am to 4:00 pm CST M-F
Paper Claims & Appeals:
WPS Medicare Part B
Claims Department
P.O. Box 8550
Madison, WI 53708-8550
(866) 590-6730 8:00 am to 4:00 pm CST M-F
<http://www.wpsmedicare.com/>

KANSAS—Jurisdiction 5

Kenneth Bussan, MD
Wisconsin Physicians Service
1707 W. Broadway
Madison, WI 53713
IVR: (866) 590-6702 24 hrs, 7 days a week
Contact Center: (866) 503-3807 8:00 am to 5:00 pm CST M-F
Enrollment:
WPS Medicare Part B
Provider Enrollment
P.O. Box 8248
Madison, WI 53708-8248
(866) 503-7664 8:00 am to 4:00 pm CST M-F
Paper Claims & Appeals:
WPS Medicare Part B
Claims Department
P.O. Box 7238
Madison, WI 53708-7238
(866) 590-6730 8:00 am to 4:00 pm CST M-F
<http://www.wpsmedicare.com/>

KENTUCKY-Jurisdiction 15

CGS Administrators, LLC
PO Box 20018
Nashville, TN 37202
(866) 290-4036
Claims: PO Box 20019
Enrollment: PO Box 20017
<http://www.cgsmedicare.com>

LOUISIANA

Sidney Hayes, M.D.
Pinnacle Medicare Services
P.O. Box 8066
Little Rock, AR 72203-8066
(866) 567-8419
www.pinnaclemedicare.com

MAINE-Jurisdiction 14

Craig Haug, M.D.
National Heritage Insurance Co.
75 Sgt. William B. Terry Drive
Hingham MA 02043-1518
Provider Inquiries/Claims: (877) 258-4442
IVR: (877) 567-3129
Written inquiries:
PO Box 1000
Hingham MA 02044
www.medicarenhic.com

MARYLAND—Jurisdiction 12

Robert Muscalus, MD
Novitas Solutions
1800 Center Street
Camp Hill, PA 17089
Part B:
Provider Inquiries: 877 235 8073
Enrollment: 866 488 0549, option 1
IVR/Fax: 877 235 8073
Phone Claims/Appeals: 866 488 0551
Enrollment:
Provider Enrollment Services
PO Box 890406
Camp Hill, PA 17089-0406
Initial Paper Claims:
PO Box 890398
Camp Hill, PA 17089-0398
Appeals:
PO Box 890401
Camp Hill, PA 17089-0401
<https://www.novitas-solutions.com>

MASSACHUSETTS- Jurisdiction 14

Craig Haug, M.D.
National Heritage Insurance Co.
75 Sgt. William B. Terry Drive
Hingham MA 02043-1518
IVR: (877) 567-3130
Written inquiries:
PO Box 1000
Hingham MA 02044
www.medicarenhic.com

MICHIGAN

Stephen D. Boren, M.D.
Medicare B/Wisconsin Physician Services

111 East Wacker Drive, #950
Chicago, IL 60601
(877) 908-9499
(877) 867-3418 to appeal
(877) 908-8476 to enroll
Send Opt Out to:
Medicare Part B Enrollment Unit
PO Box 8248
Madison WI 53708-8248
www.wpsmedicare.com

MINNESOTA

Stephen D. Boren, M.D.
Medicare B/Wisconsin Physician Services
111 East Wacker Drive, #950
Chicago, IL 60601
(877) 908-9499
(877) 867-3418 to appeal
(877) 908-8476 to enroll
Send Opt Out to:
Medicare Part B Enrollment Unit
PO Box 8248
Madison WI 53708-8248
www.wpsmedicare.com

MISSISSIPPI

Greg McKinney, M.D.
Cahaba GBA - Alabama
P.O. Box 13384
Birmingham, AL 35205-3384
Provider Enrollment:
Cahaba GBA
Attn: Provider Enrollment
P.O. Box 830170
Birmingham, AL 35283-0170
(866) 801-5301
<http://www.almedicare.com>

MISSOURI—Jurisdiction 5

Kenneth Bussan, MD
Wisconsin Physicians Service
1707 W. Broadway
Madison, WI 53713
IVR: (866) 590-6702 24 hrs, 7 days a week
Contact Center: (866) 503-3807 8:00 am to 5:00 pm CST M-F
Enrollment:
WPS Medicare Part B
Provider Enrollment
P.O. Box 8248
Madison, WI 53708-8248
(866) 503-7664 8:00 am to 4:00 pm CST M-F

Paper Claims & Appeals (for Eastern MO):
WPS Medicare Part B
Claims Department
P.O. Box 14260
Madison, WI 53708-0260
Paper Claims & Appeals (for Western MO):
WPS Medicare Part B
Claims Department
P.O. Box 7128
Madison, WI 53707-7128
(866) 590-6730 8:00 am to 4:00 pm CST M-F
<http://www.wpsmedicare.com/>

MONTANA—Jurisdiction 3

William Mangold, M.D. JD
Noridian Administrative Services, LLC
8920 N 23rd Ave. Suite 1
Phoenix, AZ 85021
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816 (option 1 for Part B)
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6735
Fargo, ND 58108-6735
www.noridianmedicare.com

NEBRASKA—Jurisdiction 5

Kenneth Bussan, MD
Wisconsin Physicians Service
1707 W. Broadway
Madison, WI 53713
IVR: (866) 590-6702 24 hrs, 7 days a week
Contact Center: (866) 503-3807 8:00 am to 5:00 pm CST M-F
Enrollment:
WPS Medicare Part B
Provider Enrollment
P.O. Box 8248
Madison, WI 53708-8248
(866) 503-7664 8:00 am to 4:00 pm CST M-F
Paper Claims & Appeals:
WPS Medicare Part B
Claims Department
P.O. Box 7238
Madison, WI 53708-7238
(866) 590-6730 8:00 am to 4:00 pm CST M-F
<http://www.wpsmedicare.com/>

NEVADA—Jurisdiction 1

Arthur Lurvey, MD

Palmetto GBA
P.O. Box 1476
Augusta, GA 30943-1476
Claims Issues address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1051
Augusta, GA 30903-1051
(866) 669-5543
Provider Enrollment:
J1 MAC – Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508
Provider/Enrollment line: (866) 895-1520
<http://palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>

NEW HAMPSHIRE- Jurisdiction 14

Craig Haug, M.D.
National Heritage Insurance Co.
75 Sgt. William B. Terry Drive
Hingham MA 02043-1518
Provider Inquiries/Claims: (877) 258-4442
IVR: (877) 567-3129
Written inquiries:
PO Box 1000
Hingham MA 02044
www.medicarenhic.com

NEW JERSEY—Jurisdiction 12

Robert Muscalus, MD
Novitas Solutions
1800 Center Street
Camp Hill, PA 17089
Part B:
Provider Inquiries: 877 235 8073
Enrollment: 866 488 0549, option 1
IVR/Fax: 877 235 8073
Phone Claims/Appeals: 866 488 0551
Written inquiries:
Enrollment:
Provider Enrollment Services
Novitas Solutions
PO Box 890036
Camp Hill, PA 17089-0036
Initial Paper Claims:
PO Box 890030
Camp Hill, PA 17089-0030
Appeals:
PO Box 890031
Camp Hill, PA 17089-0031
<https://www.novitas-solutions.com>

NEW MEXICO—Jurisdiction 4

Deborah Patterson, MD
Trailblazer Health Enterprises, LLC
8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
IVR J-4: (877) 567-9230
Provider Contact Center 866.280.6520
Send enrollment, claims, & appeals to:
TrailBlazer Health Enterprises, LLC
PO Box 650710
Dallas, TX 75265-0710
866.539.5596
<http://www.trailblazerhealth.com/>
Email: partb.tbenrollment@trailblazerhealth.com

**NEW YORK—Jurisdiction 13
Downstate/Upstate [now National
Government Services]**

National Government Services, Inc.
PO Box 4837
Syracuse, NY 13221-4837
Provider Contact Center: (866) 837-0241
Written inquiries:
Provider Enrollment [all counties]:
National Government Services, Inc.
P.O. Box 6230
Indianapolis, IN 46206-6230
For Claims / for Appeals:
National Government Services, Inc.
Downstate:
PO Box 6178 / PO Box 7111
Indianapolis, IN 46206-6178 / 46207-7111
Upstate:
PO Box 6189 / PO Box 7111
Indianapolis, IN 46206-6189 / 46207-7111
<http://www.ngsmedicare.com/ngsmedicare/HomePage.aspx>

**NEW YORK—Jurisdiction 13
Queens [now National Government
Services]**

Phone inquiries:
Provider Contact Center: (866) 837 0241
Written inquiries:
Provider Enrollment
National Government Services, Inc.
P.O. Box 6230
Indianapolis, IN 46206-6230
For Claims / for Appeals:

National Government Services, Inc.
PO Box 6239 / PO Box 7111
Indianapolis, IN 46206-6239 / 46207-7111
General Inquiries:
National Government Services, Inc.
PO Box 7052
Indianapolis IN 46207-7052
<http://www.ngsmedicare.com/ngsmedicare/HomePage.aspx>

NORTH CAROLINA—Jurisdiction 11

Elaine Jeter, M.D.
Palmetto GBA
J11 Part B PCC
Mail code: AG-620
P.O. Box 100238
Columbia, SC 29202-3232
(866) 830-3043
www.palmettogba.com/medicare

NORTH DAKOTA—Jurisdiction 3

William Mangold, M.D. JD
Noridian Administrative Services, LLC
8920 N 23rd Ave. Suite 1
Phoenix, AZ 85021
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816 (option 1 for Part B)
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6706
Fargo, ND 58108-6706
www.noridianmedicare.com

OHIO – Jurisdiction 15

CGS Administrators, LLC
PO Box 20018
Nashville, TN 37202
(866) 290-4036
Claims: PO Box 20019
Enrollment: PO Box 20017
<http://www.cgsmedicare.com>

OKLAHOMA—Jurisdiction 4

Deborah Patterson, MD
Trailblazer Health Enterprises, LLC
8330 LBJ Freeway, Exec Center III
Dallas, TX 75243-1213
IVR J-4: (877) 567-9230
Provider Contact Center 866.280.6520

Send enrollment, claims, & appeals to:
TrailBlazer Health Enterprises, LLC
PO Box 650710
Dallas, TX 75265-0710
866.539.5596
<http://www.trailblazerhealth.com/>

OREGON

William Mangold, M.D.
Noridian Administrative Services, LLC (XX)
900 42nd Street S
P.O. Box 6740
Fargo, ND 58108- 6740
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816
Provider Reopenings: (800) 279-5331
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6702
Fargo, ND 58108-6702
www.noridianmedicare.com

PENNSYLVANIA—Jurisdiction 12

Robert Muscalus, MD
Novitas Solutions
1800 Center Street
Camp Hill, PA 17089
Part B:
Provider Inquiries: (877) 235-8073
Enrollment: (866) 488-0549
IVR/Fax: 877 235 8073
Phone Claims/Appeals: (866) 488-0551
Enrollment:
Provider Enrollment Services
Novitas Solutions
PO Box 890157
Camp Hill, PA 17089-0157
Initial Paper Claims:
PO Box 890418
Camp Hill, PA 17089-0418
Appeals:
PO Box 890413
Camp Hill, PA 17089-0413
<https://www.novitas-solutions.com>

RHODE ISLAND- Jurisdiction 14

Craig Haug, M.D.
National Heritage Insurance Co.
75 Sgt. William B. Terry Drive

Hingham MA 02043-1518
Provider Inquiries/Claims: (877) 258-4442
IVR: (877) 567-3129
Written inquiries:
PO Box 1000
Hingham MA 02044
www.medicarenhic.com

SOUTH CAROLINA—Jurisdiction 11

Elaine Jeter, M.D.
Palmetto GBA
J11 Part B PCC
Mail code: AG-620
P.O. Box 100238
Columbia, SC 29202-3232
(866) 830-3043
www.palmettogba.com

SOUTH DAKOTA—Jurisdiction 3

William Mangold, M.D. JD
Noridian Administrative Services, LLC
8920 N 23rd Ave. Suite 1
Phoenix, AZ 85021
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6707
Fargo, ND 58108-6707
www.noridianmedicare.com

TENNESSEE—Jurisdiction 10

Greg McKinney, M.D.
Cahaba GBA
P.O. Box 13384
Birmingham, AL 35205-3384
(877) 567-7271
Provider Enrollment:
Cahaba GBA
Provider Enrollment
P.O. Box 830170
Birmingham, AL 35283-0170
(877) 567-7271
www.cahabagba.com

TEXAS—Jurisdiction 4

Debra Patterson, MD
Trailblazer Health Enterprises, LLC
8330 LBJ Freeway, Exec Center III

Dallas, TX 75243-1213
IVR J-4: (877) 567-9230
Provider Contact Center 866.280.6520
Send enrollment, claims, & appeals to:
TrailBlazer Health Enterprises, LLC
PO Box 650710
Dallas, TX 75265-0710
866.539.5596
<http://www.trailblazerhealth.com/>

UTAH—Jurisdiction 3

William Mangold, M.D. JD
Noridian Administrative Services, LLC
8920 N 23rd Ave. Suite 1
Phoenix, AZ 85021
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816 (option 1 for Part B)
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6725
Fargo, ND 58108-6725
www.noridianmedicare.com

VERMONT – Jurisdiction 14

Craig Haug, M.D.
National Heritage Insurance Co.
75 Sgt. William B. Terry Drive
Hingham MA 02043-1518
Provider Inquiries/Claims: (877) 258-4442
IVR: (877) 567-3129
Written inquiries:
PO Box 1000
Hingham MA 02044
www.medicarenhic.com

VIRGINIA—Jurisdiction 11 (No. VA is in J-12)

Elaine Jeter, M.D.
Palmetto GBA
J11 Part B PCC
Mail code: AG-620
P.O. Box 100238
Columbia, SC 29202-3232
(866) 830-3043
www.palmettogba.com

WASHINGTON

William Mangold, M.D.
Noridian Administrative Services, LLC
7525 NE Ambassador Place, Suite B
Portland, OR 97220
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816
Provider Reopenings: 8(00) 279-5331
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6700
Fargo, ND 58108-6700
www.noridianmedicare.com

WEST VIRGINIA—Jurisdiction 11

Elaine Jeter, M.D.
Palmetto GBA
J11 Part B PCC
Mail code: AG-620
P.O. Box 100238
Columbia, SC 29202-3232
(866) 830-3043
www.palmettogba.com

WISCONSIN

Ken Bussan, M.D.
Wisconsin Physician Services
1717 W. Broadway
P.O. Box 1787
Madison, WI 53701
(877) 908-8475
(877) 567-7176
www.medicareinfo.com

WYOMING—Jurisdiction 3

William Mangold, M.D. JD
Noridian Administrative Services, LLC
8920 N 23rd Ave. Suite 1
Phoenix, AZ 85021
IVR: (877) 908-8431
Provider Contact Center (800) 933-0614
Enrollment: (888) 608-8816 (option 1 for Part B)
Send enrollment, claims, & appeals to:
Medicare Part B
P.O. Box 6708
Fargo, ND 58108-6708
www.noridianmedicare.com

AMERICAN SAMOA- Jurisdiction 1

Arthur Lurvey, MD

Palmetto GBA
P.O. Box 1476
Augusta, GA 30943-1476
Claims Issues address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1051
Augusta, GA 30903-1051
(866) 669-5543
Provider Enrollment:
J1 MAC – Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508
Provider/Enrollment line: (866) 895-1520
<http://palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>

GUAM—Jurisdiction 1

Arthur Lurvey, MD
Palmetto GBA
P.O. Box 1476
Augusta, GA 30943-1476
Claims Issues address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1051
Augusta, GA 30903-1051
(866) 669-5543
Provider Enrollment:
J1 MAC – Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508
Provider/Enrollment line: (866) 895-1520
<http://palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>
(808) 522-1577
(877) 908-8431
www.noridianmedicare.com
Claims: 800 933 0614
Enrollment: 888 608 8816
Appeals: 800 279 5331

NORTHERN MARIANA ISLANDS— Jurisdiction 1

Arthur Lurvey, MD
Palmetto GBA
P.O. Box 1476
Augusta, GA 30943-1476
Claims Issues address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1051
Augusta, GA 30903-1051
(866) 669-5543

Provider Enrollment address & phone:
J1 MAC – Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508
Provider/Enrollment line: (866) 895-1520
<http://palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>

PUERTO RICO—Jurisdiction 9

James Corcoran, M.D.
First Coast Service Options
532 Riverside Avenue 20T
Jacksonville, FL 32202
To enroll or opt out:
Provider Enrollment
P. O. Box 44021
Jacksonville, FL 32231
(877) 847-4992
(877) 454-9007
<http://medicare.fcso.com/>

U.S. VIRGIN ISLANDS—Jurisdiction 9

James Corcoran, M.D.
First Coast Service Options
532 Riverside Avenue 20T
Jacksonville, FL 32202
To enroll or opt out:
Provider Enrollment
P. O. Box 44021
Jacksonville, FL 32231
(877) 847-4992
(877) 454-9007
<http://medicare.fcso.com/>