

Host: Hello, and welcome to today's webinar, *Risk Management and Compliance in Virtual and Private Practice*. This topical webinar is paid for by American Professional Agency, the sole authorized and preferred provider of professional liability insurance for APA members. Some important points before we get started. [silence] Allison Funicelli and Cara Staus, two of today's presenters, have a working relationship with Allied World, underwriter for the American Professional Agency.

As such, they both have a financial and intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view of risk management and compliance considerations for practitioners. APA does not endorse any products or services. The content is created by the APA's Professional Legal and Regulatory Affairs team and risk management experts of Allied World.

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Certificates will only be issued to those who watch for a minimum of 45 minutes. [silence] A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. [silence] During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions.

Attendees can view all submitted questions and upvote those they find important. This helps the presenters identify questions that many attendees want answered. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss them, don't worry. We will email them to you with the recording. Now, let me introduce our panel. Today's moderator is Deborah Baker.

Deborah leads the Office of Professional, Legal, and Regulatory Affairs at APA. Our speakers are Allison Funicelli. Allison is the Assistant Vice President of the Risk Management Group at AWAC Services Company, a member company of Allied World, and Cara H. Staus. Cara is the Assistant Vice President of the Risk Management Group at AWAC Services Company, a member company of Allied World.

Next, we have Alan Nessman. Alan is the Senior Special Counsel with the Office of Professional, Legal, and Regulatory Affairs at APA, and Rachael T. Soule. Rachael is the Director of Business Regulations and Independent Practice with the Office of Professional, Legal, and Regulatory Affairs at APA. Welcome, all.

Rachael T. Soule: Let's dive into a core concept of virtual practice, and that is interjurisdictional practice, the ability of licensed psychologists to practice across state lines. The fundamental principle here is pretty simple, but it's really important, and that is if you're providing psychological services to a patient in another state, you generally need legal permission from the state's licensing authority.

How do we get that permission? Let's explore some of the main pathways, the first being full licensure in each state. This is the most comprehensive, but often least practical. It means getting a separate full license in every state you intend to practice. It's time-consuming. It can be expensive. It involves meeting each state's unique requirements, fees, and ongoing compliance.

This includes adherence to relevant laws, as well as continuing professional development and continuing educational requirements. For most virtual practitioners, this is simply not feasible for more than just a couple of states. Another pathway is telehealth registries or certifications. Some states have created this specific pathway for out-of-state providers to offer telehealth-only services to their residents without full licensure.

Arizona and Florida, those are two states that are examples of this type of mechanism. These registries are generally less burdensome, often requiring proof of good standing in your home state, an application, and a fee. They are typically limited strictly to telehealth, meaning no in-person services. They may have other restrictions on, for example, patient type, services offered, or duration.

Because states can vary in terms of these registries or certifications, it's always important to check with the state's specific rules. A third pathway to practice interstate practice is temporary permits or license. A few states offer these types of temporary permits or licenses for specific, limited durations. Think of disaster relief or short-term consultations, or specific contractual work.

Utah and Washington, those are two states that have these mechanisms. These are generally not for ongoing therapeutic relationships, and they usually come with very strict limits on the scope and duration. Generally, exceeding those limits can lead to disciplinary action. Now I want to focus on multistate licensing compacts, and in particular, PSYPACT. This is a game-changer, and it's increasingly popular.

PSYPACT is an interstate agreement that streamlines the process for psychologists licensed in one participating state to practice telepsychology and/or temporary in-person psychology in other PSYPACT states. Once you're licensed in a PSYPACT state and get the necessary PSYPACT credentials, which we'll talk a little bit more about next, you can legally serve clients in any other PSYPACT state.

PSYPACT, like I said, it's an interstate compact that has fundamentally changed the landscape of telepsychology. Currently, there are 42 states participating in PSYPACT. Under PSYPACT, it offers two main pathways for psychologists to practice across state lines. One of those pathways is the temporary authorization to practice. This pathway permits temporary in-person face-to-face practice, but is generally limited to 30 days per year of in-person practice in each PSYPACT state.

The other pathway, which I want to focus on, is the authority to practice interjurisdictional telepsychology, often referred to as an e-passport. This pathway allows you to provide telehealth psychology services to patients in any other PSYPACT participating state. Generally, to qualify, you need to hold an e-passport, which is issued by ASPPB, which is the Association of State and Provincial Psychology Boards, have a full unrestricted doctoral-level psychology license in at least one PSYPACT state, and this point is important.

You need to declare a home state, which must be a PSYPACT state where you are already licensed, and then have no history of disciplinary action on any psychology license, and complete a certain application through the PSYPACT Commission. When practicing telehealth psychology under PSYPACT, some key rules that I want to point out are, you must be physically located in your declared home state while providing the services.

Your patient must be physically located in a PSYPACT state. You must complete three hours of annual continuing education credit relevant to technology use in psychology. Both of these pathways are designed to reduce barriers of interstate practice. However, I do want to note that PSYPACT is only available to eligible psychologists who meet specific criteria, including graduating from an APA-accredited program.

This can be a significant point for some who may not have come from an APA-accredited program. While PSYPACT is a great tool, it's not universally accessible to every licensed psychologist. When practicing under PSYPACT, psychologists have to navigate multiple jurisdictions. What law actually governs? The law in the state where you reside or the law in the state where your patient resides?

Generally both. Providers must maintain knowledge of and comply with the laws and regulations of both their home state and each PSYPACT state they practice into. Each state generally retains its fundamental authority over its own laws related to the health, safety, and welfare of its residents. The PSYPACT Commission, though, does have its own established rules that do govern this interstate practice.

They cover things like conditions of practice, adverse actions, and the dispute resolution process. What does this mean in practical terms? It means that while PSYPACT streamlines your ability to practice across state lines, it does not exempt you from understanding and following the specific laws and regulations of the state where your patient is located. Even though, for example, you might be licensed in Oregon, if your patient is in Arizona, a PSYPACT state, you must know and adhere to Arizona-specific laws.

Let's move on to the next slide and talk a little bit about what happens when the law in the state where you reside and the law in the state where the patient resides conflict. One of the most challenging and charged areas of interjurisdictional practice is conflicts of law, especially when we talk about sensitive areas like gender-affirming care or reproductive health. The core problem here is that states have widely divergent and often directly conflicting legal approaches to these types of care.

What is legal and protected in one state might be heavily restricted or even criminalized in another. I want to put the focus a little bit on gender-affirming care, since this is a really hot topic that we've seen in the news. Over the last couple of years, more than half of US states have proposed or enacted laws that either prohibit, significantly restrict, or even conversely protect gender-affirming care for minors. This creates a profoundly fractured legal landscape.

For example, your home state might explicitly protect minors' access to gender-affirming care, while the states where your telehealth patient resides might have criminalized such care. While most of these bans and limitations on gender-affirming

care focus on medical interventions, things like puberty blockers, or hormone therapy, or surgeries, it's crucial to understand that some bans may have broader implications directly impacting the services provided by behavioral health professionals.

This can include things like laws that restrict referrals for gender-affirming care. A few states have gone as far as to classify the provision of gender-affirming care or aiding and abetting it a crime. This creates immense challenges for psychologists and their patients, especially when statutory language is vague or open to broad interpretation. Terms like 'supporting' or 'facilitating' gender-affirming care can leave psychologists unsure if their supportive therapy, diagnoses, or referrals could trigger these laws, even if they aren't directly prescribing the medication or performing the surgeries.

In response to these restrictive laws, though, we have also seen countermeasures where certain states are enacting shield laws to protect providers and individuals from legal repercussions from other states where certain services are banned or restricted. Let's talk a little more about shield laws in the next slide. The application of shield laws can be pretty complex, especially in the context of interjurisdictional virtual practice.

I want to point out some of the key provisions and what these laws are attempting to protect. A fundamental aspect of these shield laws is protecting lawful in-state activities. Shield laws primarily protect actions that are legal within the state enacting the shield law. Secondly, shield laws aim at limiting cooperation with out-of-state actions, including, for example, subpoenas. They can restrict state agencies and law enforcement from assisting with state's investigation or legal actions related to these protected services.

For instance, say a psychologist in Massachusetts, which has a shield law, provides virtual therapy to a minor with a gender-related issue in, say, Texas. If a court in Texas, a state with a highly restricted gender-affirming care law, attempts to subpoena that psychologist's records to investigate the minor, the Massachusetts shield law could theoretically allow a Massachusetts court to block that subpoena, preventing the records from being released.

Another key provision of many shield laws is protecting providers' licenses. They aim to prevent disciplinary action by your own state licensing board based solely on actions related to care that was legal in the shielding state but may have been illegal elsewhere. On the next slide, I want to talk a little bit about the scope and limitations of these shield law protections.

Fundamentally, and in our jurisdictional practice, shield laws aim, like I said, to protect legally-permitted healthcare services within a state by attempting to limit the reach of other states' restrictive laws, especially when a virtual provider in a protecting state assists a patient elsewhere. Here's a vital point. The specific protections offered by the shield laws can vary from state to state.

There's no uniform shield law. Some shield laws offer much broader protections than others, and this difference in scope is something that needs to be understood to make sure the law can adequately protect a particular action, a particular provider, or

a particular patient. A very important point that I highlighted on the slide that I want to address is that the effectiveness of shield laws has not been fully tested.

These laws are relatively new. They are already facing legal challenges from states with bans, and they're raising profound questions about things like interstate comity, which is the principle where states respect each other's laws. What I'm trying to get at is we are in uncharted legal territory, and the full effectiveness of these shield laws in truly insulating providers from aggressive out-of-state legal action has yet to be definitively tested.

Moving on to the next slide, I just want to bring it all together and talk about the complex interplay between PSYPACT and shield laws. The core of the challenge lies in how PSYPACT affects state jurisdiction. While PSYPACT streamlines interstate practice, its rules explicitly state that a psychologist practicing via PSYPACT is subject to certain laws of the receiving state where the patient is physically located.

This is a critical point. Even if you, as a psychologist, are licensed in a PSYPACT-participating state that has a strong shield law, under PSYPACT, you are required to adhere to the laws of the state where your patient is receiving services, especially on issues impacting patient health and safety, which states with these restrictive gender-affirming care laws or reproductive health laws may argue their prohibitions fall under this umbrella.

This leads directly to potential conflicts and unresolved issues. The fundamental question becomes, which law takes precedence? Does your home state's shield law override the receiving state's restrictive law, or does a PSYPACT rule requiring adherence to the receiving state's law take precedence? The truth is, no clear, fully tested answer exists. While a state's shield law provides protections within the state, and such a state may be your home state, it cannot prevent other states from taking certain actions against psychologists practicing under PSYPACT.

For example, a restrictive state could potentially initiate actions impacting your ability to practice within its own borders, which could then have a ripple effect and affect your ability to practice under PSYPACT in any other PSYPACT state. Still, if your home state's shield law protects the type of care you're providing, it would aim to theoretically prevent your home state's licensing board from taking disciplinary actions against you.

In conclusion, while shield laws offer strong protections in certain scenarios, they don't eliminate all risks. Given this complexity, robust risk management for psychologists in interjurisdictional virtual practice is essential. This includes keeping up to date on the evolving laws in both your location and, crucially, your patient's location, especially when providing telehealth across state lines.

Deborah Baker: For understanding laws and policies that impact virtual practice, we'll now turn over the presentation to Allison and Cara.

Allison Funicelli: Hi, everyone. Next slide, please. I'm going to start off by covering informed consent. Generally speaking, if you are seeing patients in person or if you're providing telehealth services, the general principles for informed consent are

the same. There are some additional things you might want to also consider or put into your informed consent if you do have a virtual patient.

Now, let's start off with, "What are some of the basics that should be in informed consent documents?" It should be a description of what kind of care is going to be provided. It should include the purpose of the treatment. It should include the risks, the benefits, and the alternatives to the treatment that you are offering. It should include documentation, like the form should be signed by the patient and included in their medical record.

The informed consent and/or paperwork you give to your patient should include, "How are you going to handle emergencies? Are you available 24/7? Are you available, for example? Is there any coverage for you or not?" Again, you have to make sure that this patient understands when you're available and whether or not it's a good fit for them. Payment, right? We also want to make sure that they understand that they're expected to pay for the treatment that's being rendered.

When I get to the next slide, I don't need you to advance it yet, but I'll talk about what we deal with, with minors, on the next slide. You want to also make sure when you're talking to your patients, there's no language barriers. If you have a patient that is non-English speaking and you do not speak the native language of your patient, and they really need to have their care provided that way, we always recommend not using a family member as an interpreter.

You would have a medical interpreter that's trained in providing those types of services. HIPAA permissions, who do you have the ability to talk to and what, if you have any, if they have a family member, can you talk to the spouse, the child, or whoever of your patient? Then, for telehealth, you want to make sure that they're consenting to the use of the platform that you're using.

The platform certainly should be HIPAA-compliant. Do you have permission or not to talk to them through email, texting, et cetera? That should all be considered in your informed consent. Then you also want to make sure that you follow any jurisdictional requirements. Some states have specific requirements you have to follow regarding informed consent before you provide care.

Next slide. What about when we have minors? Most states have an emancipated mature-type minor doctrine. If you have a child, a minor under the age of 18, that falls under that, again, you should look up your jurisdiction as to how they defined it in your state, then you can get consent directly from that minor. Some states allow minors, even if they're not an emancipated or mature minor, to give consent under the age of 18.

For example, I believe California is as low as 12. Some states are 13, 14, 15, whatever. Again, whatever states, especially if you're practicing under PSYPACT, as Rachael discussed earlier, you want to be familiar with the rules in each state, right? We have 50 states with 50 sets of rules, so we need to make sure we abide by them in each of those states. If you do have a situation where the minor can consent, it's obvious, it's really helpful to also have a parent understand and know that their child is being treated there.

You always have to work out that payment situation. Just to let you know, we man a helpline at our organization, and I had somebody say, "Well, I have a minor," who, technically, in the state that this provider was, they have to be 18 or older to consent, the minor was 17 and said, "Well, I'm just going to tell my dad I need money for physical therapy, and that's what I'm doing."

That's not a good-- When you hear that scenario, a patient's already coming up with a plan to pretend something they're going to do, we don't want to really take on that risk. Then, if you are treating a minor and you get parental consent, it's always a good idea, especially for your older minors, like your teenagers and stuff, to have an agreement with the parents.

"Look, I want them to be open and honest with me. Can we agree that I'm only going to give you certain information that I feel you need to know, and certainly if there's a safety concern for your child or your child may harm someone else, I will certainly tell you that, but can we agree that your child does enjoy some sort of confidentiality?" Do understand, and there'll be a separate conversation about records requests, but just understand that parents may still be able to access that information even when they agree to try to give their children privacy.

If you have a child, a minor who has got divorced or legally separated parents, even if you're in a state where only one parent has to consent, we always say, the court has gone through the process of determining what rights each parent has, and we don't want to change on that. If the parents have joint custody or the parents have access to their child's protected health information, we want to really get **[inaudible 00:22:45]** Cara?

Cara Staus: Thank you, Allison. Next slide, please. Now we're going to talk about the virtual practice in data privacy and security. Obviously, technology is at the forefront of everything that we do. Especially when providing psychological services, you're collecting, storing, transmitting sensitive patient data. It is important to really understand and make sure that the systems that you're using and the processes that you have in place afford the utmost protection of confidentiality and privacy to you, both you and the patients that you are seeing through the virtual practice.

HIPAA, as all of us know, has compliance and state-specific regulations regarding the use and privacy of data. In addition to that, there are 20 states currently that have separate privacy laws. Some may be in line and in step with HIPAA, or some may have greater protections afforded. It's important to be aware of your state-specific statute for confidentiality and privacy.

In the event they are more strict than HIPAA, you will need to comply with your specific state statute or the state in which the patient is located in if you are practicing under PSYPACT. Be familiar with that. Those confidentiality, California, Virginia, they have more stringent. There's greater protections afforded. Be aware of your state-specific laws and regulations. As far as technology, making sure that you are on a HIPAA-compliant platform, and that if you are utilizing technology, you have a business associate agreement with a particular vendor that you're using for your telehealth practice.

That business associate agreement really is the expectations of the vendor or the service that you are utilizing complies with the basic minimum standards under HIPAA. Again, adding that extra layer of protection. In terms of technology, we are not IT professionals or risk management professionals, but what you should know is, make sure your network is private in terms of utilizing a public network.

A lot of times, you may encounter a patient who is on the go and may wish to take a session in a more public location. Understand that the Panera or Starbucks, those networks are open. They are subjected, or even in an airport, subjected to the ability for cyber hackers. Again, as Allison talked about consent, consent is important anytime you are using technology, so that you get the patient's consent in the environment.

If they choose to be in a more public environment, your duty is to then address it, document, and obtain consent to make sure that they understand the risks associated with the potential. It doesn't mean that it's going to happen, but there is a risk or a potential. The Department of Health and Human Services has great resources available for rules specifically related to telehealth in terms of what you can encounter.

They could have a checklist, making sure that you're aware of technology. With patient portals, password protection, and encryption, make sure that that's part of your standard if you are securing data and technology through an electronic health record system. Again, standard with most things, your privacy and confidentiality, it's not really going to change much. It's going to add a different layer utilizing technology as the platform. Next slide. Allison is going to take this one on.

Allison: Whether you're practicing in a virtual practice or a patient in person, generally, under the laws of HIPAA and your state requirements, if a patient wants to have access to their records, they are entitled to them with some small exceptions. If you have a patient that wants their records released to themselves or others, you want them to sign a release of information form, right?

Have their name on it, the date they're consenting, to have the records released, to whom they want them released, how they want them released. If they want them released in a non-HIPAA-compliant manner, they are allowed to do that. I always just recommend, wearing my risk manager hat, that they say, "I am consenting to having my records released in a non-HIPAA-compliant format."

Then we already talked a little bit about, but if you have parents who are divorced or legally separated and they both have access to their child's records, it's always a good idea to-- If one parent is asking for the records, we usually recommend send a courtesy copy to the other parent so that you're staying neutral, and then both parents have the same information.

If you receive, and then as Rachael mentioned earlier, you would need to be familiar with the shield laws in the states where you're practicing, because if a third party is asking for records without the patient's permission, you want to make sure that you can either shield them from them getting those records, or if you have a situation where you feel that you're being forced to release something without patient consent, we always recommend, talk to a lawyer is the best scenario.

Talk to a lawyer that's familiar with healthcare law in the state where that patient is located and follow their guidance. The same if you have a request for records through a subpoena, your malpractice carrier may provide a service for you, or if you work at an organization, usually they control the records, that the records should be released with permission of an attorney or risk management professional at your insurance carrier.

They may be able to guide you as to whether or not if you have a situation, if you're not sure if you should release it, right? We always want to be around the side of making sure when we release patients' private information, that we're doing it lawfully and following the rules. Also, be familiar with the fact that some states have privacy rules that are more strict than HIPAA, right?

HIPAA sets a certain bar. Some states are stricter. Again, you need to be familiar with that. Having a practice attorney licensed in a state where you practice, having your malpractice carrier risk management provider, perhaps through the APA, you look for services if you belong to the state association of the APA. These are places you could go that can hopefully give you guidance on what to do in almost any kind of scenario that may be affected by your practice, so you don't feel like you're standing alone on an island.

Then, if you get a court order, generally, you have to do what the court asks because a judge is ordering it. Again, get somebody to help you respond to it because not all subpoenas or court orders are the same, or there may be some exception that may protect that information from being released. Cara?

Cara: Thank you. In the virtual practice, recordkeeping, documentation, really is one of the largest pieces of that care that you're providing and that therapy that you're providing. It helps to serve a purpose, for treatment, continuity of care, supports billing, so many functions as recordkeeping. If you can advance the slide, that would be great. Each state may have specific statutes and laws for your professional duty.

Make sure you're aware of any state-specific requirements. Also, the APA has a great guideline regarding your professional guidelines and documentation. It is really no different than being in the outpatient in-person practice. You're going to document the same. The only real difference is making sure that you have those special technology consents, so that the person is agreeing to technology.

Also, when you start the session, making sure they're in a state in which you're licensed to practice. Documentation, Allison touched upon that, I believe, for emergencies, knowing where the person is located is important. Have a plan in place in the event technology gets disrupted. Document that there's an understanding. Always remember that that consent can be revoked.

Make sure that you are documenting accordingly. In addition, from a documentation standpoint, you want to make sure you're documenting emails, texts. We recommend that minimum necessary in any type of format that is less secure, but that is part of the official record. Be aware of your state-specific retention periods for records. Each state has a retention period that you're required to keep.

Most are at the conclusion of the last visit or session. Some are as few as six years. Some go up to 10 years. Minors, obviously, have different statutes as well. Be aware of those retention periods, making sure that you are keeping your records secure. Whether they are in an electronic format, make sure that, again, it is password-protected, encrypted. If you're utilizing a vendor, that vendor is going to be storing that as well.

If you're utilizing paper as your records, make sure that they are in a water-fireproof, infestation-free setting. Make sure that they are secure because, again, recreating those records are going to be difficult. Access to the records, one question that does come up, and I want to highlight real quickly is if you get obtained records from another provider, are they a part of the record?

Yes, they are. They're a part of your record if you're using it for your therapeutic treatment recommendations. Be mindful of that. We recommend, if you do have a system, use a portal. A portal is a great mechanism for you to capture, in a secure environment, any communication between your patients and you. That documentation is important, obviously, for licensure.

In the event something does come up and there's a complaint or an allegation made, making sure that you are documenting where that patient is located is going to be the laws in the state in which you're licensed in and which you are following. Be aware of that. Then, the psychotherapy notes are, again, no different in the virtual environment. They do have added protections if they are kept in a separate and distinct location or separate tab than the process notes and health record.

Next slide. Lastly, from a risk management standpoint, we're going to talk about patient termination and abandonment. It does happen at times where you may face a patient that's moving to another state in which you're not licensed to provide services to. Before agreeing to continue those services, make sure that you do verify the state. If you're a member of PSYPACT and it's a PSYPACT state, great.

If it's not, then you're going to have to work on a discharge termination plan with the patient, to, again, follow your professional standards. That's state-specific if there's state regulations that are in place and notice period. You're going to evaluate the person. Are they in crisis? Does the risk outweigh the benefit of continuing while they identify a new provider?

Again, there's not a one-size-fits-all with how you are handling a patient termination, but the keys and takeaways are, make sure that you're following state regulations. Make sure that you are providing an appropriate notice period, inclusive of referrals, and then document those conversations with the individual. We know how difficult it is to establish care, so make sure that you're having those conversations earlier, from that last date that you know that the person is transferring or moving out of state.

This comes up a lot with college students. Can I see them when they're away at school? The answer is that the license follows the state in which the patient is located. If they're not in a state where you're located or licensed to practice, then you would recommend that they see a provider in that state. Next slide. Alan, I think you're up.

[silence]

Alan Nessman: Good afternoon, everyone. I'll try to get through this quickly because we're going to try to leave time for Q&A at the end. For virtual practice, it's important to keep track of insurance and payer policies. For general insurance coverage, it's true that most major insurers provide some level of coverage for telehealth, and the largest national insurers actually provide strong coverage.

They have very broad coverage, often including audio-only, but a common restriction is that telehealth coverage only applies to practitioners who are independent practitioners, who are in-network. There are variations in the payer policies, and even for the same company, a lot of these companies are different areas, there can be variations between the commercial insurance, Medicare, and Medicaid, and there are significant variations between states on Medicaid coverage.

State-specific regulations. Many states have specific laws that require telehealth coverage by insurers and/or Medicaid programs. Some of these are extremely broad, and a lot of them include reimbursement parity, which means that services provided by telehealth are reimbursed at the same rate as services provided in person. There are a few states that have some restrictions.

For example, in some states, in one state, audio-only is allowed if there's an existing provider-patient relationship, and if it's clinically appropriate. In another state, it's only for crisis intervention, audio-only. These are restrictions you should be aware of in terms of what the states mandate. If you think that the payer is providing less coverage than the state mandates, you should check into that.

If you're practicing interstate, there are some challenges, and one thing in particular is that if you're out-of-state, you're more likely to be out-of-network, and as I mentioned earlier, a number of major insurers only provide telehealth for independent practitioners who are in-network. Next slide, please. Now we're going to talk about some private practice trends, particularly around insurance.

Next slide, please. In the last few years, we've seen escalating challenges with insurance companies, and this is something that makes life very difficult for psychologists. We've seen increased audits, reports of intensifying audit activities, more scrutiny of provider documentation, billing practices. Most of you are familiar with what audits are, and that's something that isn't too new, but the prepayment reviews is something that's come up in the last few years.

In this case, the company requires extensive documentation before it pays the claim. In other words, you submit the claim, and then the company says, "Oh, well, we need to see extensive records before we decide to pay this claim," and that often extends the time before they pay the claim, which seems to be a payment issue, and then they may not pay all of the claim.

We've had a recent victory with some advocacy around that. One of the major companies that was doing prepayment reviews, we did advocacy, and then the company advised us that they had paused these prepayment reviews. We still had some isolated reports, but we're pleased to have generally stopped that practice. An

unusual feature of the prepayment reviews was, they were starting to very extensively hit people who were out-of-network.

This also caused a lot of patient privacy concerns because patients were finding that their records were now being scrutinized in a way that they had never been scrutinized before. This caused a lot of concerns. Finally, I want to mention, the administration has recently announced that the final parity rule that came out in September, they do not plan on enforcing it, and they may be taking steps away from stronger parity enforcement that causes great concern.

This is troubling because mental health parity is one of the main advocacy tools we use to try to get insurers to stop these practices. APA is going to continue to advocate for strong parity practices federally and at the state level. [silence] Let me check my notes to see what else I should cover. We've been doing outreach to insurance companies and to regulators about the effects of these practices.

These practices are the things that cause psychologists not to want to be in insurance networks, and we argue that if they fix these practices, there's more likely to be access to care. Some tips to protect you if you are subject to these practices are, one, you should be aware of the payer's policies, particularly around documentation and billing, and coverage services. The other thing to think about is to have leaner recordkeeping and/or keep separate psychotherapy notes, as Cara mentioned.

These separate psychotherapy notes are not accessible to insurers or auditors, so that's a way of protecting patient privacy and also means that you're producing less records in an audit, prepayment review, et cetera. The other big issue, which you'll see up there, is clawbacks. After you've provided services, the insurance company essentially does an audit and decides that they want money back, and that is very difficult for practices, and it really is a problem in terms of the financial stability of practices.

Next slide, please. Now I want to talk about potentially happier news, which is the Blue Cross Blue Shield provider antitrust settlement. This case has been going on for over a dozen years. The Blue Cross Blue Shield companies were accused of limiting competition and underpaying providers. The settlement amount was a record \$2.8 billion, but from that it gets subtracted about \$900 million for attorneys' fees and administrative costs.

The available funds for that then get separated further because most of that money, the remaining money, is going to go to hospitals and large facilities. Individual providers like psychologists only get 8% of the remainder, so that's about \$150 million, to save you from the math. That still sounds like a lot of money, but these funds are going to have to be spread out to thousands and thousands of providers nationwide.

These may not result in very large recoveries for psychologists, but we recommend that you do submit a claim if you're eligible. The important deadline is July 29th of this year, and we recommend that if you're eligible, and that is you're a US provider who served Blue Cross Blue Shield patients between July 2008 and October 2024, you're eligible. Next slide, please. Since we have limited time, let me skip over that.

Some of the resources that are provided give you information on how the settlement payments are calculated. Next slide, please. There are two methods of filing your claim. The default method is the-- Claims attorneys have amassed a large database of claims, and if you receive a settlement notice from the claims administrator over the winter, that's an indication that you're likely in the database, and you can use the easiest default method, which allows you to just rely on the information they have about you.

No extra documentation is needed for the years not covered by the database, which only goes up for about half of the period. If you're not in the database, you can still submit a claim, and you should provide records for the years you have available, and they have a way of accounting for the years that you may not have records for. There are further resources at the Blue Cross Blue Shield Provider Settlement website.

We may also be providing additional information. We also have an article, which Rachael wrote, on the provider settlement and some steps for submitting a claim. We recommend that if you're eligible, that you submit a claim. It's possible that, at the settlement hearing on July 29th to finalize the settlement, it's possible that something may happen to the settlement, but in any event, we recommend that if you're eligible, you go ahead and submit a claim. Thank you.

[silence]

Deborah: All right. We are now going to transition to Q&A. There have been a number of questions that have come in during the course of the presentation, some of which we have tried to answer as we go along. I do know there was one question that came up because of some audio issues, so I'll start off with that one. It said-- Hold on, let's see. It keeps moving. "In a state that requires only one parent's consent for treatment," and I think this is for Allison and Cara, "do you recommend still pursuing consent from both parents in the case of shared medical decision-making?"

Allison: I'll take that one first. Yes, so even if you're in a state, I believe, like Texas, might be one of them off the top of my head, that you only need one parent's consent, if the parents are married, you only need one parent's. If the parents are divorced, separated, never married, anything like that, and both those parents have the legal right to consent, as we talked about earlier, then we do recommend you get both parents' consent because we don't want to impinge on the other parent's rights.

They may have a strong opinion or reason why they don't want their child in care, and they could become a real problem in your practice. They could make your practice disruptive. We always just say the best thing to do to just mitigate your risk is to get the consent from both. We don't want to wind up with a licensing board complaint because somebody is not happy or feels that their rights have been impinged.

[silence]

Deborah: Okay, let's see. There was another. This one might be a bit open-ended. Oh, let me just switch to this one. "What is the best practice for managing high-risk

patients when seeing them virtually?" Again, I think this is an Allison/Cara kind of question.

Cara: I can take that one on, Deborah. The best practice, high-risk patients is, number one, determine whether or not they're appropriate for telehealth. Not all patients are appropriate, so you would need to make that determination. If you feel that the risk is too great, then work on an appropriate transfer to an in-person provider. Documentation and your treatment and therapy plan is going to be critical, in the event that there is limited resources in the area, providing that plan, giving them safety.

What is their safety plan? Have you alerted them in the event of an emergency, what they should do? Do you have the ability to speak with an emergency contact or a family member? A lot of times, I know, this happens in crises where we don't have access to a family member. That's one of the most important times, so establish that at the start of care. "Is there someone I can speak to in the event of an emergency?"

That way, you can coordinate and assist that person the best way you can. Again, not all patients are going to be appropriate for telehealth, and that's a big consideration to evaluate in the event they are presenting with harmful behaviors.

Deborah: Thank you. All right, I have two questions that are related for Alan. The first question, and I'm going to ask both of them together, "Is the Blue Cross Blue Shield settlement only for private practices, and would that be applicable to out-of-network providers?"

Alan: Yes, so it is not only for private practices, and there's nothing about it that applies to whether you're in or out-of-network. It's just did you provide services to Blue Cross Blue Shield patients during those time periods?

Deborah: Thank you. All right, this question is for Rachael. "Are there any updates on the No Surprises Act, and are therapists still having to provide good-faith estimates?"

Rachael: There haven't been any significant changes to the No Surprises Act requirements since its implementation. That means generally, psychologists are still required to provide good-faith estimates, which primarily means for uninsured or self-paid patients, or generally those not using insurance. You are responsible for providing a good-faith estimate of the expected costs for services, and this estimate, it should be provided in writing and include details like the anticipated cost of treatment, the provider's fees, and any other relevant information. Generally, no, there haven't been any significant changes there.

[silence]

Deborah: Thank you. Let's see. This one, I think, will be more for Allison and Cara. "Coverage and liability as a supervisor. Since the supervisor is legally liable for the activities conducted by the supervisee, do you need extra liability insurance? Does the supervisee need their own separate insurance?"

Allison: We always recommend, if you're providing a service, if you're not sure it's covered by your insurance policy, then you should just talk to the broker, agent, carrier, whoever your contact is, through your malpractice carrier. Usually, the underwriter or the broker can explain to you what is or is not covered under the policy. You understand that, typically, it's covered, but again, it depends on what role.

Some policies may say, "If you're just generally supervising, it's covered, but not if you're acting in like a medical director or a psychology director role." Again, you want to just make sure that it's really best to just talk to your insurance carrier and make sure that it's covered. Just understand, when you supervise people, you are technically, in most states, vicariously liable for their actions as well. It does somewhat increase your liability as well.

[silence]

Deborah: Here is a question that I will allow whoever is interested in answering to answer. "When keeping separate therapy notes, what has to be documented in the official record?"

Alan: I'll take a stab at that.

Deborah: You want to take that one? Okay.

Alan: The definition of psychotherapy note excludes from it certain things like diagnosis, treatment plan, et cetera. We refer to that as the clinical record sometimes, but some of the basic things, and I don't have the list right in front of me, but the basic things that other people in the healthcare world need to know about, like the timing of sessions and things like that, those are things that have to be in the clinical record.

Then the psychotherapy notes can cover a lot of the detail, particularly that's a good area to put sensitive detail about the patient, anything that the patient may not want to have getting out to their payer, or things like that. Also, if you're somebody who takes notes that are very detailed, it's a good way of just having all that detail available for your use, but not so available in the system. Allison, Cara, do you want to add anything to that, or Rachael?

Allison: Yes, you have to put in, like you said, the session start and stop times, the diagnosis, the treatment plan, the prognosis, how well is the patient doing, all those kinds of things. If you're collaborating with other providers, that should all be in the records, as well as anything that you need to put in there to substantiate your billing.

Cara: You want to make sure that there's that continuity of care. If somebody else is looking at it, you want to make sure they understand what's the diagnosis, as everyone said, and what's your plan, the therapy, are they moving towards progress goals? Again, the psychotherapy notes by design is really the therapist's notes, personal notes, versus anything related to the treatment goals and therapeutic goals.

Deborah: Okay. I think we have time for one final answer, so there's one question seeking a clarification, and I think I will tag Rachael for this one. "Do forensic

psychological evaluations require a good-faith estimate as such evaluations evolve? At the last seminar you provided, it was stated that estimates for forensic work was an exception to the No Surprises Act. Could you please comment?" [silence]
Rachael or Alan, do either of you feel comfortable with answering that?

Rachael: Sorry. I can answer that question. Generally, yes, good-faith estimate requirements do apply to forensic psychological evaluations when they are provided to uninsured individuals. Again, are those choosing not to use their insurance or self-pay? Generally, the regulations, they define a healthcare provider pretty broadly, and there's no specific specialty services or practice types that are exempted from the good-faith estimate requirements

Generally, forensic evaluations are typically scheduled in advance. The good-faith estimate requirements apply to services scheduled at least three business days ahead. Yes, the answer to that question is yes, good-faith estimates do apply.

Deborah: Okay. I think we have unfortunately run out of time. I appreciate all of the robust number of questions that have come in. I believe that for those of you who submitted questions and they weren't answered, whether you submitted them as part of your registration or during the course of the presentation, I believe our email was included in the chat, so you're welcome to email us as follow-up. I will wrap up today's presentation. Thank you again for joining us.

[silence]

Host: Thank you so much to our speakers, and thank you to all our listeners for your participation. We'd also like to thank the American Professional Agency 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.

[00:56:10] [END OF AUDIO]