



# A Psychologist in Every Clinic: The Business Realities of Pain Psychology

Brent Van Dorsten PhD

President: Colorado Center for Behavioral Medicine

303-256-6625 (O); [vandorsten@ccbm.com](mailto:vandorsten@ccbm.com)



# Psychology Controversy in the Assessment and Treatment of Pain

- ▶ Biopsychological Model of Pain – Engle 1977
- ▶ Years of efficacy data in assessment and treatment of chronic pain
- ▶ Psychological factors strongly influence the onset, duration and intensity of pain factors
- ▶ Psychological care appears in multiple insurance treatment pathways
- ▶ However, several insurers who “mandate” psychology involvement have NO pathway for payment of their “mandatory” services
- ▶ Psychology reimbursement with MINIMAL change over past 20 years

# Biopsychosocial Pain Treatment

- Efficacy of Cognitive-Behavioral Pain Management
  - CBT constitutes the cornerstone upon which “functional restoration” programs are established
  - **Strong evidence** that CBT reduces pain related **disability**
  - **Strong evidence** of benefit in adults/adolescents/children
    - Allen & Woolfork 2010; Brox et al. 2003; Eccleston et al. 2003; C De C Williams et al. 2021; Morley et al. 1999; Palermo et al. 2010; Turner & Jensen 1993
  - Meta-Analysis of RCT's of CBT and BT for chronic pain show the **effectiveness of active behavioral therapies for pain** with an average significant effect size of **0.5**

Morley et al. 1999; Ostelo et al. 2005

# “Biopsychosocial Law” for WKCP

4

Bruns D, Mueller K, & Warren PA (2012) Rehabilitation Psychology

- Pre-1992 Colorado in top five states in WCKP costs in US
- Legislature demanded reform – developed evidence-based treatment guidelines for top 10 issues (chronic pain, back, neck). **Biopsychosocial Law in CO since 1992 for WKCP**
- In accordance with published evidence – *recommended psychological evaluation and intervention in patients failing to show improvement within 6-12 weeks with medical care*
- Goal was to improve outcomes, refrain from limiting care but to emphasize insurance approval for only those interventions with a reasonable data base of support

# “Biopsychosocial Laws” for WKCP

5

Bruns D, Mueller K, & Warren PA (2012) Rehabilitation Psychology

- ▶ Compared CO data to 45 other national states WKCP costs, inflation and progress from 1992-2007. Study summarized medical treatment costs and cost inflation for **520,000+** injured workers in CO versus **28+ million** across US
- ▶ In the 15 years following WKCP reform in Colorado:
  - ▶ Cumulative **inflation** in medical costs expenditures were **less than 1/3 of the cost of the rest of the nation**
  - ▶ **Saved an estimated \$859 MILLION in 2007 alone !**
  - ▶ **Stands directly in the face of insurer concerns that adding the cost of psychological care will increase costs**
  - ▶ **Supports an aggregate of cost savings for psychological care**



# Mood Epidemiology in Patients With Chronic Pain

## Major Depression in Medical/Pain Populations

► 5-40% Primary Care

Bair et al. 2003

► 30-55% Patients with Pain

Turner 1984; Banks & Kerns, 1996; Bair et al. 2003, Reid et al. 2002

## Anxiety in Medical/Pain Populations

► 25-30% Primary Care

Gatchel 2005; Reid 2002

► 40-50% Pain Patients



# Impact of Mood on Pain Treatment Outcomes

## Depression and Anxiety Disorders

### INCREASED:

- Health care utilization, MD/ER visits
- Medication use (**3-6 fold increase in opioid prescriptions**)
  - Reid et al. 2002; Sullivan et al. 2005
- Premature treatment drop-out, relapse after treatment
- Sedentary activity, alcohol/drug use
  
- Number of health and pain complaints
- Pain severity
- Post-operative pain
- Duration of pain
- Functional limitation and disability

Adapted from Van Dorsten 2018

# Impact of Mood on Medical Treatment Outcomes

## Depression and Anxiety Disorders

### DECREASED:

- Return to work
- Adherence with treatment recommendations
  - 1.79-3.0 odds ratio of poor adherence
    - Grenard et al. 2011, DeMatteo et al. 2002, Gonzales et al. 2008
- Overall rehabilitative outcome
- ~50% retention of information provided

Adapted from Van Dorsten & Weisberg 2011



# Accuracy of Pre-Surgical Psychological Evaluations in Predicting Treatment Outcome

## Accuracy of Psychosocial Predictions:

Block et al. (2001) empirically tested predictive accuracy of various factors

- Evaluated 204 patients prior to lumbar fusion or laminectomy
- Considered multiple medical and psychological risk factors
- Evaluated predictions against outcomes
  - VAS, medication use, Oswestry

# PPS Medical Risk Factors

## Risk Factor

Chronicity of complaints

Previous spine procedures

Destructiveness of procedures

Non-Organic Signs

Non-Spine medical treatments

Smoking

Obesity\*

**Medical** Total Risk Score

## Risk Score

0-2 duration

0-2 (number)

1=laminectomy,  
2=fusion

2 = present

1-2 = amount

1-2 = amount

1 if 50% < ideal

**8 or more = high risk**

Adapted from Block AR, Ohnmeiss DD, Guyer RD, et al. The use of presurgical psychological screening to predict the outcome of spine surgery. *The Spine Journal* 2001; 1(4): 274-282.

# PPS Psychological Risk Factors

## Risk Factor

Pending litigation

Worker's compensation - current

Job dissatisfaction

Heavy Job Demands

Substance Abuse

Family Reinforcement of Pain

Marital Dissatisfaction

Physical/Sexual Abuse

Pre-Injury Psych Treatment

## Risk Score

2

2

1 = moderate, 2 = severe

2 = >50 lbs lifting

1 = pre-injury, 2 = current

1 = moderate, 2 = extreme

1 = moderate / 2 = extreme

1 = prior, 2 = current

1 = outpatient , 2 = inpatient

Adapted from Block AR, Ohnmeiss DD, Guyer RD, et al. The use of presurgical psychological screening to predict the outcome of spine surgery. *The Spine Journal* 2001; 1(4): 274-282.

# PPS Psychological Testing Risk Factors

<u>Risk Factor</u>	<u>Risk Score</u>
<b>MMPI-2 Elevations &gt; 70 (max = 4)</b>	
HS – Hypochondriasis	2
HY – Hysteria	2
D – Depression - Pre-existing	2
Reactive to Pain	1
PD – Resistant to Authority/Anger	2
PT – Psychasthenia	1
<b>Coping Strategies Questionnaire. (max = 2)</b>	
Low Self-Reliance	2
Poor Ability to Control Pain	2
<b>Psychological Total Risk Score</b>	<b>10 or more = high risk</b>

Adapted from Block AR, Ohnmeiss DD, Guyer RD, et al. The use of presurgical psychological screening to predict the outcome of spine surgery. *The Spine Journal* 2001; 1(4): 274-282.

# PPS Prediction of Surgical Prognosis

GOOD – Low Medical and Psych Risk

15.2% of Block (2001) Sample

FAIR – One HIGH and One LOW Risk

58.8% of Block (2001) Sample

POOR – High Medical and Psych Risks

26% of entire Block (2001) Sample

Block AR, Ohnmeiss DD, Guyer RD, et al. The use of presurgical psychological screening to predict the outcome of spine surgery. *The Spine Journal* 2001; 1(4): 274-282.

# PPS Accuracy of Prediction

GOOD Prognosis Group

9.7 False Positive Rate (3/31)

FAIR Prognosis Group

19.2 False Positive Rate (23/120)

POOR Prognosis Group

11.3 False Negative Rate (6/53)

74% predicted to have a “good/fair” outcome

65.7% actually achieved this outcome (34.3 % poor)

Block AR, Ohnmeiss DD, Guyer RD, et al. The use of presurgical psychological screening to predict the outcome of spine surgery. *The Spine Journal* 2001; 1(4): 274-282.



# PPS Factor Contributions to Overall Prediction of Surgical Outcome

## Psychological Testing Data

Correctly Classified 78.4% of Cases

PLUS

## Psychological Interview Data

Correctly Classified 83.3% of Cases (4.9%)

PLUS

## Medical Risk Factors

Correctly Classified 84.3% of Cases (1%)

\*\*Only Obesity > 50% of ideal body weight contributed to prediction of outcome !!

# Medically Unexplained Symptoms

- ▶ Constellation of somatoform disorder symptoms most commonly referred to as MUS in literature
  - ▶ Physical symptoms for which there are no confirmatory anatomical, biological or pathological findings

Nezu 2001

- ▶ Symptoms are chronic, patients may demand diagnostic testing and treatment with confirmation or symptom improvement
- ▶ These symptom characteristics are thought to be prevalent in **10-25%** of primary care visits

Gureje 1997, Kroenke et al. 2007; Ormel 1994

# Medically Unexplained Symptoms

## ▶ Hallmarks of MUS Patients

- ▶ **Excessive use of healthcare system**
- ▶ Over 2 x the number of in- and outpatient visits per year
  - ▶ Minor stressors increase medical use by **50%** Naessens et al 2005
- ▶ Lifetime healthcare expenses at **6-14 x** the US average
- ▶ Significant physical limitations
- ▶ Bedridden on average **2-7** days per month
- ▶ **> 25% of MD visits are for complaints lacking a clear etiology**  
Kroenke et al. 2007; Smith 1986; Woolfolk & Allen 2007; Gureje 1997
- ▶ **50%** have current co-morbid DSM diagnosis  
Allen et al. 2001, Simon & Von Korff 1991
- ▶ **80% lifetime DSM- IV** diagnosis  
Smith, Monson & Ray 1986; Robins & Reiger 1991

# Medically Unexplained Symptoms

## ➤ Treatment?

- Without treatment, only **30%** of MUS reported diminished complaints at 15 year observational follow-up

Coryell & Norton 1981

- No recognized medical treatment approach in the literature

- CBT treatment supported as effective in decreasing health complaints, healthcare utilization, mood disturbances and increased function



Kroenke 2007, Nezu et al. 2001; Escobar et al. 2007; Allen and Woolfolk 2010

# World-Wide Effect

World-wide 17 nation survey of 85,088 community adults investigating prevalence of depression, anxiety and substance use in patients reporting pain at one versus multiple sites.

Gureje et al. 2008

- ▶ Compared to those with no pain:
  - ▶ Patients with **Single** Site Pain: **1.8** odds ratio for depression; **1.9** odds ratio for anxiety disorder
  - ▶ Patients with **Multi-Site** Pain: **3.7** odds ratio for depressive disorder; **3.6** odds ratio for anxiety disorder
- ▶ No differences across genders or cultures

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- In light of the past 30 years of published data, psychological services are now commonly “mandated” as a component of pain assessment and treatment (multiple insurances, Worker’s Comp, Medicaid, mandated by one insurance for “three sessions of CBT prior to patient being authorized for any surgical procedure.





# Long-Standing Issues in Psychology Reimbursement for Clinical Service

- ▶ Many pain providers, working in multiple environments including hospital-based, community facility/programs, group practices, and private individual practices seek to hire psychologists to provide care to their patients
- ▶ Despite proposed “value” of services by many professions, MINIMAL change in reimbursement for psychology services over past 20 years
- ▶ Several potential means of assessing psychology productivity – each with their own associated professional and financial challenges



# Pain Fellowship Standards 2023


- ▶ Averages for three top Academic Based Pain Psychology Fellowship announcements for 2023
- ▶ Salary: \$68,500 PLUS education monies, conference monies, medical insurance, housing stipends, and moving stipends (average \$8000) plus medical insurance. Roughly one month of vacation/education/sick/holiday leave
- ▶ Cost averages \$6900/mo plus med insurance over 11 months
- ▶ Most all fellowships offer 30-50% research time....

# Pain Fellowship Standards 2023

- ▶ POTENTIAL **BENEFIT**: Often viewed as an inexpensive way to obtain clinical coverage for poorly reimbursing payor mixes which offsets licensed provider time to provide care to reimbursing patients
- ▶ POTENTIAL DISADVANTAGE: Requires a considerable time commitment from licensed (and qualified) professional to provide training, supervision and academic opportunities for the trainee fellow
- ▶ CLEAR DISADVANTAGES: 1) **Fellow is NOT licensed and cannot BILL or COLLECT** for clinical activities; 2) **Licensed psychologist cannot bill for fellow activity on their license (e.g., "subsequent to...")**; 3) Likely to increase referrals to your program to provide care to patients with little/no reimbursement
- ▶ A new licensed provider will cost substantially more than a Fellow to hire. **For the purpose of this lecture/examples, lets assume you got a great deal for \$100,000 salary PLUS 30% benefits and overhead - or your new provider for \$130,000 per year. Assuming one month vacation, one month sick/holiday leave – about 10 months billing time....or 1000 billed hours per year to collect salary/benefits/profit (\$130 per hour average collection to break even).**



# Means of Establishing and Assessing Psychology Clinical Productivity

- ▶ Hours of Clinical Contact Per Week
  - ▶ RVU (relative value units) per week/month/year
  - ▶ Clinical Collection
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# Clinical Contact Hours

- ▶ Perhaps the easiest metric to estimate/establish based upon clinical volume, but...
  - ▶ Different hours of service x CPT codes billed x differing reimbursement rates might yield **highly variable collection potential**
  - ▶ Does not account for additional **unreimbursed time** including no show/cancellation, schedule/re-scheduling, **report writing**, formal/informal meetings, calls/emails
  - ▶ Most common current metric in practice? **5 hrs per day face-to-face with 2.5 hours for records and non-direct clinical duties (~25 contact hours per week)**



# RVU: Relative Value Units

- ▶ A means of evaluating provider “productivity” on a common metric
- ▶ RELATIVE VALUE UNITS (RVU) established by Medicare and AMA to determine the amount to pay doctors based upon productivity. A means of defining the volume of work doctors perform when treating patients for all procedures and services covered under the Physician Fee Schedule.
- ▶ RVU's consider the **time, skill and training** required to provide a given service, but does not consider administrative time (record review, EMR charting, non face-to-face patient time). **Often estimated that providers spend TWO hours of non face-to-face time for every hour with a patient.**
- ▶ RVU measurement of productivity may be GREAT for those providers performing procedures or surgeries and TERRIBLE for those providing standard follow-up visits and non-invasive services
- ▶ A commonly used measure in medical facilities/hospitals as they VERY infrequently understand mental health billing/coding/collections, many disciplines do not bill independently and collect NOTHING, and facility may want ONE “simple” measure of evaluating all providers with variable degrees/backgrounds/skills



# Average RVU Standards for Evaluating Psychologist Productivity

- ▶ Sullivan Cotter RVU 12-month benchmarks for productivity
- ▶ Annual Psychology RVU Benchmarks –
  - ▶ 20<sup>th</sup> percentile 1523
  - ▶ 80<sup>th</sup> percentile 2503
  - ▶ **2400 is a common standard for psychology**
- ▶ At an average of 44 clinical weeks/year = **54.5 per week**
- ▶ **Shouldn't be that tough, right?**
- ▶ Oddly, RVU requirements for neuropsychologists are ~20% higher since they are widely accepted as being “more medical” than other psychologists and are commonly accepted upon medical panels as “acceptable providers”

# 2022 RVU Standards for Psychologists by CPT Billing Code

CPT Code	Description	RVU
90791	Psych Diagnostic Evaluation	3.84
90837	PSY Tx 60 minutes	3.31
90834	PSY Tx 45 minutes	2.24
90832	PSY Tx 30 minutes	1.70
90853	Group Therapy	0.59

# 2022 RVU Standards for Psychologists by CPT Billing Code

CPT Code	Description	RVU
96136	PSY Testing first 30 min	0.55
96137	PSY Testing (each add'l 30 min)	0.46
96130	PSY Test: Integration/Treatment First 60 min	2.56
96131	PSY Test: Integration/Treatment Each add'l 60 min	1.96
96132	NEUROPSY Test: Integ/Treat	2.56
96133	NEUROPSY Test: Integ/Treat Each add'l 60 min	1.96

# 2022 RVU Standards for Psychologists by CPT Billing Code

CPT Code	Description	RVU
96156	H&B Assessment/Re-Ass't	2.10
96158	H&B Treatment (first 30 min)	1.45
96159	H&B Treatment Each Add'l 15 minutes	0.50
96164	H&B Group (first 30 min)	0.21
96165	H&B Group (each add'l 30 mn)	0.10

# RVU for common medical procedures

## Medicine RVU For Injection Visits (2015)

20605, 20610: Joint injections – 1.68 - 2.23

64479, 64483: Epidural - single level – 7.02 - 7.73

Each Add'l level – 2.83 -2.9 (10 -11 RVU average)

64491, 64493: Facet – single level - 5.11-5.72

Each additional level – 2.6-2.9 (8-9 RVU average)

Can often do many procedures/levels per patient visit

# RVU for common medical procedures

## Medicine RVU For **Surgical Procedure** Visits

29873, 29889: Knee **arthroscopy** – 6.24-17.11

22800: Spinal **fusion** – 40-70

22856, 22857: **Disc replacement** surgery – 47.48

63610: Spinal cord **stimulation** – 25.0 base

*Implant electrodes – 12-25*

*Implant spinal pulse generator (battery) – 11.4*



# RVU for Corrective Medical Procedures

Is there a **complication “penalty”**?

Spinal **fusion**

hardware removal – 20.4 RVU

hardware re-insertion – 37

**Disc replacement** revision – 54.59 (47.48 for initial procedure)

Spinal cord **stimulation removal** - 21

revise electrodes – 22 (12-25 initial implantation)

revise / remove battery – 10.3 (11.4 implantation)

# Simple...Average full time “productivity” schedule using RVU’s – 54.5 per week

- ▶ Billing **Mental Health** CPT's: would require:
  - ▶ Mon – Thurs: one new patient (6), four treatment patients per day (16) Friday: one testing patient: five hours (27 hrs FTF)
    - ▶ 96136 (1), 96137 (3), 96130 (1), 96131 (2)
    - ▶ Total RVU's: **55.11**
  - ▶ In all clinical endeavors, must consider no-shows, cancellations/reschedules, schedule conflict with other providers (inpatient) – commonly ~ **25%** of scheduled patients
  - ▶ If this provider faced 25% clinical interruption to this schedule (41.33 RVU) – would have to **significantly** increase the number of scheduled patients
  - ▶ No reimbursement for record review, report preparation, calls/emails, record copy

# Simple...Average full time “productivity” schedule using RVU’s – 54.5 per week

- ▶ Billing **Health & Behavior** CPT's: would require:
  - ▶ Mon – Thurs: 1.5 new patients (9), 3.5 treatment patients per day (14) Friday: one testing patient: five hours (28 hours FTF)
    - ▶ 96136 (1), 96137 (3), 96130 (1), 96131 (2)
    - ▶ Total RVU's: **55.31**
  - ▶ In all clinical endeavors, must consider no-shows, cancellations/reschedules, schedule conflict with other providers (inpatient) – commonly ~ **25%** of scheduled patients
  - ▶ If this provider faced 25% clinical interruption to this schedule (41.48 RVU) – would have to **significantly** increase the number of scheduled patients
  - ▶ No reimbursement for any activity/time aside from “face-to-face” time

# The Bizarre World of Clinical Reimbursement for Mental Health Care

- ▶ Medicare/Medicaid reimbursement often establishes the “standard” for mental health reimbursement
- ▶ Minimal increase in reimbursement over past several years
- ▶ Medicaid “mandates” pre-surgical psychological evaluations but does not reimburse them
- ▶ Insurance C “mandates” three visits of pre-operative behavioral care before they will authorize surgery, but with minimal reimbursement
- ▶ All commercial and several prominent WKCP insurances DO NOT reimburse for late cancellation/no show appointments (at least 20% of scheduled patients)
- ▶ H&B codes reimburse only for “face-to-face time” with patient
- ▶ New testing codes in 2021 (added multiple codes for each service) but reduced reimbursement for each incremental code vastly lowering reimbursement
- ▶ Typically multiple reductions in actual collections for overhead, owner/proprietor “taxes,” payments to billing/collection companies

# 2022 Various Reimbursement Averages for Mental Health CPT Codes

CPT Code	Medicare	Medicaid	INSUR U	INSUR B	INSUR C
90791 EVAL	180	154	128	109	114
90837 – 60"	152	130	124	96	99
90834 – 45"	103	90	83	82	72
90832 – 30"	102	89	78	84	91

# 2022 Various Reimbursement Averages for Health and Behavior CPT Codes

CPT Code	Medicare	Medicaid	INSUR U	INSUR B	INSUR C
96156 EVAL	98	0	94	173	79
96158 30" TX	67	0	64	46	54
96159 15" TX	23	0	22	19	19



# 2022 Various Reimbursement Averages for CPT Testing Codes

CPT Code	Medicare	Medicaid	INSUR U	INSUR B	INSUR C
96136 test 30"	46	64	45	53	46
96137 addl 30	41	46	41	49	42
96130 report	122	124	111	83	118
96131 report	91	98	84	83	90
96132 Neuro	Same as	96130 and 96131			
96133 Neuro					

# Clinical Schedule for Collecting Our \$130K for Psychologist

- ▶ Billing **Mental Health** CPT's: would grossly require:
  - ▶ Mon – Thurs: **one** new patient per day (6), **five** treatment patients per day (20) Friday: **two** testing patients: five hours each with component codes (10) - (~ 30 hrs FTF)
    - ▶ 96136 (1), 96137 (3), 96130 (1), 96131 (2)
    - ▶ Total Gross Collections: \$3350
  - ▶ **Accepting 2.5 hrs day non-clinical administrative time – adds 12.5 hrs/wk**
  - ▶ In all clinical endeavors, must consider no-shows, cancellations/reschedules, schedule conflict with other providers (inpatient) – commonly ~ **25%** of scheduled patients
  - ▶ If this provider faced 25% clinical interruption to this schedule (22.5 hrs FTF) – would **have to significantly increase the number of scheduled patients**
  - ▶ No reimbursement for record review, report preparation, calls/emails, record copy
  - ▶ Will inevitable have to **collect more to pay for owner profits and collection fees**

# Clinical Schedule for Collecting Our \$130K for Psychologist

- ▶ Billing **Health and Behavior** CPT's: would grossly require:
  - ▶ Mon – Thurs: **1.25** new patient per day(7.5), **five** treatment patients per day (20) Friday: **two** testing patients: five hours each with component codes (10) - (~ 32 hrs FTF)
    - ▶ 96136 (1), 96137 (3), 96130 (1), 96131 (2)
    - ▶ Total Gross Collections: \$3290
  - ▶ No reimbursement for any activity/time aside from “face-to-face” time
  - ▶ In all clinical endeavors, must consider no-shows, cancellations/reschedules, schedule conflict with other providers (inpatient) – commonly ~ **25%** of scheduled patients
  - ▶ **If this provider faced 25% clinical interruption to this schedule (24 hrs FTF) – would have to significantly increase the number of scheduled patients**
  - ▶ No reimbursement for record review, report preparation, calls/emails, record copy
  - ▶ Will inevitable have to **collect more to pay for owner profits and collection fees**



# Clinical Care Transition From Hospital to Community/Private Practice

- ▶ Hospital/University Affiliation Clinical Contract Agreements
  - ▶ Insurances/Codes/Reimbursement Amounts negotiated by facility and include you within their contract
  - ▶ Typically multiple insurances including Medicare, Medicaid, perhaps Tricare
  - ▶ Due to volume negotiations, contract rates generally positive
  - ▶ Overall reimbursement to charges rates commonly quite low (38%)
  - ▶ As a clinician, it is typically increasingly difficult for you to bill/collect your salary + benefits + overhead due to low reimbursement and rising salary (1.5 X salary)
  - ▶ Facility clinicians very commonly driven out as years of experience increases
  - ▶ Many facilities use an RVU-based system to determine full time productivity
    - ▶ Many pitfalls including schedules, no-show, cancellations and any non-clinical duties

# Clinical Care Transition From Hospital to Community/Private Practice

- ▶ RECOMMENDATIONS FOR ANY ACADEMIC CLINICIAN TRANSITIONING
  - ▶ Request Monthly/Quarterly Meetings with Billing/Collection Specialist to Review What Insurances You're Covered On Under University
  - ▶ Review Your Personal Monthly Billing/Collection/Deduction Patterns
    - ▶ Who is taking what percentage of your collections? Where are your denials?
  - ▶ Create A CLINICAL CHART For Your Services
    - ▶ Insurances You Routinely Bill – Include Medicare, Medicaid, Tricare
    - ▶ Most Common Codes You Bill (Mental health CPT's, Testing/Health & Behavior Codes)
    - ▶ Who Reimburses What for Which Codes?
      - ▶ Often HUGE differences in reimbursement related to THEIR criteria – Not Yours
    - ▶ Maximize Billing Efficiency and UPDATE in Six Month Increments





# Community/Private Clinical Practice and Insurance Challenges

- ▶ No longer included on anyone's "panel" and must re-apply to insurers as a "new" or "independent" provider
- ▶ Upon initial contact, insurance "gate-keepers" often say that their panels are full and "not taking new providers"
  - ▶ Must have an individual person contact name/number to initially contact
  - ▶ Can get these by contacting any physician group or facility and asking for their insurance "go to person" for issues. This usually gets you started on the "inside"
  - ▶ Contact any private provider you know and ask them to consult/advise with the easiest steps to go through to get contracted
- ▶ Once you know what you were being reimbursed at your prior facility, you can then request rates and negotiate same or higher for care
- ▶ You may not wish to contract with certain insurers as they typically reimburse less per hour than it costs to keep your practice open





# Summary

- Significant challenges to reimbursement for psychological services have substantially limited the availability of well-trained providers to assist in the management of complex pain problems
- In turn, many facilities and practices choose less expensive (and less trained) providers to provide “mental health” services to their patients. This forces them to accept/market their chosen provider as an “expert” in the management of pain
- Many providers who refer to the community find limited resources to see their insured patients. Failure to obtain quality pre-surgical assessments or specialized pain psychology services may either limit their ability to obtain authorization for procedures, or the overall outcome of their pain care
- Many psychologists limit their practices to only worker’s compensation, medico-legal assessments or cash patients to maximize their incomes
- Psychology reimbursement **MUST** improve to improve the number/quality of available providers and Psychology as a field will require the active advocacy of Physician organizations to expedite improved reimbursement for services