



# National Academy of Neuropsychology

*Bulletin*

VOL. 16 No. 2  
2001

## **Some Thoughts on the Business Aspects of Private Practice in Clinical Neuropsychology**

Edward A. Peck III, PhD  
Neuropsychological Services of Virginia, Inc.

This article is designed to provide information concerning the business aspects of running a practice in Clinical Neuropsychology. During the past decade, as the managed health care reimbursement system has increased the restrictions on funding for clinical services, neuropsychologists have come face to face with the grim reality of trying to pay their bills with diminishing health care reimbursement dollars. We are now quite aware that most insurance companies currently pay less per hour for mental health services than they did in 1990 while, in virtually every cost category, our cost of practice expenses have increased. It really doesn't matter whether you work in a private practice, multi-specialty medical practice, medical school or hospital. If your practice involves billing insurance companies for revenue, then any reduction in the funding for your services becomes a critical issue. In conversations with my colleagues around the United States, I have repeatedly heard the message there is a basic fear for the continued survival of many clinical practices.

As professionals dedicated to providing quality patient care, we also need to recognize that the effective management of the business aspects of our clinical activities is vital to our continued ability to provide patient care. In this context, I offer four Guidelines (and some closing thoughts) for managing the financial aspects of a neuropsychological practice. These and other guidelines are described in greater detail in Peck (in press).

**Guideline 1. *Realize that you are in business.*** Your profession may be Clinical Neuropsychology and it may involve patient care, but it is still a business and it has to be run using basic business principles. The first reality is that your business requires ongoing funding to pay overhead expenses. If you can't meet your overhead costs, you must: (a) lower your expenses and salary in order to balance your costs (unfortunately, you may not have the option of merely raising your rates to balance your overhead shortage if you are constrained by the fees set by insurance companies); (b) go into debt and, eventually, you may have to file for bankruptcy when you can no longer meet your financial obligations; or (c) close your practice due to your inability to pay your bills.

**Guideline 2. *Understand how much it costs to operate your business on a per hour basis.*** You need to develop an understanding of basic accounting and financial management principles, and you need to hire an accountant to set up an accurate financial analysis of your practice. I am not talking about the mere act of writing a check to pay a bill. Rather, I am talking about the systematic collection of your financial information for analysis and decision making purposes. Typically, your financial data can be displayed in a spreadsheet where your expense categories can be broken down and analyzed by the present month (e.g., August) and current year to date (January to August) data and where these figures can be compared with (a) the same monthly

### **Issue Contents:**

From the Editors .....	page 2
Procedural and Diagnostic Coding .....	page 3
Billing for Outpatient Rehabilitation. ....	page 4
Bulletin Grand Rounds.....	page 5
Grassroots Neuropsychology Network.....	page 8
Clinical Practitioner's Corner.....	page 8
Summary of Minutes, Board Meeting .....	page 9

## From the Editors

Greetings! As newly appointed co-editors of the NAN Bulletin, we would like to share our vision for the direction of the Bulletin. Simply put, we feel that the Bulletin should serve as a source of information that helps neuropsychologists succeed in doing what they want to do for a living. While many journals publish the research findings driving our activities, few forums exist that discuss the logistics of doing what we do. All of us, whether involved in private practice or academia, frequently find ourselves faced with practical, everyday issues for which formal guidelines do not exist (e.g., understanding billing procedures and legal issues, interacting with insurance companies). Neuropsychologists also continue to struggle with “guild” issues as our professional identity develops and evolves. We envision the Bulletin as providing a vehicle for discussing these issues and for disseminating practical information to help us deal with these issues.

We will also be continuing and elaborating on NAN’s innovative use of the internet in communicating with its members. The Bulletin will be available on NAN’s website ([www.nanonline.org](http://www.nanonline.org)). In addition, we will be able to use NAN’s website to provide additional space for appendices that we feel are likely to be helpful to our readers but that space limitations preclude publication in the printed version of the Bulletin.

In addition to feature articles devoted to practice issues, we will continue to provide updates on organizational activities, messages from the NAN leadership, and relevant clinical case studies. In his Clinician’s Corner, Ron Paulman will update us on relevant regional legislative or organizational activities. We encourage you to write to us with your own suggestions for topics to cover. We have chosen to kick off our inaugural issue with a number of articles related to billing practices that increasingly affect those of us in institutional settings as well as those of us in private practice. We hope that you will find them useful!

Finally, we would like to thank Phillip Schatz for his hard work as the previous Bulletin editor, and both he and Gregory Lee for their assistance with our transition into our roles as co-editors.

With best wishes,  
Daniel L. Drane  
David J. Williamson

expenses for the prior year and b) for the prior year to date. The “Sample Financials” available online at NAN’s website shows a sample “dummy” set of financial data and expense categories that may be relevant to your practice. Certainly, each practice will have its own specific expense categories and there may be other categories not cited in this Appendix.

**Guideline 3. *Establish a program to effectively manage your practice overhead.*** Your financial data can help show you (a) where your practice money is being spent and (b) whether there have been unexpected and/or unusual changes in the pattern of your expenses. Once you have an overview of your expenses, you can better understand where your patient reimbursement dollars are being spent. It can lead to cost cutting decisions as well as comparison shopping for the best rates for office insurance, long-distance telephone plans, office equipment, etc.

All sorts of complex statistical based financial models can be applied to your financial data, and the results can be used to address questions such as: (a) How much does it cost per hour to have my practice open for business? (b) Can I financially afford to spend more professional time working on a patient case (who is not seeking pro bono services) than was preauthorized and will be reimbursed by their insurance company? c) Where and how can I change my office policies and procedures to reduce my office overhead?

**Guideline 4. *Use effective written documents to deal with common patient interactions such as collecting information and contractual issues.*** Who collects the patient insurance or self pay information for your practice? Is it a designated employee? How systematic and accurate is your information collection system? Are insurance companies refusing to pay your practice because you have not followed the rules as documented in the contracts you signed with them? Are you providing professional services that are not covered under these insurance contracts and then not billing the patient for these services? A good example of the latter problem is providing educational testing to a patient, where such a service is not covered under his/her insurance plan, and not demanding an a priori self-pay agreement with the patient/responsible party.

I expect that every practice has a set of forms

**continued on page 13**

**How Do I Code This?**  
**Q & A with Antonio Puente, Ph.D.**

*Editor's Note: The Current Procedures Terminology guide has an inescapable impact upon the ability of neuropsychologists to be paid for their professional activities, as the codes provided in the "CPT manual" are those used by Medicare and other agencies to determine what services will be covered. Dr. Puente has played a central role throughout the past decade in informing such agencies about the nature of neuropsychological services, helping the agencies devise coding systems that accurately describe our services, and informing neuropsychologists about the practices and preferences of these agencies. His annual talk at our national conference is one of the "must-see" sessions for neuropsychologists who must understand these issues to make a living.*

Basic coding questions: Which CPT codes do you use to code:

Q. Neuropsychological testing of an adult or child?

A. 96117

Q. Neurodiagnostic interview of an adult or child?

A. 96115

Q. Neurodiagnostic interview of a family member?

A. 96115

Q. Psychodiagnostic interview with a child?

A. 90801

Q. Psychological testing of a child?

A. 96113 or 96100

Q. Outpatient follow-up regarding results of evaluation?

A. 96113 (child) or 96115 (adult)

Q. Monitoring neuropsychological progress on an inpatient medical or rehabilitation unit?

A. *Stay tuned on this one. There will be a new set of codes coming out later this year that will allow for the coding of health and behavior management activities -- essentially close to what physicians call evaluation and management.*

Q: Switching to diagnostic coding rather than procedural coding. How do you code for the evaluation in which someone presents with cognitive complaints but you conclude that the complaints are a function of "psychiatric" disturbance rather than neurological disease or injury?

A: *If you are performing a neuropsychological assess-*

*ment, then the referral question must involve an explicit or implicit question about neurological function. Use the ICD-9 code corresponding to the condition that you are being asked to evaluate.*

Q: Does one bill differently for the time spent by the neuropsychologist directly providing service vs. the time spent by a technician being supervised by a neuropsychologist?

A: *We are proceeding with the development of testing and professional codes. For now, there is no difference.*

Q: I have heard that, in billing Medicare for patients seen in inpatient units or even in buildings directly affiliated with hospitals, one is not allowed to bill services that are deemed "incident to" the patient's care? What does this mean in terms of my ability to bill for the procedures that I or my supervisees provide to such patients? What does "incident to" mean, anyway?

A: *In general, the use of technicians is allowed, but it is assumed that their services are being reimbursed through the inpatient bundled amount to the hospital. The only time that is allowable in terms of billing in inpatient situations is that of the professional time spent by the doctoral level psychologist.*

*The latest version of these issues involving neuropsychological services is found at Dr. Puente's website, [clinicalneuropsychology.com](http://clinicalneuropsychology.com).*

## **Billing for Outpatient Neurocognitive Rehabilitation: Experience with CPT code 97770**

**Barbara P. Uzzell, Ph.D.**

Some find it remarkable that many practitioners are reluctant to engage in treatment after a diagnosis of some type of brain damage from head injury, stroke, aneurysm, arteriovenous malformation, cerebral tumors, multiple sclerosis or other disruptive brain disorders. This may be a disservice to brain damage individuals since no other group is better suited to provide treatment after a brain insult than neuropsychologists who know and understand well aspects of brain functioning. With a minimum effort neuropsychologists can develop rehabilitation techniques and expand their practices and revenues. On the other hand, some practitioners may be reluctant to engage in treatment because of fear that they will not get paid for their services, or it is a hassle to obtain precertification for these services. Because of my past experiences with treatment and payment for these services I have been asked to share what I know with you about these topics in this NAN Bulletin on billing issues.

The treatment provided, for either out- or inpatient services, is listed as cognitive rehabilitation and billed under CPT code 97770 in 15 minute increments with direct one-on-one patient contact with the provider. Other labels for this service have been cognitive remediation, cognitive retraining, neurorehabilitation, and cognitive therapy. Because these labels have various connotations in other domains besides treatment after brain damage, I prefer to call this treatment Neuropsychological Rehabilitation in my practice. Furthermore, since the neuropsychologist ends up treating the brain, as well as the whole person, Neuropsychological Rehabilitation is more appropriate (Uzzell, 1999).

In a way this is a testimonial acknowledging payments can be received for services under CPT code 97770. I have been using this code since its inception for four 15 minute periods per treatment, and have been paid by many different insurance carriers for service with this code including carriers that underwrite workers compensation programs. The treatment is considered prevocational, and for that reason is useful in developing methods to compensate or retrain for cognitive losses prior to vocational rehabilitation prior to a work return. Additionally, treatment under this code allows individuals to live independently and function safely in their

environment.

Precertification of services is always obtained in my practice before launching into treatment in order to provide a more likely payment guarantee in this day and age of managed care. I would not recommend commencing treatment without precertification approval. Sometimes this requires educating insurance carrier or case manager about the nature of the service and how it is conducted in order to obtain precertification approval. Other times education is not required since the carrier already knows about the treatment. A tip practitioners might want to follow is to request the number of precertified sessions in increments. Insurance carriers like to see progress in treatment and to evaluate it, so they can justify payments. Practitioners requesting precertification of a few treatments at a time permits insurance carriers to perform their evaluations and note the beneficial effects of treatment as it progresses.

In using 97770 through the years I have been denied payment only on two occasions. The first instance occurred when an insurance carrier denied precertification approval because there was no scientific evidence that cognitive rehabilitation worked or would be successful. While many of us feel such statements are untrue, a recent article (Cicerone, et al., 2000) provides scientific evidence for the effectiveness of cognitive rehabilitation. Although this article was not in print at the time of my rejection, it is now available for other practitioners as proof of treatment should they encounter such a rejection.

The second rejection I received with 97770 was on the basis that these services can only be provided by occupational or speech and language therapists. In this instance, I tried to obtain from the insurance company a written copy of this policy. I was unsuccessful and unable to treat this patient after a brief educational program with a few company administrators/medical personnel. Had I been successful in obtaining a written copy of the insurance carrier's policy it would have been forwarded to Dr. Antonio E. Puente who is involved in negotiating CPT code usage nationally. (Denial of a neuropsychologist to provide the treatment suggests a restraint of trade requiring national attention).

In February 2001, I received a communication in a health newsletter that 97770 would be fractionated into two codes during 2001: 1) CPT 97532 (for the development of cognitive skills to improve attention, memory, problem solving, including compensatory training); and 2) CPT 97533 (for sensory integrative techniques to enhance sensory processing and promote adaptive responses to environment demands). The first code, 97532, is intended for use with adults and the second code, 97533 is intended for pediatric populations, although the latter can also be used with adults. In Texas I have not yet been required to use either 97532 or 97533, so I have no experience with either of them to date. Both of these codes are billed in 15-minute increments with one-on-one direct patient contact with the provider, just as 97770.

Because my experience with CPT 97770 has generally been positive, I will continue to use this code. I have certainly had more precertification rejections for assessment using CPT 96117 than I have had using 97770. I would certainly encourage other practitioners to provide treatment with 97770 to their patients with little fear of nonpayment for services once precertification approval has been obtained.

#### **References**

Cicerone, K.D., Dahlberg, C., Kalmar, K., Langenbahn, D.M., Malec, J.F., Bergquist, T.E., Felicetti, T., Giacino, J.T., Harley, J.P., Harrington, D.E., Herzog, J., Kneipp, S., Laatsch, L. & Morse, P.A. (2000). Evidence-based cognitive rehabilitation: recommendations for clinical practice. *Archives of Physical Medicine & Rehabilitation*, 81, 1596-1615.

Uzzell, B.P. (1999). Neuropsychological rehabilitation. In A.-L. Christensen & Uzzell, B.P. (Eds.). *International handbook of neuropsychological rehabilitation* (pp. 353-369). New York: Kluwer Academic/Plenum Publishers.

---

**NAN Web Address:**

<http://www.NANonline.org>

## **Grand Rounds:**

### **Promoting Real World Outcomes in Neurorehabilitation: A Case Study**

**Mark A. Sandberg, Ph.D.<sup>1</sup>**

**Debra K. Smith, Ph.D.**

**Celeste Ann Racicot, M.Ed.**

**John McGinley, M.S.**

Community Re-entry Program  
St. Charles Hospital and Rehabilitation Center  
Port Jefferson, NY

#### **BACKGROUND**

Residual neurocognitive dysfunction following an acquired brain injury (ABI) can be a primary cause of disability. While research abundantly documents this fact, the literature is less overwhelming in its provision of research-based practices that guide clinicians toward scientifically sound interventions. The neurorehabilitation community is making progress toward this end as demonstrated, for example, by the evidenced-based review conducted by the American Congress of Rehabilitation Medicine Brain Injury-Interdisciplinary Special Interest Group (Cicerone et al., 2000). Work of this kind is helping neuropsychologists to become more specific about the defining features of the cognitive therapy technique or intervention employed or under study. The neurorehabilitation community is also evolving in how we define applied clinical neuropsychological therapy or cognitive rehabilitation. Conceptually, our definition of this work has become broader, targeting less tangible issues such as quality of life, motivation, and altered identity. In turn, many clinical neuropsychologists are wisely shifting their rehabilitative focus from remediation of discrete deficits or impairments to more global issues of daily life functioning. The purpose of this presentation is to illustrate these conceptual priorities within the context of neurorehabilitation geared toward the community reintegration of a severely injured 58-year-old man. Practice considerations for the clinical neuropsychologist are offered.

#### **CLINICAL HISTORY**

Mr. S is a right-handed, 58-year-old, married, Caucasian man. He is a highly intelligent reading teacher and is a community volunteer who was known for his erudite

interests and active social life. A car estimated to have been traveling approximately 40 mph struck him while he was riding his bicycle. He was assigned a GCS score of 3 on the scene, as well as upon admission to the Hospital. In the ER, brain tissue and blood were noted in the left ear. A CT scan revealed bitemporal contusions, an intracerebral hematoma, and multiple skull fractures, including a left depressed skull fracture. Multiple fractures of the base of the skull were present, and herniation of brain matter required evacuation by way of suctioning. He underwent a left frontotemporoparietal craniotomy. He was able to demonstrate sustained physiological stability about three weeks post injury, and was then transferred to the inpatient rehabilitation unit where he remained for an additional 6 weeks. Mr. S was still demonstrating evidence of post-traumatic amnesia upon discharge. His continued rehabilitation needs were met through participation in our outpatient Community Re-entry Program.

**NEUROREHABILITATION COURSE**

The inpatient rehabilitation service employed an interdisciplinary approach to address a wide range of deficits, most notably in the domains of cognition, communication, and, to a lesser extent, motoric functioning. Interdisciplinary priorities included bolstering the patient’s compromised awareness and orientation, and assisting the family to adjust to his residual deficits and plan for his evolving needs.

Upon admission to the Community Re-entry Program, neuropsychological examination was conducted together with measures of patient and family-identified daily living problems and community participation. The Craig Handicap Assessment and Reporting Technique (CHART; Whiteneck et al, 1992) was used to quantify community participation. Functional rehabilitation goals were shaped based upon Mr. S’s priorities and stated interests (e.g., return to gardening, resumption of volunteer work with the city opera, resumed ability to do crossword puzzles) as well as the team’s estimates as to what could realistically be attained. Progress toward identified goals was accomplished through cognitive rehabilitation strategies that were developed in light of assessed neuropsychological strengths and weaknesses and knowledge of activities that were of high personal interest to Mr. S. For example, deficits in reading comprehension, attention, and pragmatic communication skills were addressed through exercises such as reading and acting out scenes from *Orpheus Descending* by Tennessee Williams. A tendency toward tangentiality was addressed in part through creation of Haiku poetry. Throughout his outpatient rehabilitation, he was encouraged gradually to assume greater independent responsibility and make approximate advances toward functional goals. His family and friends worked closely with the rehabilitation team and played a critical role throughout rehabilitation.

**NEUROPSYCHOLOGICAL FINDINGS and OUTCOME DATA**

Formal neuropsychological examination conducted 3 months post injury found evidence for severely diminished intellectual functioning (VIQ = 71; PIQ = 91), with focal deficits in the areas of lexical access, verbal memory (impaired storage and retrieval), arithmetic reasoning, written expression, and comprehension. Re-examination 9 months post injury demonstrated neuropsychometric improvements (VIQ = 92; PIQ = 105). Generative naming remained severely depressed. Deficits in word finding and verbal memory remained severe and largely unchanged from the 3-month examination (WMS-R LMII = 5<sup>th</sup> %ile). Neuropsychological examination 21 months post injury demonstrated gains in verbal memory (WMS-III LMII = 37<sup>TH</sup> %ile), but phonemically and categorically cued verbal fluency and confrontation naming remained at least moderately impaired. Executive functions, such as self-regulation, initiation and planning, were judged to be largely intact, although there was some compromise in the area of hypothesis testing as measured by the WCST. Intellectual test findings suggested improved language based abilities (VIQ = 111; PIQ = 107) with overall intellectual functioning judged to be diminished from premorbid estimates. Data concerning Mr. S’s community participation is outlined below:

<b><u>Selected CHART Item ratings</u></b>	<b><u>3 months post injury</u></b>	<b><u>21 months post injury</u></b>
# of hours per day requiring assistance for accomplishment of personal care activities	24	0
Assistance needed to address deficits in cognitive functioning	Constant observation/ supervision	Left alone without supervision
# of hours per week involved in home maintenance activities (e.g., gardening)	0	7
# of hours per week spent in recreational activities	0	8

Functional rehabilitation objectives were met, including fluent reading and writing skills, fluent conversational skills with ability to compensate for residual word finding difficulties, ability to return to his volunteer work at the city opera and library board, independent ability to use public transportation, resumption of driving, and successful ability to complete the New York Times crossword puzzles.

### **CLINICAL PRACTICE CONSIDERATIONS**

The rehabilitation of Mr. S provides a forum to comment upon a wide range of important points for discussion. For example, the case surely underscores the grossly imperfect relationship between severity of injury and severity of disability and speaks to the importance of family involvement. We wish, however, to limit our discussion and magnify three themes that, in our opinions, were strongly associated with the good outcome that Mr. S was able to demonstrate.

Embedding neuropsychologically-sound therapeutic strategies within the context of personally meaningful material was critical to Mr. S's high interest in therapy and capacity for self-initiated practice during times outside of the formal therapy schedule. The benefit of using material that is of high functional importance to the individual was also recently emphasized by Park & Ingles (2001) in their review of the rehabilitation of attention.

The notion that meaningful neuropsychological interventions have an impact at the level of disability rather than that of impairment was key in guiding goal selection and treatment approaches. Outcomes were measured in a multifaceted manner, including standardized measures of neuropsychological functioning, with Mr. S's capacity to resume real-world activities and meaningful life roles as a governing principle. This case also illustrates the loose tie between residual neuropsychological impairment and community participation/quality of life. Mr. S continued to demonstrate impaired functioning on neuropsychological tests but was living his life as he had planned. The neuropsychologist's assessment and reassessment of those who have sustained a brain injury should include measures that focus on the presence and prominence of daily living problems as well as social and community participation. We find the CHART to be a useful tool to measure participation.

The multifaceted neuropsychological problems faced by each unique person who has sustained an injury to the

brain will never be sufficiently addressed by the kind of results produced by randomized controlled trials. Stricker and Trierweiler (1998) address this issue when they speak of the practitioner as being a "local clinical scientist" who uses research methodology as a framework for critical thinking in real clinical contexts. Recognizing that science at best can offer only partial solutions to complex problems such as those found in ABI rehabilitation they write "scientific training...can provide an attitude and an orientation to the problem at hand that will lead to an informed solution that is the best the state of the art can generate" (p.999). This style of evidenced-based practice dominated our work as rehabilitationists in the case of Mr. S. It is also this style of clinical thinking which allows us as neuropsychologists to "locally" pick up where scientifically demonstrated techniques leave off.

### ***References***

Cicerone, K.D., Dahlberg, C., Kalmar, K., Langenbahn, D.M., Malec, J.F., Bergquist, T.F., Felicetti, T., Giacino, J.T., Harley, J.P., Harrington, D.E., Herzog, J., Kneipp, S., Laatsch, L. & Morse, P.A. (2000). Evidenced-based cognitive rehabilitation: Recommendations for Clinical Practice. *Archives of Physical Medicine and Rehabilitation*, *81*, 1596-1615.

Park, N.W. & Ingles, J.L. (2001). Effectiveness of attention rehabilitation after an acquired brain injury: A meta-analysis. *Neuropsychology*, *15*(2), 199-210.

Stricker, G & Trierweiler, S (1995). The local clinical scientist: A bridge between science and practice. *American Psychologist*, *50*(12) 995-1002.

Whiteneck, G.G., Charlifue, S.W., Gerhart, K.A., Overholser, J.D., Richardson, G.N. (1992). Quantifying handicap: a new measure of long-term rehabilitation outcomes. *Archives of Physical Medicine and Rehabilitation*, *73*, 519-26.

<sup>1</sup> Please direct correspondence to:

Mark A. Sandberg, Ph.D.  
 Director, Community Re-entry Program  
 St. Charles Hospital & Rehabilitation Center  
 200 Belle Terre Road  
 Port Jefferson, NY 11777  
 (631) 474-6298  
[Mark.Sandberg@StCharles.org](mailto:Mark.Sandberg@StCharles.org)

**Grand Rounds submissions/inquiries  
 should be directed to:**

**Shane Bush, Ph.D., ABPP  
 St. Johnland Head Injury Rehabilitation Center  
 Kings Park, NY 11754  
 (631) 269-5800 x. 427  
[sbushphdnp@medscape.com](mailto:sbushphdnp@medscape.com)**

**Grassroots**  
**Neuropsychology Network**  
Neil Pliskin, Ph.D.

In 1999, members of the Policy and Planning committee of the National Academy of Neuropsychology and the Practice Advisory Committee of Division 40 of the American Psychological Association met with Dr. Tony Puente in order to learn more about his efforts in influencing policy development at a national level that is favorable to the practice of our specialty. An issue raised in that meeting was the importance of getting neuropsychologists around the country involved in the advocacy effort and particularly for them to become aware of the latest developments regarding coding, administration and billing practices that they could then share with other professionals in their region. It was decided at that meeting to develop a national Grassroots Neuropsychology Network to be comprised of individuals concerned with the economic and public policy struggles we face as a specialty. Grassroots members might be in positions of leadership within their state associations, have political connections or just be willing to volunteer their time to quickly educate and mobilize as many neuropsychologists as possible in their region when crucial policy issues or legislative votes arise that affect our profession. The Policy and Planning Committee sent out a survey/invitation to the NAN membership and the Division's Practice Advisory Committee compiled an initial list of volunteers. Additional invitations to join were extended through the various neuropsychology listservers and an organizational meeting was held at NAN's 2000 Convention. Dr. Paul Malloy volunteered to create a listserv devoted exclusively to the Grassroots Network that is hosted at [Grassroots\\_list@neuropsychiatry.com](mailto:Grassroots_list@neuropsychiatry.com).

The Grassroots Network is working closely with Division 40 through its Practice Advisory Committee (Dr. Chris Grote, Chair) and Federal Advocacy Coordinator (Dr. Steven Honor) and is under the auspices of the NAN/Division 40 Interorganizational Committee. The Grassroots Network has been involved in promoting the recently completed NAN-Division 40 Practice Survey project and getting the word out on the important "Patient Bill of Rights" legislation. With the formation of NAN's Professional Affairs and Information Office, an office solely directed to the individual assistance of professional issues, new projects will be developed that will require the help of the Grassroots Network.

The Grassroots Network currently has 73 members representing 36 states and Canada. However, we need many more members and there are a number of states/regions not yet represented. These include New Hampshire, Hawaii, Massachusetts, West Virginia, Virginia, Mississippi, Iowa, Kentucky, Montana, Oregon, Idaho, Nevada, and Kansas. We will hold another organizational meeting at this year's NAN Convention in San Francisco. If you are interested joining the network, please email Neil Pliskin at [npliskin@uic.edu](mailto:npliskin@uic.edu).

### Clinical Practitioner's Corner

Ronald G. Paulman, Ph.D.

On May 22, 2001, the Texas State Legislature sent to the Governor for signature a bill prohibiting insurance carriers from excluding coverage for neuropsychological evaluation, neurocognitive rehabilitation, and a variety of related services for persons with acquired brain injury or neurological disease. This bill is the first of its kind in the U.S. mandating such coverages. The bill further requires adequate training of personnel responsible for pre-certification or utilization management of such services. A "sunset" provision requires review of the law in four years with respect to efficacy of these interventions and changes in insurance rates resulting from this legislation. Overall, this bill is a positive step toward universal recognition by insurance carriers of the utility of neuropsychological and related techniques in the evaluation and treatment of brain-injured persons.

**Summary of Minutes, Board of Directors Meeting**

**San Antonio, May 19-20, 2000  
Hyatt Regency Hill County Resort**

**Present:** Jeffrey Barth, Munro Cullum, Carl Dodrill, Robert Elliott, Ruben Echemendia, Gerald Goldstein, Josette Harris, Sandra Koffler, Gregory Lee, William Perry, Neil Pliskin, George Prigatano, Cecil Reynolds, Ronald Ruff, Laetitia Thompson, Barbara Uzzell, Penelope Zeifert, and Eric Zillmer.

Dr Barbara Uzzell (**President** 1/00 - 12/00) called the meeting to order and gave a brief overview of the issues that the board would be dealing with during the next two days and specifically pointed out HMO and managed care, policy and planning, public relations, lobbying activities, website, cultural diversity, prescription privileges, long term planning, collaborative activities (Division 40, APA committees), and practitioner issues would be topics of discussion during the board meeting.

**Secretary Report** (Robert Elliott)

The minutes of the November 1999 Board Meeting were reviewed by those in attendance at the board meeting. It was moved by Thompson and seconded by Dodrill that we approve the November 1999 minutes, as amended. The motion carried unanimously.

**Executive Director Report** (Josette Harris)

*Personnel.* Two new employees have been hired by NAN. Barbara Braun has been hired to replace Julia Hensley, who resigned, to take over coordination of office administration. Marcia Stauffer has been hired as conference coordinator and website coordinator. She will be replacing April. It was pointed out that we do not have a job description for either position. Yoonie will continue as a consultant and will receive a stipend. Records associated with recent personnel action may be reviewed only by elected board members.

NAN employees will no longer be employees of the university or be able to participate in the Colorado State Personnel system. Discussion was held about the need for employee employment contracts.

*Ethical Issues.* NAN has received two anonymous letters claiming that two NAN members have committed ethical violations. One member was allegedly convicted of four felony convictions. The second member was accused of not having training in neuropsychology. There was discussion about NAN's willingness to accept anonymous complaints. The new NAN membership renewal application includes a required disclosure statement (felony convictions and APA ethical violations) for membership renewal that is consistent with NAN by-laws requirements. Three NAN members disclosed information about a history of a conviction or an APA ethical violation.

There was discussion about the feasibility of an ethics advisory committee, the boards' degree of involvement and responsibility when ethics issues arise, a need for a process to handle such complaints, following APA guidelines and methods for handling of such complaints, patient implications, NAN's vulnerability, potential harm to the individual about whom the complaint was filed against, and legal liability.

The specifics of the complaints against NAN members were discussed in Executive Session (Notes were distributed only to President, President- Elect, and Executive Director).

*Action Items:* Decisions made in Executive session included the following:

- 1) A revised dues statement/membership application will include a no change for the last six months' statement for individuals who previously disclosed a violation/conviction.
- 2) Members who disclose that they have been subject to an APA ethical violation complaint will be asked to submit verification of APA final action.
- 3) A member discussed in executive session will be asked to submit documentation that either APA or the member's state licensing board has investigated his case and that the member is currently in good standing with both/either organization.

4) Present to the full executive board a recommendation that if a member fails to disclose a history of a conviction or an ethical violation then that member's membership in NAN will be reviewed by the executive committee.

*Site Selection.* Dr. Harris discussed issues associated with the site selection process and the use of third party negotiators. Site Services has been used in the past and was paid \$40,000 by the Las Mansion and the Hyatt hotels last year despite their providing little in the way of services to NAN. Accelerating costs associated with housing at the NAN annual conference is a major concern. NAN's ability to continue to meet the room quota/room block is a major issue although NAN has historically always made its room block.

A site management organization will probably charge NAN \$12,000-\$15,000 per year for on-site meeting management and negotiations. There were discussions about proposals from organizations that have submitted bids to NAN for such services. Additional discussion was held about the three proposed options submitted by Dr. Harris for the board's consideration. There was consensus that we need additional bids for site management services.

*MOTION:* It was moved by Barth and seconded by Ruff that NAN attempt to negotiate a fee at or under \$20,000 with a site selection company for the 2004 conference. *AMENDED :* Authorize up to \$10,000 for budget year 2000 for pursuit (bid) of a site selection contract for the 2004 conference.

*Action Item:* The motion passed and \$10,000 was authorized for site selection which will be allocated to Executive Directors Office.

**Conference Committee Report** (William Perry)

*Budget.* Dr. Perry submitted a report to the executive board. Attendance at San Antonio for 1999 was 1257. The three highest rated speakers for 1999 were non-clinicians. NAN attendance was too large for the Hyatt and the La Mansion. Total revenue was \$384,633 for the 1999 conference. Expenses were \$234,625, which was under the 1999 budgeted allotment. Net profit for 1999 was approximately \$150,000. The budget for 2000 is \$258,000.

*Speakers/Submissions.* Last year several potential speakers turned down offers to present because of travel/room costs. For selected speakers the room cost will be included in the offer for next year. Problems with last year's drayage company were encountered but those problems have since been resolved. GES in Florida will be used next year. Poster proposals were handled electronically and will be an option for submissions for next year. Poster proposals are down 20% this year. No budget for electronic poster submissions has been submitted.

*Social Activities.* The insurance company told the Executive Director last year that they would not insure NAN's conference if the official activities included a NAN endorsed tennis tournament or a run. The consensus of the board was that such activities should not be under the control of the Program Chair but the executive board encouraged the Program Chair to endorse and develop such activities.

*Action Items:*

- 1) Dr. Harris will investigate, with the existing underwriter, the cost of including in the existing insurance contract activities such as the tennis tournament and run. Dr. Zillmer will check on insurance for athletic activities at the annual conference and will provide the executive board with his findings via email in time for the 2000 conference. The board members will respond to his findings as soon as possible.

*Exhibitors:* Costs were briefly discussed. An issue involving tiered cost has been resolved.

- 2) Recognition of previous Conference Chairs during the annual meeting was discussed by Dr. Uzzell. Such recognition may not be possible for 2000 but should definitely be part of the program for 2001.

**Treasurer's Report** (Tish Thompson)

*NAN Foundation.* Dr. Thompson distributed a proposed 501 Articles of Incorporation for the National Academy of Neuropsychology Foundation which could be used for sponsoring students and disabled members and making charitable donations and grants. The Articles are filed with the state of Colorado and IRS and are fairly broad. You do not have to be a NAN member to be eligible for a grant under this proposal. The proposed articles do not cover lobbying activities. NAN membership organization can contribute to the NAN Foundation. The Grants program could be integrated into this Foundation. This foundation does not have members. The NAN Board of Directors would be the Foundation Board of Directors but the members would not be personally liable. The NAN Executive Director would serve as the Director of the Foundation. Under the rules the Director could be compensated.

*MOTION:* Reynolds moved and Dodrill seconded that NAN approve the NAN Foundation Articles of Incorporation. The motion passed unanimously.

The 2000 budget was approved 11/99. Overall expenditures for 1999 were under budget but a few offices/committees were over budget. Dr. Thompson distributed the balance sheet and the income statement. Profit for 1999 was \$187,485. Assets on deposit total \$1.3 million at end of 1999 with a few hold over conference expenses yet unpaid. Income is increasing a little because of investment income and membership appears to be stable. At the end of 1999 NAN had \$474,000 cost basis. Market value includes \$485,000 in reserves.

A trial balance report for 1999 was distributed by Dr. Thompson, which details expenses, by office/committee. The Balance Sheet indicates that our assets as of 3/31/00 are approximately \$1.4 million. Our overall financial status is stable and our income continues to exceed our expenses.

*Audits.* Dr. Thompson discussed the frequency of audits. There was group discussion about the advantages and disadvantages of conducting audits every two or three years. An audit every year would cost NAN approximately \$5,000.

*MOTION:* Moved by Prigatano and seconded by Dodrill that an audit be conducted every two years of even number calendar years. (Motion Passed)

*Executive Directors Office.* The Executive Director requested an increase in budget for 2000 because of increased expenses. Telephone, employee health costs, part-time contract work, and the directory are items that have increased the operating costs for the office. A funding increase of \$21,430 is requested (\$131,000 total for 2000).

*MOTION:* Moved by Cullum and seconded by Thompson that the Executive Secretary's office budget for 2000 be increased by \$21,430. The motion passed. The board expressed their gratitude for Dr. Thompson's exceptional and tireless work on the budget and treasurer related tasks.

**Policy and Planning Committee** (Jeffery Barth and Neil Pliskin)

Three position papers have been approved and two are in process (Cognitive Rehabilitation and Informed Consent in the Practice of Neuropsychology) at the present time.

*Definition of Neuropsychologist Task Force.* Dr. Barth commented on the work of the committee on the definition of a neuropsychologist. The committee expects to finish a definition that is broad and inclusive for future review. It was agreed by the executive board that a definition that would be understandable and useful for the lay public and managed care is needed. Drs. Dodrill and Reynolds commented on APA Division 40 efforts on development of a definition that are taking place. There was consensus that NAN should not defer to any other organization nor delay in the development of a definition.

*Cultural Diversity Task Force.* Dr. Pliskin addressed the work of the task force, which is chaired by Dr. Pedro Ferraira. Four areas were identified by the task force as priority concerns. These areas include education and training, assessment issues, research priorities, and education and training. Proposed concrete action items will be developed for the Fall executive board meeting.

*Grass Roots Survey.* Dr. Pliskin announced that last Fall the committee surveyed the NAN membership about practice issues. 163 individuals in NAN and

Division 40, in 47 states and Canada, expressed an interest in becoming involved in managed care issues. NAN merged a list with a Division 40 list of individuals who expressed an interest in becoming involved in professional practice/managed care issues.

*Managed Care Task Force.* Dr. Pliskin announced that the task force's progress report and recommendation is being coordinated with APA Division 40. The report on the managed care task force is for information purposes only. One discussion item being considered by the NAN Managed Care Task Force involves scheduling a summit of organizations involved in the practice of neuropsychology where managed care issues would be discussed. Dr. Barth described a paper or alert that might be made available to the NAN general membership on a regular basis.

The possibility of developing a professional affairs office or development of lobbying efforts was briefly described by Drs. Pliskin and Barth. There was discussion about using Mealys Journal as resource for a list of attorneys that have litigated managed care cases. Dr. Perry pointed out that the primary topic the task force is focusing on is reimbursement parity. Dr. Uzzell indicated that she has been contacted by NAN members about the development of guidelines for negotiating with managed care organizations. Dr. Reynolds pointed out NAN needs to compliment the work of other organizations that are also working on managed care issues. Specifically, patients need to have access to documents that will help them in their challenges of their managed care providers. The APA Practice Directorate is in the position of monitoring such efforts. There was brief discussion about making a donation to the APA Practice Directorate for their efforts in working on managed care issues. Dr. Thompson cautioned the board to be sensitive about the potential implication of a donation to the APA Practice Directorate on NAN's legal status.

*Action Item:* The board directed the President or her designee to contact the APA Practice Directorate to discuss a donation to the Practice Directorate for purposes of representing neuropsychology in their advocacy efforts.

*Informational Brochures Project.* Dr. Pliskin requested guidance from the executive board about the development of an informational brochure for the NAN membership. Development of liaisons with other organizations that can provide relevant information was encouraged by the board. The need for specific practice information (i.e., costs, hours to conduct an evaluation, etc.) needs to be considered in the development of such brochures.

*Professional Practice Survey Task Force.* Dr. Pliskin presented the survey and the budget developed by the NAN task force and Division 40. The revised budget for this survey has doubled to \$8,000. NAN is responsible for 50% of the total expenses for the project. After all of the information has been compiled by the task force and made available to the membership of both NAN and Division 40, the information may be used to negotiate for reimbursement rates by members and/or organizations. Dr. Koffler recommended that the task force conduct a trial run before the final survey is printed and distributed. Dr. Goldstein pointed out that the draft survey does not identify practitioners that work in VA settings who conduct research and provide administration services. The task force is committed to mail the survey out as soon as possible. The NAN task force plans to publish the results of the survey for the NAN membership at the 2000 Annual Conference.

*MOTION:* Moved by Barth and seconded by Prigatano to increase the Policy and Planning Committee 2000 budget by \$4,000 to cover NAN's share of the cost for the Professional Practice Survey. (Motion Passed)

*Practitioner Task Force.* Dr. Barth briefly reviewed the report submitted by the NAN Task Force on Clinical-Practitioner Issues. One issue addressed in the survey focused on board certification. Discussion was held about a claimed inaccurate statement in the NAN Bulletin article on ABCN authored by Ivnik. The statement in the article claimed that ABCN was associated with APA. There was discussion about how the NAN board could handle this matter. Discussion ensued regarding the term "endorsement" in the article. Dr. Cullum pointed out that he included a disclaimer that accompanied the original article. Dr. Uzzell indicated that the complaining member's view recognized the inaccuracy as a potential restraint of trade issue. The NAN board will remain neutral about board certification issues. Dr. Reynolds will discuss with the NAN Bulletin editor publishing a response letter.

Reimbursement is being discussed by the task force according to Dr. Barth. Advocacy efforts by Dr. Puente and Dr. Rosenstein, grass roots liaison efforts with APA Division 40, development of brochures, and discussion with managed care organizations are efforts that are dealing with reimbursement issues. NAN needs to improve the use of the Bulletin to provide feedback to the NAN membership about reimbursement and advocacy efforts. Dr. Barth proposed that a Town Hall process needs to be implemented where such issues can be discussed. There was discussion about the NAN annual conference needing to emphasize education in the conference and both science and practitioner issues being viewed as relevant to practitioner work efforts. Dr. Barth suggested that every time a new board member is elected a brief biography should be published.

#### **Membership Committee** (Elizabeth Kozora)

Dr. Harris presented the Membership Committee report for Dr. Kozora. Membership as of 5/16/00 was 3222. 112 member applications are pending and a number of those will be deleted if the applications are not completed. The Membership Committee members are concentrated in Denver and the committee sees a need to expand the committee to be more diverse. The committee will also seek direction from the Board at the November annual meeting regarding criteria for membership at the various levels.

Dr. Pliskin reported that a conference call took place earlier in the morning with Dr. Chelune, Dr. Grote, Dr. Puente & Dr. Rosenstein. There was Board discussion about making a donation to APA. There was general support for contacting Russ Newman to explore making a donation. Dr. Pliskin reported that Div. 40 is pleased with the support of NAN for the proposed practice survey. A neuropsychology summit was proposed by Dr. Puente during the conference call to explore what issues of concern to neuropsychologists exist and to address the development of a grass roots network to intervene in those issues. Dr. Koffler noted that CNS already exists and could be used to facilitate this.

*Action Item:* Dr. Uzzell will contact Russ Newman about a possible donation.

Dr. Pliskin requested that the Board consider the possibility of setting up a Professional Affairs office. Dr. Pliskin asked that the Executive Director be involved in the task force and exploration of a professional affairs office. Dr. Dodrill pointed out that the proposal to set up a professional affairs office could be a major expense for NAN. There was also discussion about posting responses on the website or to create a Listserve to respond to questions about reimbursement. Dr. Prigatano suggested the committee should continue its work, further develop ideas in the task force report, and report back to the Board in November, 2000.

#### *Action Items:*

- 1) Dr. Pliskin, with the assistance of the Policy & Planning Committee, will develop the ten most common questions and responses for posting on the website.
- 2) The feasibility of various alternatives, including an interactive site, listserv, and website postings will be discussed by Policy and Planning with the task force.

#### **Nominations Committee** (Munro Cullum)

The report was given by Dr. Cullum. Dr. Jim Hom met the 1% rule to be placed on the ballot for President. The Nominations Committee submitted Rick Naugle as the second nominee for President. Bill Perry and Drew Gouvier are submitted by the Nominations Committee for Member-at-Large. Greta Wilkening and Leslie Rosenstein are submitted by the Nominations Committee for Treasurer.

*MOTION:* Moved by Thompson and seconded by Ruff to accept the Nominations Committee recommendations. The slate of nominees was unanimously accepted.

**Clinical Neuropsychology Synarachy.** Dr. Uzzell reported on the Synarachy. The Board's input was requested regarding a request by Dr. Kerry Hamsher for a financial contribution from NAN to facilitate Dr. Hamsher's participation at relevant meetings. Dr. Prigatano clarified that it was previously agreed that each organization would rotate responsibility for paying expenses for relevant

meeting attendance. Dr. Uzzell and Dr. Hamsher had been unable to communicate regarding specifics of this request.

*MOTION:* Moved by Reynolds and seconded by Prigatano that the request by Clinical Neuropsychology Synarachy for a financial contribution by NAN be tabled because the parties have not been able to communicate further regarding this.

#### **Awards Committee** (Ruben Echemendia)

The Committee has developed a quantitative system for rating articles for the Nelson Butters Award. Dr. Cullum reminded the Committee that the award must be a research article and inquired whether this criteria was met. Dr. Echemendia confirmed the article recommended to receive the award this year is a research article.

*MOTION:* Moved by Cullum and seconded by Thompson to accept the Awards Committee's recommendation that Reitan, R.M. & Wolfson, D. (1999), Two faces of mild head injury be awarded the Nelson Butters Award. (Motion Passed).

Dr. Echemendia brought a committee recommendation to the Board that a Distinguished Service Award be developed that would recognize service to the organization or to the field. The Awards Committee recommended that Dr. Antonio Puente receive the first award because of his extensive advocacy work and collaboration with related agencies.

*MOTION:* Moved by Reynolds and seconded by Thompson to establish a Distinguished Service Award. Motion passed.

*MOTION:* Moved by Prigatano and seconded by Thompson to designate Antonio Puente as the first recipient of the Distinguished Service Award. Motion passed.

Dr. Echemendia asked that the Board consider a recommendation by the Awards Committee to increase the term of the Chair from one to two years. The benefits of increasing the term were discussed. Dr. Prigatano suggested an alternative that members on the committee be rotated into the Chair position. It was also noted that the By-Laws state that the chair may have been a member of the committee.

*MOTION:* Moved by Thompson and seconded by Cullum that a bylaws amendment be brought before the membership to increase the term of the Awards Chair from one to three years. Motion passed.

#### **Members at Large**

The status of the Sexual Harassment Policy/Discrimination Policy was raised by Dr. Uzzell. Dr. Thompson informed the Board that an attorney reviewed the draft version of the sexual harassment policy and recommended broadening the policy to an Anti-discrimination Policy, which was drafted. Dr. Reynolds reminded the Board that the original concern about having a sexual harassment policy stemmed from reports that organizations had been sued for inappropriate behavior of their speakers. Discussion ensued concerning whether speakers should be required to sign the statement. It was suggested that guidelines for our speakers could be developed by the Program Chair and disseminated to speakers and a summary statement of the anti-discrimination policy could be included, as well as information on the organization, and its goals.

*Action Item:* Thompson will take responsibility for finalizing the Sexual Harassment Policy/Discrimination Policy draft and will provide the draft to the Executive Director for posting in the central office.

*NAN Clinical Research Grants Program.* Dr. Dodrill reported that an initial survey was completed at the luncheon of the NAN Research Grants Program in November 1999. A follow-up survey was mailed to the membership with 438 returned. 5% of the survey recipients (21 individuals) expressed the most negative views concerning the program. Of those who voted 80% were strongly supportive of continuing the Grant program and 10% were in the middle. The next lowest rated category of ratings expressed a concern that changes in the award granting process are needed. Three grant recipients have been identified for 2000 and there is consideration of attempting to award 1-2 more grants from the remaining funds in the grant budget. Changes in the

rating system were considered by the Committee this year. Dr. Zillmer inquired whether there were plans to publish the results of the Grant program survey. Dr. Dodrill will publish the survey results in the Bulletin.

*Action items:*

- 1) There was consensus to limit additional grants be funded from the remaining grant budget this year.
- 2) The survey results will be presented in the NAN Bulletin, web page, and a brief announcement made at the annual meeting regarding the survey results.

*Book Series Report.* Dr. Prigatano reviewed the goals for a book series and distributed a list of authors for the first book in the series. The deadline for chapters is September 2000 and the plan is for the book to be in the hands of the publisher by February 2001 so that the book can be published by the 2001 NAN meeting.

**Publications** (Gregory P. Lee).

Dr. Gregory Lee reviewed the issues concerning the termination of Dr. Reynold's term as editor of Archives of Clinical Neuropsychology 12/31/00 and termination of the contract with the publisher, Elsevier, 12/31/01. Dr. Lee requested Board direction regarding whether to extend Dr. Reynold's contract for one year to coincide with the termination of the Elsevier contract. Suggestions for seeking candidates for Editorship were discussed, including advertisement in the Archives and the Monitor, submission of names by the Board, and solicitation of the membership via a mailing. Dr. Reynolds suggested a call be issued for nominations, along with criteria for editorship, and specification of materials for review. Deadline for receipt of Nominee materials is October 2, 2000.

*MOTION:* Moved by Dodrill and seconded by Cullum to extend Dr. Reynold's term as editor of the Archives of Clinical Neuropsychology for one year through December 31, 2001. Motion Passed.

*Action Item:* Publications will distribute to the Board of Directors the top five editor applicants and their materials for review by November 6, 2000.

Dr. Schatz will resign his editorship of the NAN Bulletin at the end of 2000. The call for a new Bulletin editor will be combined with the call for a new Archives Editor. Deadline for nominations will be August 1, 2000.

Dr. Lee asked whether the Board would like the Committee to continue work to develop a proposal for ongoing review of the Editors and journals.

*Action Item:* The Publications Committee will develop a proposal for the November meeting.

**Education Committee** (Penelope Zeifert)

Dr. Zeifert noted that although there was a large number of overall "negative" comments about the 1999 conference, these comments included suggestions for improvement as well as negative comments. Dr. Zillmer noted that the majority of the "negative" comments concerned the facilities in San Antonio, a variable that cannot be controlled once a site is committed.

The Committee continues to explore offering CME to physicians. However, CME requirements are being revised, and we will be unable to pursue CME for physicians for our conference this year.

Clarification was requested by Dr. Prigatano regarding the honorarium in the exchange of speakers with the American Academy of Neurology. There was support expressed for continuation of this exchange.

*DistanCE.* Dr. Koffler reviewed the history of course offerings. There was some discussion regarding tracking of revenue for DistanCE. Dr. Koffler, Dr. Thompson, and Dr. Harris will review revenue and develop procedures for processing of DistanCE payments.

*Action Item.* Dr. Koffler suggested that with the addition of Marcia Stauffer to the staff that processing of payments can be managed in the future in the main

office.

**Fellows** (George Prigatano)

Dr. Prigatano reviewed the procedure for soliciting and processing applications for Fellow status.

*MOTION:* Moved by Dr. Prigatano and seconded by Reynolds to accept 34 new Fellows to the Academy. Motion passed.

**Past Presidents Report** (Gerald Goldstein and Carl Dodrill)

Dr. Goldstein noted that the interest rate of the NAN credit card is 26%. Dr. Goldstein would like someone to explore obtaining a lower rate.

Dr. Dodrill noted that a past president's representative to the Board of Directors and to the Awards Committee needs to be selected at the annual Past President's Breakfast.

**President-Elect Report** (Ronald Ruff)

Dr. Ruff briefly discussed an idea to quantify "neuropathological" disorders such as head injury by establishing criteria to define disorders and their severity and to establish criteria to guide further evaluation.

*Action Item.* Dr. Ruff will further refine his proposal and will prepare a written proposal for consideration at the November meeting.

**New Business**

*Houston Conference Report.* Dr. Barth reported that a petition, submitted by Dr. Jim Hom, based on Dr. Reitan's recent survey, was submitted to the Board asking for reconsideration of NAN's actions in response to the Houston Conference report.

A group of individuals has expressed dissatisfaction with regard to the process of participation in the Houston Conference and have expressed concerns regarding the outcome of the report.

*Action Item.* The board asked for documentation in regards to how the Houston Conference was used to influence hiring practices. The board felt that it could not vote on any resolution without adequate documentation.

Dr. Reynolds noted that there have been decision-making issues with regard to hiring of neuropsychologists that are related to the interpretation of the Houston Conference report. Dr. Reynolds wrote a resolution that he asked the Board to adopt regarding NAN's position concerning the Houston Conference report. Dr. Reynolds read the resolution that he authored aloud and asked that the written resolution be entered into the minutes.

The draft document reads as follows:

*"Be it resolved that the Executive Board of the National Academy of Neuropsychology, while meeting in open session and having been a sponsor of the Houston Conference, views the requirement for employment that a neuropsychologist 'be trained in accordance with the principles of the Houston Conference' or similar statements to be premature and not an appropriate application of the Houston Conference document. The Houston Conference Training Guidelines are properly considered as aspirational and should not be subject to rigid application under any circumstances."* (drafted by Cecil Reynolds)

There was discussion about the mechanism of submission of the petition and its inclusion in the packet of Board Meeting materials, which did not allow Board members to adequately review the petition in advance of the meeting. It was suggested that Dr. Reitan submit his survey results to Archives of Clinical Neuropsychology in response to Dr. Reitan's request for assistance in distributing the information to NAN and Division 40 members.

*Action Items:*

- 1) Dr. Uzzell will write a letter of response to Dr. Reitan indicating that the Board of Directors will take the petition under consideration.
- 2) Dr. Uzzell will express to APA that NAN has interest in participating in the process of developing specialty track guidelines.

**continued on page 14**

*Private Practice - continued from p. 2*

which are used on a routine basis. Please note that the forms discussed in this article (available at [www.nanonline.org](http://www.nanonline.org)) use language that has been approved by my corporate attorney for use in the Commonwealth of Virginia. You need to have an attorney review any patient-related business forms and/or contracts used in your practice for compliance with your state laws. Also, each of these forms is designed to be completed on an *a priori* service delivery basis. This issue is critical in many of the circumstances relevant to these forms.

A. Intake or Referral Form: (available online) This form is typically completed during a telephone call from either the referral source, the patient or a third party. Page 1 asks for the typical information regarding the patient, while page 2 addresses insurance information. Please note that it also prompts for secondary and tertiary insurance information. Why is this relevant? It is common that a patient may have a non pre-authorization type primary insurance but the secondary insurance is a managed care plan and the preauthorization process has to be addressed. You do not want this issue to come up for the first time when the patient is already in the waiting room for his/her appointment. Page 3 is used if the referral involves a litigation or Workers' Compensation referral.

B. Patient Registration Form: (available online) Page 1 asks for the typical patient referral information. Page 2 addresses a number of specific issues which I have found to be common in my practice and which can be highly problematic if not addressed in writing on an *a priori* basis.

C. Waiver of Insurance: (available online) This form is an adaptation of the standard Medicare "Advance Notice for Medically Unnecessary Services - Waiver of Medical Necessity" form. This type of form should be used in those situations where you have a Medicare enrollee who is requesting services that are not likely to be deemed medically necessary by Medicare. This might include professional contact situations involving referrals for assessment involving civil or criminal type legal matters or administrative related testing only to determine whether the beneficiary meets the criteria for a private disability insurance award. In many situations, Federal rules still require the provider to submit the claim, even though the provider has good reason to believe in advance that the service will not meet the Medicare standard of medical necessity. This signed waiver allows the provider to bill the enrollee for the service instead of having to write off

the claim if it is denied by Medicare. For further information regarding this complex issue, please refer to the web reference [www.the-medicare.com/pubs/2000/Va/Va69color.pdf](http://www.the-medicare.com/pubs/2000/Va/Va69color.pdf) for important, additional information regarding the rules for the use of this form with Medicare patients.

An "Other Insurance" form (available online) is designed to address similar issues with patients who are enrolled in other types of insurance. This form might be used to address a non-covered service such as an educational evaluation leading to the diagnosis of a learning disability, or for forensic or purely administrative services.

D. Insurance Coverage Limitation On Service: (available online) This form is designed to be given to patients who are financially able to pay for services which have otherwise been denied or severely limited by their insurance plan. It is **not** to be used as an "opt out" with pro bono cases. Instead, the form is designed to educate the responsible party that there is a clear discrepancy between what you, the professional, has determined to be an appropriate level of service and what the insurance company has determined to be medically necessary and appropriate. The responsible party is given the *a priori* opportunity to purchase the additional services that have been denied by the insurance company for one or more reasons. You can negotiate the hourly rate with the responsible party. If the responsible party chooses not to agree to fund the non-covered services, you may still choose to provide the services, but you have the *a priori* knowledge that you will not be compensated for your time and expertise. You should attempt to clarify in advance which insurance companies will not permit this type of arrangement with a patient.

A good example of a situation where this form can be useful is when an insurance company will not authorize more than 1.0 hour of testing for an individual referred for a differential diagnosis of ADHD versus another problem. Some insurance carriers assert that a professional diagnosis can be offered on the basis of a few questionnaires and nothing else. Concerns about differential diagnosis issues and comprehensive assessment techniques are not viewed by such an insurance company as reflecting medically necessary services. In these situations, the form is designed to provide a written document indicating that the psychologist has given the responsible party, who is financially able to pay for the service, the option of purchasing the additional time to appropriately complete the consultation or to document that the responsible

party is refusing to be held financially responsible for the additional services.

### Some Closing Thoughts Regarding The Business Aspects Of The Practice Of Clinical Neuropsychology

Unfortunately, in the current health care environment, there is often a presumptive ethical/professional conflict between the level of service delivery considered appropriate for a patient and the restricted services authorized and/or actual fees paid by their insurance company. In some circumstances, the indigent patient, who can claim access to pro bono services, may actually be allowed access to a higher level of service than the “working wealthy” or those who do not qualify for indigent care but who also refuse to pay out of pocket for services which are denied and/or otherwise restricted by their insurance company.

Many health care providers no longer can afford to provide “Cadillac cost based quality of care at Pinto rates of reimbursement.” Certainly, it is easier to make business decisions regarding the extent of patient service delivery when you (or your business and its employees) do not suffer the difficult financial consequences of your choices. However, if you continue to operate your business at a loss, it is highly likely you will not stay in the business of helping others. Striking a balance between cost effective and appropriate professional level care is a difficult but necessary task in the current health care reimbursement situation.

I support recommendations that health care provided by neuropsychologists be patient-oriented in terms of care that is respectful of and responsive to individual patient needs, values and preferences. At the same time, we can educate the patient about choices that can be offered to them on a fee-for-service basis versus the restricted access often authorized by their health care insurance company.

#### References

1. Peck, E. A. (in press). Business aspects of private practice in clinical neuropsychology, in Lamberty, G. J., Courtney, J. C., & Heilbronner, R. H. (Eds.), *The Practice of Clinical Neuropsychology: A Survey of Settings and Practices*. Lisse, The Netherlands: Swets & Zeitlinger Publishers.

2. [www.the-medicare.com/pubs/2000/Va/Va69color.pdf](http://www.the-medicare.com/pubs/2000/Va/Va69color.pdf)

**Note:** if the above styled complete reference leads to a “blocked access” web response, then start with [www.the-medicare.com](http://www.the-medicare.com) website. When the web page opens, select browse - “Publications” choice. Next, elect the year - “2000” choice. Then select publication type- “Medicare Part B” choice. Next, scroll to Medicare Part B Newsletter No. 69. When this particular newsletter has loaded, go to pages 66 – 70 for the information on Waiver of Liability.

#### Minutes Summary - continued from p. 12

*Program Chair Appointment.* Dr. Uzzell raised the issue of appointing a new Program chair. There was support expressed for Dr. Troster who is prepared to assume the duties of Chair, having served on the Program Committee as Poster Chair.

*MOTION:* Moved by Zillmer and seconded by Cullum that Dr. Troster be the 2001 and 2002 Program Chair.

*Vote:* Yes: 10; No: 0 (Motion Passed)

Dr. Uzzell inquired about the successor to Dr. Troster. It was agreed that Dr. Troster will select his program committee and that typically a member of the committee is appointed as the next chair.

*Website Permission/European Meeting.* Dr. Zillmer asked permission of the Board to include NAN's website in his book. Permission was granted. He updated the Board on an idea to hold a meeting in Europe. Support was expressed for possibly holding an additional meeting in Europe at some time in the future.

*Continuing Education.* It was noted that NAN is taking a leadership role in continuing education and there was discussion about taking a lead in diversity training and related issues, perhaps by offering a comprehensive conference in the future.

*Joint Conference.* The International Bar Association has requested that NAN participate in a joint conference on a variety of topics concerning law and neuropsychology, with topics to be chosen by each organization. The Board did not feel this should be pursued at this time.

*Student Organization Proposal.* The proposal for a Student Organization was considered. The Board does not approve of the proposal to mail a survey to the student membership. The Board is not prepared at this time to develop a student organization but is agreeable to integrating students into the existing structure.

*Action Item.* Dr. Koffler and the Members at Large will meet with the students proposing a student organization at the annual NAN conference.

*Liaisons with Other Organizations.* There was discussion regarding development of liaisons with other organizations.

*Action Items.* Dr. Cullum will communicate with the National Association of Psychometrists, Dr. Koffler with American Neuropsychiatric Association, Dr. Lee with Behavioral Neurology, and Dr. Uzzell with the Society for Cognitive Rehabilitation.

*MOTION:* Moved by Cullum and seconded by Thompson to adjourn. The motion was unanimously passed and the meeting adjourned on 5/20/00 at 4:30 p.m.

# NAN distanCE

## Continuing Education Courses over the Internet

---



### **Mild Traumatic Brain Injury:**

30 CE Credits

Course Instructors: Ron Ruff, Ph.D. & Jeffrey T. Barth, Ph.D.

October 2001 Registration: in Progress

---

### **Neuroanatomy and Medical Neuroscience:**

30 CE Credits

Course Instructors:

Philip Schatz, Ph.D. & Douglas L. Chute, Ph.D.

Registration: in Progress

---

### **Ethics in Neuropsychology:**

Course Instructor: Joel Morgan, Ph.D., ABPP(CN)

Course Development in Progress

Anticipated Start Date: October 2001

**Upcoming Courses:** Neuroimaging, Sleep Disorders

---

NAN distanCE courses provide comprehensive post-doctoral training for professional psychologists. Courses incorporate asynchronous component, utilizing custom CD-ROM's containing teaching modules, movies, reprints, graphics, and all Internet-mediated content. The Internet is used synchronously to enhance communication through the use of e-mail, course-specific Message Boards, web-based Self-Testing, and Case Studies.

---

**For More Information, contact:**

**(web) <http://www.nanonline.org/nandistance/>**

**(e-mail) [info@nanonline.org](mailto:info@nanonline.org)**

The NAN **Bulletin** is published three times each year by the National Academy of Neuropsychology. The information contained in this publication is for the interest and convenience of NAN members and does not imply endorsement by the National Academy of Neuropsychology or the Bulletin editors. Advertisement specifications are available from the editors and the NAN central office.

*Correspondence regarding this issue* should be addressed to: Daniel Drane, Ph.D., Harborview Medical Center, University of Washington Regional Epilepsy Center, Box 359745, 325 Ninth Avenue, Seattle, WA 98104. Fax: (206) 731-3576. Submissions for future issues should be sent via email or on 3.5 inch diskettes to Dr. D.J. Williamson, Neurology Child & Adult, PC, 100 Memorial Hospital Drive, Suite 200A, Mobile, AL 36608, email [dj.williamson@alumni.duke.edu](mailto:dj.williamson@alumni.duke.edu).

*Send change of address to:* Administrative Assistant, National Academy of Neuropsychology, 2121 South Oneida Street., Suite 550, Denver CO 80224-2594 [e-mail: [office@nanonline.org](mailto:office@nanonline.org)].

### Board of Directors of the National Academy of Neuropsychology:

<i>President:</i> <b>Ronald M. Ruff, Ph.D.</b>	<i>President Elect:</i> <b>Jim Hom, Ph.D.</b>
<i>Executive Director:</i> <b>Josette G. Harris, Ph.D.</b>	<i>Secretary:</i> <b>Robert Elliott, Ph.D.</b>
<i>Immediate Past President:</i> <b>Barbara P. Uzzell, Ph.D.</b>	<i>Treasurer:</i> <b>Greta Wilkening, Psy.D.</b>
<i>Past Presidents:</i> <b>C. Munro Cullum, Ph.D.; George P. Prigatano, Ph.D.</b>	
<i>Members-at-Large:</i> <b>Eric Zillmer, Psy.D.; Cecil Reynolds, Ph.D.; Wm. Drew Gouvier, Ph.D.</b>	

David J Williamson, Ph.D.  
Daniel L. Drane, Ph.D.  
Co-Editors, NAN Bulletin  
National Academy of Neuropsychology  
2121 South Oneida Street, Suite 550  
Denver, CO 80224-2594