

Title: Billing Breakthroughs: Strategies for Recession-Proof Practices

Date & Time: February 23, 1pm ET

Moderator 1: Hello and welcome to today's webinar, Billing Breakthroughs, Strategies for Recession-Proof Practices. This webinar is paid for by Owl Practice, Reimbursify Practice Solutions, Psyquel, and Zencare. Some important points before we get started. Dr. Vatsal Thakkar, one of our panelists, is the founder of Reimbursify, a strategic partner with Owl Practice. As such, Dr. Thakkar has both a financial and intellectual interest in the webinar content.

The purpose of this presentation is to provide a balanced view of billing strategies for recession-proof practices. APA does not endorse any products or services. The content was created by Owl Practice and does not reflect the views of APA or its editorial staff. Email advertising at apa.org to learn more. Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes.

Moderator 2: I'm sorry, everyone. Our moderator's audio went out. A recording of this presentation will be emailed to everyone in about two weeks' time, and that email will also include a copy of the presentation slide. If you have a question, you are on mute, and we ask that you communicate with us using the Q&A box in the webinar screen. Please submit your questions for our speakers using that Q&A box. A copy of the presentation slides will be posted in the chat box on your screen. With that, we'd like to turn it over to today's moderator, Megan, who will then let the panelists introduce themselves. Thanks, everyone, and welcome.

Megan Gunnell: Thanks so much for that. I am so excited to be moderating this discussion today. We're going to be having a wonderful panel discussion on billing strategies and how to recession-proof your private practice. We have over 800 mental health professionals who have registered to join us today from across the country to learn more about this important topic.

My name is Megan Gunnell, and I'm the founder and director of the Thriving Well Institute, where we provide coaching courses, retreats, and summits to help therapists learn how to build and scale their business. The chat is open in the Q&A box, and we encourage you to share any questions that you would like to ask of our panel of experts, and we'll get to those questions at the end of our discussion. For now, I'd like to turn over our introductions of each of our expert panelists. I'll have Kym Tolson go first.

Kym Tolson: Hi, I'm Kym Tolson. I'm known as the traveling therapist. I'm a therapist that lives in Airbnbs and travels the world. I'm passionate about redefining the way therapists work in their private practices by using travel and innovation as inspirations. I founded Bill Like a Boss to empower insurance-based therapists. I also created the Clinical AI Club, where I help therapists integrate AI into their practices.

Megan: Glad to have you with us, Kym.

Kym: Thank you.

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Megan: Now we're going to go to Dr. Thakkar.

Vitsal Thakkar: Hi, thank you so much, Megan. It's a pleasure to be here. My name is Vatsal Thakkar. I'm a psychiatrist. I used to run a thriving private practice. Because I ended up hating admin work so much and hated the fact that people seeking mental health care don't get proper reimbursements, I launched a software tech company called Reimbursify, which automates the out-of-network claims and benefits checks process. Excited to be here and discuss all things billing-related.

Megan: Glad to have you. Next, we'll go to Paula Kana'an. Good afternoon.

Paula Kana'an: Good afternoon. I am Paula Kana'an, owner and operator of Kanaan Therapy and Behavioral Health Services. Thank you for having me this afternoon. It's really great to be a part of this discussion. It's imperative for any clinical office that is hoping to get the most out of their billing.

Megan: Glad that you could join us. Last but not least, Derek Lee.

Derek Lee: Thanks, Megan. My name is Derek Lee. I'm a therapist and a professor for Texas Tech, and that's a little bit misleading as I've got a large private practice in Northwest Ohio. I'm also the CEO of the Hope Institute, and we have offices in several states.

Megan: We're so glad that you could join us today. We're going to dive in because we have a lot to cover. Here's my first question to our expert of panelist. In navigating the changing landscape of the mental health billing, particularly amidst economic uncertainties, how can therapists boost their practice with Medicare and insurance clients? What insights can you share about how accepting insurance helps expand clientele diversity and how it helps impact financial resilience for therapists in private practice? We'll start with Kym.

Kym: Taking insurance in your practice actually gives you access to a larger client base. Our clients have insurance and they want to use it. They're searching for providers that take their insurance. Clients tend to come longer to therapy if they can use their insurance, they can make more progress over time and it's more affordable for them. Reimbursement rates might be lower for insurance-based clinicians, but the consistency of referrals can lead to a more predictable income stream for therapists.

Then lastly, to diversify, taking insurances like Medicare, TRICARE, it really opens you up to more diverse populations like the aging, the disabled, service members, and their families. You can really expand your reach that way too.

Megan: You make some great points. Thanks so much for that, Kym. Dr. Thakkar, what do you think about this question?

Dr. Thakkar: It's a great one. In this day and age, all practitioners have to be proficient with insurance, even if they don't accept it, which is most of the people I talk to. At the end of the day, this question came up with a colleague of mine, which is why would someone go out of network versus stay in network? The bottom line is people are more likely to do that which is easy or cheaper. If they can get the same

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service for lower costs in network, they're going to do that. If they have to go out of network, they might do that.

As someone who handles billing issues all the time as a clinician, which is a weird hat to wear, I never thought I would specialize in billing if you asked me 10 years ago. There's just a lot of confusion and complication. For example, my son had to have orthopedic surgery a few months ago, and I got a clear explanation of what was covered, who did what procedures or provided what services, what my cost contribution was, regardless of whether I was happy with that or not, but it was very transparent. I know that a hospital has tons of billing staff to make sure everything is properly done and documented and transparent.

I think, in this day and age, since people are cost-conscious, it's a service level that people want in having the most cost-effective care, whether you're in or out of network. There's things that practitioners can know about and learn and be savvy about to make sure either they're getting proper reimbursement as in-network or their clients are getting proper reimbursement as out-of-network services. I think the days of cash practitioners, especially saying, it's your problem to the client, those days are over. I think everyone needs to provide that service and have that knowledge.

Megan: You bring up a great point about that. I think that sometimes we think if we have a cash fee practice, we can turn the other way, but it is great to be informed. Paula, tell us what you think about this first question.

Paula: Thank you. I know a lot of practices in my area that really only accept a minimal high-reimbursing insurance clientele. I personally think that this is an ethical issue that we all need to consider and look at. We went into this line of practice to help support other people in one way to keep a robust skill set and reaching the most number of people is to take on multiple different types of insurance for reimbursement. I agree with what Doctor said, gone are the days where you just be worried well with cash payments only.

I do think that if you want a full caseload, then getting in the game with insurance is critical. If you want to keep high skills, then you need to have a broad spectrum of people you're serving.

Megan: Very true. It's a win-win so that everyone has better access to care and our caseloads are also full. It's helping both the therapist and the client in that arena. Derek, what would you think about this first question here? I'm very curious to hear your thoughts.

Derek: I couldn't agree with Paula more. I'm completely aligned with that. I think the other piece is that when you work with private pay clients only, you're typically either working with a very small population that can afford to pay for medical services out of pocket, or you're working with individuals who really need that service but can't get them in network. The issue with those clients is that it is creating a financial strain, but they're also going to discontinue services at the earliest possible convenience. By adding insurance clients, whether it's commercial, Medicaid, or Medicare, it creates accessibility to nearly 90% of the population that really couldn't sustain cash pay rates for an ongoing period of time. Insurance should allow for a treatment

model to be completed and outcomes achieved, while a low bank account for a lot of people might not.

The insurance allows you as a clinician to actually create a portfolio that's not only sustainable but grows within those networks. Rather than setting a cash rate and a sliding scale, you begin to work on averages among the rates of those payers. I will say in our practice, we still do have a number of cash-pay people, and again, I think that speaks to the level of services, but we also want to make sure that those services are available to everyone.

Megan: You make a great point there. I think everybody's in agreement on that first question. Let's take a look at this next question here. The concept of value-based billing can really be transformative, though it does feel daunting at times. What do providers really need to know right now about insurance requirements and the ever-changing world of value-based billing? Kym, you're such a billing expert, I thought I'd start with you again.

Kym: There's things you can do right now to be on track with this. It's going to be evolving, we have to pay attention to it, but really using tools like the PHQ-9, the MDQ, little brief assessments like that, you can do them every quarter, or you can do them every session if you want to be able to demonstrate progress in your treatment with your clients, for the insurance companies. Then always, most of us are already doing this, focus on setting trackable specific goals, measurable objectives with your treatment plans, and make sure you're documenting that and really showing the progress over time through the goals and everything that you're working with the client on, including the measures that you're incorporating.

Megan: It does sound very daunting, but there are tools and resources that can certainly make this easier for clinicians. I think we do have to pay attention because value-based billing is really becoming a new norm. Dr. Thakkar, what would you say about this question?

Dr. Thakkar: I think anytime someone is paying for something and healthcare is a very complicated pay or system, results are expected. Everyone involved wants the client, the patient to get better. There can be and should be incentives to make sure that people are made to get better at the most cost-effective or in the most appropriate way with cost-effective care.

I mentioned my son's surgery, the difference between mental health and something like orthopedic recovery is it's easy to measure orthopedic recovery. Is his muscle strength back? Is his flexibility back? Is his restriction from activities now diminishing? It's easy to say, well, he doesn't need three times a week PT. He can go down to once a week and then after this month, maybe stop. It gets a little trickier with mental health care because there's less universal objective measurements, although the PHQ-9 and the GAD-7 and other scales are a great tool.

I think the challenge becomes what if value-based care results in making treatment choices more protocolized, for lack of a better word. For example, maybe value-based care system might say, everyone should get cognitive behavioral therapy first regardless of what diagnosis they're coming in with or what past psychological

history they're coming in with because we all know that though OCBT is great, it's not for everybody and there might be a more or different treatment plan for certain people. We as practitioners should not get penalized for that. One of the problems-- I know in certain hospital systems, because they want to have great ratings and great outcomes, they don't take the most difficult cases. That would be a tragedy if that happened in mental health care.

Megan: Something else that comes up often in this topic area is the fear of clawbacks. I don't know if you have some tips on that or things that maybe practitioners should be aware of when it comes to a clawback issue.

Dr. Thakkar: Clawbacks, for anyone who's not familiar with it, is when an insurance company can actually reassess what reimbursement was paid usually just to the practitioner. This can happen in or out of network, although it happens more commonly in network. I've known people that were affected by this. It all goes back to transparency and what care was delivered and for what cost. We as practitioners have to document the care that was delivered.

I know in mental health care, sometimes there can be appropriate sensitivity in not documenting exactly what happened, meaning word for word. For example, if a patient tells me that their spouse is leaving them, in the note, I might just write having severe marital difficulties. I might sanitize that for the record while maintaining some level of privacy. I think with proper documentation, our treatment, whatever it is, should be justifiable. Sometimes it might require calling up the insurance company. The person I'm thinking of that I know that was affected actually hired a lawyer and was able to fight the clawback to a great extent. Yes, it's uncomfortable for everybody, but unfortunately it happens.

Megan: Sometimes, yes, something we have to be aware of and figure out the path forward when that thing comes across our business provider model. For sure. Paula, I'm just really interested in what you have to say about value-based billing. What do you think?

Paula: I do believe that value-based billing is here to stay. I also think that it can be a good way to separate some-- I don't know quite how to say this. When you are shopping for a therapist, finding a therapist that aligns with-- has the skillset that you're looking for for your particular issue. Sometimes that is-- The onus of responsibility is really on the therapist to explain, this is what I specialize in. Here's my approach. If it's not the right fit, then do the ethical thing and refer them on to somebody who is a better fit.

I do think that value-based billing can be helpful in that it really encourages clinicians to continue to grow and learn and expand their skillset, and make sure that they're using evidence-based practices. That's what insurance companies are looking for, are these evidence-based practices? Are they being applied appropriately and is the client making progress towards ending that plan of treatment?

Megan: Those are really great things we have to keep in mind for sure. I like your perspective. It really takes a broad view look at macro and micro concepts here. Derek, I'd love to hear what you have to think about this question.

Derek: Thanks. I think one of the things we have to remember is that we're still on the precipice of value-based billing. I know in my position as the chair for the Insurance Advocacy Committee in Ohio, in talking with insurance companies, they're still trying to figure it out too. I think that's important to remember. In the meantime, it is gaining traction, and I think there are some great benefits for the field of mental health. Measures have always been a cornerstone of our profession, and this really comes down to doing the right thing and setting an expectation and expecting payers to follow suit. We will do the work appropriately. We can provide measures and we expect to get paid for it.

Even if it takes a little bit longer than it should, the concept really, I think, aligns with a lot of our treatment goals. It can result in better care, and I think it will continue to legitimize mental health in the medical field. As Dr. Thakkar was talking about, in a lot of areas of medicine, there are concrete measures, there are tests. We can do blood tests, we can look at X-rays, look at bones. That's very difficult mental health. A lot of my work is suicide-specific. Those measures really are critical. Being able to show the progress we've made and what we've done, and they are possible. I really think it's a promising area in our field if it's managed well.

Megan: That's really another great perspective. I love hearing from all of you on these topics.

Dr. Thakkar: If I could jump in real quick. Derek, you said something very interesting, which was the payers are still trying to figure this out. That's important for us to keep in mind because that means they will be open to feedback as they figure it out. We should make ourselves vocal about this.

Derek: Absolutely, and actually it was a Medicaid payer that I had a conversation with this week. They said to me, "We like the idea, but we want to make sure that this works for everybody long-term." It is something that-- I love the fact that you highlight that because it is, it's ongoing.

Megan: Very true. Now we're going to move to how we save time because every therapist I know wants to save time. Efficiency is crucial for maximizing billable hours and consequently, financial stability. What collective strategies, tools, or technological solutions would you recommend to help streamline administrative tasks, reduce paperwork, and create more time for client care, which ultimately fortifies practices against economic uncertainties? Kym, what do you think about this? I know you have a lot of great tools up your sleeve.

Kym: Yes. I always recommend that therapists use an EHR like Owl. It's just a no-brainer to use an EHR. It can automate your billing, your scheduling, you can keep track of these qualitative measures that we're talking about, you can keep your treatment plans there. There's portals for your clients to sign paperwork, to send paperwork to them, intake paperwork, all of that. Then I really recommend taking a look at things you don't want to deal with like SEO, social media, that sort of thing, and farming that out to somebody. Finding somebody that is an expert in it that can do it for you.

Then starting to incorporate AI into your practice. I use AI for just about everything in my private practice, and it's just made everything more efficient for me.

Megan: I love that. Definitely savvy entrepreneurs know when to outsource because we can't really do it all, and it's hard to manage all the aspects of running a business. Dr. Thakkar, what do you have to say about this?

Dr. Thakkar: I have to confess, I've been at the forefront in my cohort of adopting technology. In fact, in my residency program, I once complained about having to do paperwork in triplicate or something, and I duly got assigned to the paperwork reduction committee. They gave me more work, but in the effort of reducing work. From the early days of my private practice in New York City, this was in the days where there was, I think, only one web-based EHR available, and that's what I needed because it was a small practice to start, and I was also in multiple offices between an academic med center and my private office. I needed access no matter where I was.

That just started me down that path of like, okay, I need a fax machine, but I don't want to have a fax machine. I got one of the first e-fax numbers, and I just assembled all these different services. It was probably five or six different ones all cobbled together, and it made me both appear and actually function at a higher level than what my small, at first, part-time private practice was. It had a return on investment. It made me more efficient, it made me actually be able to do that in the way I wanted to.

Now, of course, we have a lot of great services that are all bundled together, usually within the EHR. That actually extends to me launching Reimbursify because that was-- I saw this analog process that was basically, clients were forced to fill out mail-paper forms to get reimbursed, and I thought that needed to be brought into the digital age. At the end of the day, I know that sometimes practitioners of all kinds can be a little resistant to technologies, but you have to ask yourself that if it's in the market and people are using it, then someone's finding a return on investment with it, whether it's a time return in sparing time, or whether it's actually helping in terms of monetary return on investment.

That behooves us to explore what might be possible to include or add to our practice in terms of tech that can actually help us practice better, faster, and more, at the end of the day, more happily.

Megan: For sure. Gosh, when I think back to the beginning of my own private practice, I had my Palm Pilot and my paper notes, and I was mailing in our insurance claims. Now it's just such a different world, and it's so much more efficient. It just seems like I was doing a lot of things in triplicate, too, so I can relate to that. Paula, what are your best tools and tips for this question?

Paula: I want to piggyback on what Kym had to say. Really using an electronic health record is imperative. I cannot imagine doing the work any other way. It just wouldn't make sense. You can use encrypted messaging right in your platform to send information to doctors, hospitals, psychiatric facilities. It is just a necessary tool, for sure.

Other pieces that I want to lean into a little bit refers back to your clawback question. In this answer, I want to say to people, please make sure that you understand and know what each insurance company is expecting from you with your notes. Your electronic health records can help you keep track in a more consistent fashion about what that looks like. In all insurance companies, either on their website or in their manuals, there's information about that. Look at that, read that, familiarize yourself with that material.

Megan: I think that's something we tend to overlook because people are just moving so quickly that you just go from one note to the next. It's good to review what those requirements are. It's our responsibility to do so. Derek, I'd love to hear how you could make things more efficient for us.

Derek: This is a hard one to follow up because the other three panelists have given such great answers. One of the things I will say goes back to something people have talked about for years, yet our profession tends to drag its feet on, which is concurrent documentation. I was actually just at a hospital system in Georgia this week, and people were talking about the difficulties in doing that. I'm specifically talking about with DBT clients. I actually think it's not only good for our time savings, but it's actually good care because as you recap it, you're catching things that they misunderstood or that they took differently.

We think about concurrent notes as this work we have to do at the end of the session, but really it can act as a recap that we should be doing anyway to make sure that we're on the same page with our clients. The other thing I would say that I haven't heard mentioned is sometimes insurance companies will create excessive requests for us and want us to do things outside of session. I think we should be doing those in session. I think, number one, it helps us to get paid for it, but two, our clients know that we're not reimbursed like other medical professionals. When they see the things that we're having to do, that can actually increase advocacy.

We've had several families in our practice that lately have actually changed insurance companies. They had an option and they saw the extra work we were having to do with one of the large insurance companies and they said, "That's ridiculous. We have options for these two. Does one of them work better?" The clinician was like, "Either."

Megan: Wow.

Derek: Again, it's also about helping our clients be literate in what's happening in the process and being advocates as well because it does affect them, their families, and we're all in this together.

Megan: Very true. I like that perspective of engaging the client in a more proactive role with all of this. Let's take a look now at our last question that I have for the panelists, and then we'll jump into the chat. It looks like we're getting a lot of questions from the audience. Let's talk about the challenges of balancing client needs with insurance requirements. How can therapists strike a balance between meeting the needs of our clients while also adhering to the requirements imposed by insurance companies? What do therapists need to be aware of when it comes to

insurance companies' expectations of progress notes, treatment plans, and goal-directed care? We'll start with Kym again.

Kym: Mainly just realizing that there are specific documentation guidelines that the insurance companies have. It's different for different insurance companies, but mostly if you reach out, if you look through the handbook, if you ask your provider relations person, they've got standards that you can follow. I recommend everybody get that handbook when you first get credentialed and look through it and make sure that your documentation is matching what they're looking for.

Talking about clawbacks earlier, that's a way to avoid those. If you're following those documentation standards, mostly if they do an audit and everything looks good, they're not going to do a clawback. That's one way to really avoid those. Then just obviously making sure you're sticking to the detailed treatment goals and specific progress notes and tying it all in together, that golden thread that you hear people talk about with your documentation. I always have a conversation with my client about what medical necessity is and what I'm going to have to report to the insurance company, so we're all on the same page that I have to give you a diagnosis, and here's why. I'm going to be documenting your progress and the insurance company at any time might be able to access your records, but we're going to work together as a team to make sure this gets paid and you get the best possible care for what you're going through.

Megan: That's a really good point. It's so important that we consider all of these things because it's just overwhelming at times for the therapist to manage all these moving parts. Dr. Thakkar, what do you say about this question?

Dr. Thakkar: It's a real challenge, and struggle for everyone out there in practice. I think sometimes it factors into the decision for some to maybe not accept insurance initially because then it cuts down on the burden, but like I said earlier, chart requests are not unheard of out of network either. I think, again, back to technology, really can leverage a lot of this.

Kym, I totally agree with what you said about giving people a diagnosis, explaining what it is. That can be-- As a psychiatrist, I often had to do that routinely more so because certain meds won't get approved if I have to put someone on medication without a diagnosis to support it. It does open up discussion, but once that's there in the documentation, I think making sure all the ducks are in a row with why you're doing what you're doing, it actually makes you a better practitioner and helps you think through cases in a more systematic way.

I think that's the goal of the insurance requirements in the first place, is partly to make sure that we're being thoughtful about the treatment we're providing. Also, again, back to the healthcare system is a lot of dollars flying around and they want to know what is being done and that people are getting better with those dollars. I remember years ago, a colleague of mine said that for privacy reasons, he doesn't take any notes. Probably aside from they showed up today.

That shocked me because aside from the insurance question, the note is a legal document and it behooves us as practitioners to make that note as accurate and

sound as we can, and it can serve both roles at the same time. In training, they taught us your notes should be sufficient so that you could never see that person again and someone else can take over the care exactly where you left off. That stuck in my head. Again, not to say that you can or should document every little private detail of what people tell us in sessions, but summarizing and sanitizing in a way to make it accurate for insurance and legal purposes, but also private enough that it's not too intrusive to the client that we're seeing.

Megan: Very true. Paula, I'm curious what you think about balancing client needs and the insurance company requirements.

Paula: I think this question really brings together everything that's been mentioned so far in our discussion, truly. Making sure that your t's are crossed, your i's are dotted, that you're using smart goals, those specific measurable, achievable, relevant, time-bound goals in your plan of care. Kym mentioned that golden thread. Making sure your assessment aligns with your plan of care, your notes are following your plan of care.

I will say an electronic health record is what really makes it so much easier because you can have your plan of care up, be writing your note and referring back to what you've done, what's already been achieved so far, where you need to go in the future, developing a plan for upcoming sessions, just to make sure that everything aligns well and that you're covering all of your bases. Which means if you're doing that, you're meeting the client's needs in a helpful, professional way, an ethical way, and you're satisfying the requirements of insurance because there's proof of what you've been doing. There's that, as Kym mentioned, that golden thread that ties throughout.

Megan: It's important that I think we're thinking of the whole picture from the beginning, the intake, all the way through to termination. You make a great point about that. Derek, I'd love to hear your thoughts on this final question that I have, and then we're going to hop into the questions from the audience.

Derek: Great. This is why I think it's a great place to really make sure that you're matched up with the right EHR. I'm parroting what Paula was talking about in that-- I know I've been in the field for a while now, and when I learned how to write notes in my master's program initially, they wanted three pages of stuff that just doesn't apply anymore. I know there are still programs out there showing that, so what we need to do is make sure that we've got EHRs that have systems that are aligned with the notes we need.

I would say most EHRs, if you're doing something specific like we do a few very specific things in our facility that the EHR has been willing to add notes for or adjust notes for, I think that's critical, not only to make sure that we're getting good notes, that they're addressing the client's needs, but it's also really important in our time and making sure that we're using our time effectively. I know we do a lot of training with young clinicians, and it keeps them on the rails, too. When I say keeps them on the rails, it gets that good clinical data there, but it's also asking all the questions the insurance companies are going to need.

Again, I work with some supervisors that really worry about, well, this person's putting too much in their note, this one's putting too little. I said, "Well, you've got the framework, though." These are some pieces that are tweaking. Have them stick with a framework and teach them, and I think, again, with a good note through an EHR, it can really streamline that process, especially compared to 10, 15, 20 years ago.

Megan: I have faith that you're helping the next generation because it is really complicated. I didn't have a lot of that training myself in my own graduate studies, so it's great to hear that that's part of what you're bringing to the next generation of therapists. Let's hop in with some of the questions I'm seeing here in the chat. I'm going to start with this one, how do we request or ensure that we're using value-based therapy if we do have appropriate documentation? I think this might be referring to making sure that we're doing it correctly with regards to what the requirements are for insurance companies. Who would like to hop in on that one? Do you have some thoughts on that?

Kym: I'm trying to find the question. Can you say the question-

Megan: In the chat box for us, how do we request, ensure we are using value-based therapy if we do have appropriate documentation? Just making sure, what would be maybe a good resource for making sure that clinicians are following a value-based documentation model? Is there anything that comes to mind? Maybe if we've stumped the panel, we may be able to drop a link to a resource in the email when we send this back out on the replay. Anybody have anything that comes to mind?

Kym: I think I mentioned earlier the PHQ-9 and the MDQ, using those really brief assessment tools. They're super easy. They're just a few questions. A lot of EHRs have a tool where you can just send it out to the client before the session, even. You can get the answers back and you can do a quick look and just say, "Oh, it looks like your anxiety might be a little bit higher, some of your depression symptoms." Then it's something to talk about in the session, but you can also show that you went from that assessment to the treatment plan to the progress note, and you're working on that based on this evidence-based measure that you're using.

Megan: That's great. To use some of those tools, those measurement tools. I think that's what the insurance company is like in terms of watching that progress happening and being able to document that. While I have you-- Oh, go ahead.

Dr. Thakkar: I was just going to add, how I read the question, it almost might require knowing each individual insurance company's requirements. They might have slightly different definitions of value-based care. There might not be one exact answer for each of them.

Derek: Actually, going off that-- Sorry, go ahead, Megan.

Megan: I was just going to say what Paula was saying earlier about that, checking to see that everything's in alignment with what the insurance companies are asking us for.

Derek: I can tell you from my standpoint, this is actually data that I run on a regular basis. I have yet to have an insurance company actually request it from me. I will call meetings with the insurance company where I'm trying to bump up my rates and show them the data. There are a variety of things you can pull, but I think if you can look at quarterly data, if you can look at outcomes, if you can look at some of the measures like the PHQ-9, you can see where those numbers shift. Again, when we talk about value-based, it doesn't necessarily mean that you're closing somebody in 12 weeks, it means you're showing reasonable progress over time. That's something to remember too. It doesn't mean you're closing them and they're not necessarily successful right away. Think about programs like DBT, which can last a couple of years easily. It's about steady progress.

Megan: That's a good reminder. Kym, I wanted to also ask here, there's a question for you about how do you use AI in your practice. I know this is a hot topic. We did a webinar on this recently. Tell us.

Kym: I could go on and on and on, but literally for everything, marketing, emails, blog posts that are going to attract people with SEO on my websites, treatment plans, customized homework assignments. If I have a client that has a certain problem going on, you could just put it in there and say, "My client's struggling with this specifically. I need an evidence-based homework assignment that I can give to them and I can measure their progress, but it can also help them with these specific problems that they have going on." The possibilities are endless really with what you can do.

Megan: Not only in the practice, but also the social media side, right? Maybe even ideas for blogs or ideas for client newsletter, email topics and things like that, social media content and-- Lots of ways to get ideas generated for sure.

Kym: Yes. That's amazing, and it's evolving every day.

Dr. Thakkar: I want to comment about AI because I think that's a technology that we get very sensitive about, rightly and wrongly. Rightly for privacy reasons and maybe wrongly because we don't want to relinquish some of these tasks like treatment planning, maybe, to AI. I think we all have to recognize that there are pitch meetings in Silicon Valley that goes something like this, hey, I have an idea to use AI for therapy without needing a therapist. I'll just say that. I'm not saying that that's where I want the world to go, but there are people and there's money chasing that problem.

I think we have to embrace it and show that we can become better with AI tools and that they still need to be steered by a professional who knows what they're doing. I think some of our maybe hesitance or fear around AI in the treatment process might be a little unfounded.

Megan: You think about where we were even five years ago, people wouldn't want your Apple watch to document your steps. Now that just feels like something that we're used to. As we get more accustomed to using this technology, I think we're going to find that it can be a useful tool when done ethically. Another question we have here is, is value-based reimbursement going to be implemented for

psychological and neuropsych testing? What are the resources available? Does anybody have some ideas there?

Derek: I can tell you my initial reaction is that that's probably not an area that's being heavily looked at because, at least from the insurance standpoint, the idea behind value-based reimbursement is about progress through therapy. One of the potential downfalls of value-based reimbursement is that if there's a client who is expected to close in a year, you may get higher rates in that first year that will reduce over time. Again, there are a lot of things to be worked out, but given the fact that the idea behind it is about outcomes over time, I wouldn't anticipate any quick movement when we're talking about testing.

Megan: Some of these things may be more slow-moving. Have we heard any insurance companies pushing back on the use of AI for treatment plans or notes? That's a really good question. Kym, you probably would know that with the work that you do.

Kym: I really am trying to stay in touch with the licensing boards and ethical boards. There are lots of committees meeting right now to discuss this, I think, and I think that's going to dictate towards the insurance companies what we should and shouldn't be doing with AI. I think it's just so new, there's no standards around it as far as I know. I don't know if anybody else does but--

Megan: Anybody else want to contribute to that one?

Paula: The only thing that I might add is I live in the state of Michigan. I happen to work two different jobs. I'm a supervisor for a mental health clinician team at my other job and was talking with the head of Medicaid about this because I am all about let's see more students and reduce the time spent doing paperwork. The head of Medicare here in our state said so long as when you're using AI, it's accurately recording what happened in session. There are timeframes that are appropriate and accurate in the note and a diagnosis. I was excited to get the green light for both places that I work in, just helping to be more efficient and in a way of time.

Megan: Time-saving is so important to us all. Let's take a look at this one, this is a great question. "I'm interested in how you go about requesting a meeting with the insurance companies to discuss or negotiate rates. This has been something that I and my admin team have struggled to be successful with."

I'll actually hop in on this myself because we wrote a letter to Aetna and described our justification for increasing our rates, and they did it. Sometimes you can submit a letter, but I would be really happy to hear what the other panelists have had success with when it comes to this.

Kym: Most of the insurance companies do have a protocol you can follow. It might be reaching out to provider relations or another credentialing department and just asking what the protocol is. That's the first step. Then submit the proposal, talk about any certifications that you have. Really explain why you are a super great candidate to keep in their network and why you need your rates to be increased. It works with most insurance companies.

Cigna's really good about giving routine raises. Blue Cross Blue Shield isn't that great with it. They tend to just do blanket raises across the state or locality for everybody at the same time. You could try but you're probably not going to be too successful. The other ones, they do have protocols for it.

Dr. Thakkar: Yes. I think it wouldn't hurt to add if rates have not gone up in X amount of time, years, and to document that my rent went up. It's not reminding them that this is a business and almost-- They feel like you have no choice but to accept their plan, but you can make the counterargument that you might not have any choice but to reconsider that network. I think they can respond to things like that.

Megan: In the letter we sent, we did a comparison of averages that other insurances were reimbursing us for the same CPT code just to show there was such a significant difference in their rate of reimbursement. That helped a lot.

Dr. Thakkar: Peer pressure.

Megan: Because ultimately, you have choices, right?

Derek: I would also throw out that a lot of insurance companies like to make it sound like this is what we pay, and that's not accurate. You can actually get reimbursement reports. They're incredibly expensive to get, but you can buy reimbursement reports per insurance company per state, and you will see that they're all over the place.

Actually piggybacking on what Megan said, if you write a simple letter, there are a lot of programs out there saying, oh, use our template, write a letter. If they give you a quick response and give you the increase, you probably didn't ask for enough. That means you're probably under what their normal market rate is, and they're just getting you up into the area. I would say look at that.

The other thing I would say is quite often, sometimes those letters will work. Quite often what I will have to do, because I really want to push the envelope on this, is get in with provider services reps. Quite often they have to bring in a regional manager, and I'm showing them why. It's based on patient outcomes. I'm showing them how I'm saving them money in different ways. I'm showing them outcome reports. I'm shifting people that way.

Again, I'm in a little bit different field. When I can show an insurance company that this person has been going to the ER four times a year and averaging two hospital admissions, and I've kept them out of the hospital for the last eight months, we need a little bit more money because we've saved you literally tens of thousands.

Megan: Absolutely. My gosh. Very good strategy there. Another question we have is, does anyone have any clarity to add about using the psych technician testing code? Some say they are billed by the technician while others believe they're billed by the psychologist. Any thoughts on that? I'm a social worker, my training is social work, so I don't have any insight on that particular question. Again, when we send out the replay, we may be able to connect you to some answers and resources in that follow-up email.

What are your thoughts on platforms that do billing for insurance that charge additional fees for clients who are paying towards their deductible? Is this ethical? Does it require an additional conversation about options to either use that platform or do private pay with a super bill? That's a great question.

Dr. Thakkar: I'll take that one. It's somewhat in my domain. If I understand the problem correctly, it sounds like the billing service is charging a percentage of what's collected. If someone has a deductible that's not fulfilled, then the practitioner is not really collecting anything. How does the billing provider get paid? That's a very unique problem. I'd love to hear others on this topic.

I know what we do in the out-of-network space is that we never ask a client to pay anything unless in certain situations where the client is seeking the reimbursement without any involvement from the practitioner. We have models and we don't charge a percentage, which is also different from this question, but we have practitioner plans with Reimbursify where the client doesn't get billed for the service. Is it ethical, I think, to ask a client to pay additional just to have the claim be put up against their deductible? With proper disclosure and consent, I think anything like that could be-- I wouldn't say it's unethical. Is it appropriate? Does it leave the right experience for someone? I'd love to hear others' thoughts on that.

Paula: The first thing that comes to my mind is you can't bill Medicaid. You can't bill a Medicaid client, that's law. I hope that's not tied up in the question the person asked in the chat. My other thought is in our electronic health record, we do use super bills. In the state of Michigan, where I am located, I think maybe a couple of others are as well, we have to disclose. There's a law called the No Surprise Act. When the client comes in, we have that conversation right up front, this is what our fees are. Please check with your insurance company. They're all different. It may reimburse this, you may have a deductible at the beginning of the year.

I started back in November, late October, November, December prompting my client saying, "Hey, this is where we're at in your treatment plan. This is how much time I'm roughly expecting it will take us." You have the Cross and the Shield, for example. You have your deductible based on whatever agreement you made with your employer. Know what your deductible is. You will owe that before we are able to start billing. I don't think it's a matter of ethics. In fact, if we don't collect copays and deductibles, then we're breaching the law. We get in muddy waters there.

It's our responsibility to communicate openly and appropriately with the client, and then also help coach them with this is what you need to ask. Here's your number on the back of the card, go to the website. We're working with human beings. I'm a human being, and I'd like people to treat me the way they would treat a sister or a friend. I apply that in my practice with the folks I'm working with. I always say, "If you need to make payments along the way, I'm going to work with you on that. So long as you're doing your working therapy, I got you."

We work out a comfortable plan with them. I just think that that's appropriate and kind. That's my approach. I don't know if that answers your question. I hope it does. I don't know, what do I-

Derek: I want to throw too. I practice in several states and there are a few pieces of this question that we would need to know because one of my other worries is if you tack on things to an EOB, that in some states could be insurance fraud also. I would say what you're asking is a great question, but there are some pieces that need to be feathered out before anybody could really give you a straight answer on that.

Dr. Thakkar: The private pay piece of it, the last part of the question which is, would an option be to just do private pay with a super bill, you can't do that if you're in contract. It's a tough question.

Megan: Just a quick follow-up to Derek. We had a question in the chat, how can I get those comparison rates for insurance companies? I'm in network with Blue Cross Blue Shield and haven't gotten a raise in many years.

Derek: I believe that the APA is going to put out our contact information next week. If you want to reach out to me, I can put you in contact with a couple of companies that do that. I'm not associated with either, but there are a couple of companies out there that can provide those lists.

Megan: It's time, unfortunately, for us to wrap up this amazing panel of experts and our wonderful discussion today. I want to thank everyone who joined us to learn more about billing strategies and how best to recession-proof your private practice. This event is proudly sponsored by the following: Owl Practice provides comprehensive and compliant practice management to help mental health professionals manage their practice, deliver digital therapy, and acquire new clients. As a special offer for all APA members, get 20% off lifetime discount on any Owl Practice plan. Go to www.owlpractice.com/apa for more information.

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Moderator: Thank you so much for joining us, and thank you to all our listeners for your participation. We'd also like to thank Owl Practice, Reimbursify Practice Solutions, Psyquel, and Zencare for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[00:58:03] [END OF AUDIO]