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In This Issue
Volume 63 Issue 4

Page 3
Editors Note
Rebecca Resnik, Psy.D.

Page 4
President’s Message
Shreya Patel Hessler, Psy.D.

Page 6
Continuing Education Corner
Esther Finglass, PhD

Page 8
Here + There
Stefanie Reeves, MA, CAE

Page 10
Making Assessments Meaningful to Diverse Communities
Richard Ruth, Ph.D.

Page 20
Lessons Learned: Multiculturalism, Socioeconomics and Assessment
Linda McGhee, Psy.D., J.D.

Page 27
Psychological and Neurological Testing Codes are Changing, Effective January 1, 2019
Paul Berman, Ph.D.

Page 36
Classifieds

Page 32
Cecil’s Six Things To Do To Write Effective Psychological Reports

Page 14
Neurodevelopmental and Neuropsychological Assessment of our Smallest NICU Survivors: Assessing Children with Severe Motor and Visual Impairments

Page 34
What’s to like about R-PAS?
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Welcome to a dense and diverse issue of the TMP! The term ‘assessment’ covers a wide range of clinical practices. Psychologists are among the few mental health care providers trained in evidence-based, quantitative assessment practices. Psychologists create value for both patients and clinicians by providing a deeper (and hopefully more objective) data-driven understanding of a person’s functioning. Psychologists are unique members of the clinical team. Our extensive, rigorous assessment training allows us to weave together the qualitative and the quantitative data to inform critical treatment decisions for our patients.

From a business perspective, psychological assessment has a serious ‘branding problem.’ Our field has not done a very good job of communicating the value of our assessment skills. People generally seek out testing as a last resort. To be fair, our assessment practices have a long history of cultural bias that has done harm to countless individuals (take a moment to Google the eugenics movement, early testing of immigrant populations, or The Bell Curve). Dr. Ruth’s column addresses both the shameful history of assessment but also his delight in the power of testing to improve lives. In this issue, we are also grateful to have two articles (by Dr. Gwendolyn Gerner and Dr. Linda McGhee) that address diversity and ethics in assessment practices. Even in 2018, some consumers still mistrust our assessment procedures (how many times have we heard, “I don’t want my kid labeled!”?). Prominent experts in mental health commonly devalue or argue against psychological testing in favor of rating scales or structured interviews. I am certainly not alone in the opinion that the DSM-5 could certainly have done more to promote the role of psychologists and psychological testing in the diagnostic process. Considering all this negativity associated with psychological assessment, it is no surprise that insurance companies under-value testing and too often deny coverage to those who need it most.

Speak with a psychologist who does testing for any length of time, and you will soon hear of frustration with insurance companies, high overhead costs, and small profit margins. Those of us at MPA know how hard it can be to run a sustainable testing practice. In this issue, Dr. Paul Berman authored an invaluable guide to the new testing codes coming in January 2019. I know I’m not the only one who will be reading this article repeatedly (feeling both gratitude that he wrote it, and sinking dread about what is to come!).

On the bright side, it is an exciting time to be a testing psychologist. Everyday thrilling new research about the brain informs our assessment practice. We owe it to our patients to keep up with this research, and MPA is here to help (e.g., check out the upcoming CE presentation on reading assessment by Dr. Steve Feifer). In this issue, you’ll find Dr. James Gormally’s article about the new RPAS system for using the Rorschach—a another example of how our field improves on tradition with increased scientific rigor. Additionally, Dr. Cecil Reynolds generously shared his article describing how to improve the quality of our assessment reports to enhance our impact on patient’s lives.

Enjoy and happy holidays!

Dr. Rebecca Resnik, Licensed Psychologist, Rebecca Resnik and Associates LL
Greetings, fellow MPA members,

It is an honor to serve as President of MPA this year. When I joined MPA 15 years ago as a newly minted licensed psychologist, I was overwhelmed with what lay ahead. But this association has remained a constant in my career. My first referrals in solo practice came from the MPA referral service. The listserv connected me with professionals generous with their knowledge and resources. I attended countless continuing education courses confident I was learning skills I could bring to my clients the next day. And I was privileged to present courses at convention. Participating in the Public Education committee allowed me to meet other psychologists around the state with a common interest in providing Maryland residents important information about mental health and help seeking. The Ethics Committee served as a lifeline for me as I struggled with difficult cases. And volunteering on the BOD as a representative to the Board of Examiners gave me firsthand experience about how the practice of psychology is regulated.

My experiences show that membership in MPA matters. And the organization is active and energized on many levels with the dedication and hard work of so many volunteer members.

The Legislative Committee (LC) is one of the busiest standing committees within MPA. They meet monthly throughout the year along with additional conference calls and video conferencing to discuss, debate, and research the best direction for the association to take a position on legislation and regulatory issues across the state. This means that the LC reviews hundreds of proposed bills during the 90-day legislation session every winter into the spring along with proposed regulations that are out for public comment every month. Individual members of the committee are tasked with subject matter research, writing of pertinent statements for public consumption, and direct meetings with legislators on issue of importance to our association. Without the work that they do year after year, our profession could have been eroded by attacks from other professions and their interest groups. We could have been restricted in providing services or not included in new initiatives where the perspective of a psychologist would be important such as a task force or workgroup on legislation. The LC has engaged in policymaking in areas such as school counseling, firearms and mental illness, child abuse and neglect, custody determinations, and many others.

The MPA PAC is a war-chest funded by members' generous contributions that are pooled together and dedicated to campaign contributions to candidates for state office that have made a meaningful contribution or support toward our profession. This may include sponsoring legislation in our best interest, or being a champion for the mental health industry with regards to patient access, or someone that the association would like to develop a deeper relationship with. These contributions are critical during election seasons because it helps a candidate make it across the finish line and back into
office. When a legislative champion loses their seat, it means that our association is starting over with educating new legislators on our goals and even the very basics about our profession and professional services. As a reminder, the MPA PAC is a separate entity from the association.

The Legislative Committee's collective knowledge has given us a seat at the table in Annapolis ensuring that our profession remains invaluable to those we serve. Our recent lunch and learn with Paul Berman, Julie Bindeman, and lobbyist Julia Worchester generated so much enthusiasm for advocacy that a Legislative Academy is in the works to help prepare members to have additional boots on the ground in Annapolis this upcoming session of the General Assembly.

Other committees are also actively working to serve our members in new ways. Thanks to a dedicated task force led by the incomparable Melinda Capaldi, we have a dynamic new website that will allow us easier access to information we need about upcoming courses, committee work, and the capacity to connect with our colleagues. Early this fall, MPA held an extraordinary Business of Practice workshop spearheaded by our Professional Practices Committee. With so much positive feedback, future programs will grow from half day to full day with larger space to accommodate attendees. The response to these and other workshops is a testament to the work of our Educational Affairs committee to secure the best quality courses are offered to our members.

Our Diversity Committee is growing and has recently contributed to developing statements on issues on behalf of the organization. These statements have been crafted to address our commitment to our members and consumers of mental health services so that they feel seen, heard, and supported. Recently, our BOD met to discuss this trend of reactive statements and how we as an organization can instead be proactive and put words into action. As we continue to provide resources for those affected by issues such as youth violence, immigration trauma, and sexual assault, we are actively working to connect with community organizations to help those who are underserved. We will need to consult not only with those providing direct services, but also academic psychologists in our state who have researched these issues extensively. It is my hope that these ventures will combine scholarly work and practice to serve our Maryland residents.

Finally, another initiative involves the maintenance and access to institutional knowledge. As we are energized in growing our organization and adapting to changing times, we recognize the tremendous value of those who have previously served in leadership. Throughout this year, we are inviting past presidents to attend executive committee meetings with the hopes of creating an advisory board. It allows those of MPA past to impart wisdom and experiences to MPA present, to guide MPA in the future.

It is an exciting time to be a part of MPA. I am in awe of the energy, intelligence and drive of the BOD and our committees. Their commitment to protecting and enhancing our profession is steadfast and strong. I welcome you to be a part of the story. Your contribution, no matter the size, needed. I look forward to working with and serving you this year.

Yours,

Shreya Patel Hessler, Psy.D.
MPA President
Another year is winding down as we prepare for holiday festivities shared with family and friends. With Thanksgiving leftovers still in my fridge, I think about gratitude, especially for our MPA family and the lifelong friendships I have found within our ranks. I am grateful for the opportunities throughout the year to meet up at continuing education events. Just last month, I reconnected with cherished friends who relocated to the New York-Canadian border and traveled to be a part of our fall convention, as they do every year, to rekindle relationships.

We have just completed the first revised Post-Doctoral Institute (PDI) on Attention Deficit/Hyperactivity Disorder and will survey participants for feedback. If you attended one or more of the workshops, please share your impressions and suggestions with me at Efinglass@estherfinglass.com. We let no grass grow beneath our feet. The next PDI on Major Mood Disorders starts early next year with 9 workshops scheduled between 2019-2020. Participants can sign up for the full complement or an abridged 6 workshop series for PDI certificates or join us for individual workshops. After each one, PDI members meet for in-depth discussion and supervision with the presenter. The series begins on February 22 with an introduction by the PDI Esther Finglass, PhD Chair, Educational Affairs Committee
MPAF Continuing Education

Jan. 11, 2019
The Neuropsychology of Reading Disorders: An Introduction to the FAR
Steven Feifer, D.Ed.

Jan. 28, 2019
Working in a Tertiary Care Setting
Linda Herbert, Ph.D.

For more details about the upcoming workshops and/or to register: https://www.marylandpsychology.org/psychologists/continuinged.cfm

coordinator, David Roth. On May 3, David Jobes will present on Suicide and Parasuicide. In the fall, we focus on treatment with a workshop on October 21st on psychological treatments including psychodynamic and cognitive-behavioral therapies and on November 1st on medical and somatic treatments. Specific populations will be addressed in 2020 with a workshop on January 10th on mood disorders in women, on March 27th in children and adolescents, on October 16th in the elderly. We will also have a session dedicated to grief (date TBD) and on May 8th on bipolar disorder.

We welcome back some assessment rock stars this year. On January 11, Steven Feifer, author of the Feifer Assessment of Reading, will discuss the Diagnosis of Reading Disorders. Starting in May, James Gormally will provide a 2-part series on the RPAS Rorschach scoring system and in December, George McCloskey returns for a 2-part series on the Assessment and Treatment of Executive Functioning.

Please join us on February 8 for a workshop on Comprehensive Behavioral Interventions for Tic Disorders presented by the Tourette's Association in conjunction with the Centers for Disease Control.

The annual Essential Requirements Conference will be held on March 8 for ethics, diversity, and supervision training. Morning topics will include a new model for Diversity Training, Communications about Diversity in the Workplace, working with Aging Populations, and Countertransference in Supervision. As always, the ethics committee will present in the afternoon with discussion of ethical vignettes.

Please check our website for webinar updates. That workshop you meant to attend might just be there.
Speaking of convention, a big shout out to our Educational Affairs Committee, our speakers, our awardees, volunteers, staff and attendees for a great annual convention. Hearing positive feedback about sessions, speakers and, speeches made during the awards luncheon. Mark your calendars now for the 2019 Convention on Friday, November 1, 2019 at the BWI Marriott. Another exciting event coming up in 2019 is our next Business of Practice event. This year, over 60 psychologists joined us at the Women’s Club in Bethesda for a morning of sharing best practices about business development and promotion. Besides filling nearly every seat at the Women’s Club, we’ve found that we have way more content than time to present. In years ahead, we’re looking to shift to an all-day workshop. Fingers crossed, we can start that transition in 2019. Another big change for us is our location. We’re approaching our first anniversary in our new digs at 10480 Little Patuxent Parkway. While the space is smaller than our previous office, we can still provide the same level of quality service you expect here at MPA. Our conference room still hosts our Board and committee meetings as well as lunch and learns and a few 3-hour workshops.

Stefanie Reeves, MA, CAE
Executive Director

If you haven’t had a chance to visit us, please do so. We’re on the 9th floor in suite 910!

I’ve been the Executive Director for MPA for over 3 years now. As with any position, it hasn’t been without its challenges. However, I consider myself one of the lucky EDs with members who care about this association. I’m grateful to everyone who has reached out to me over the last three years with your suggestions, your observations and your support. I wouldn’t have made it this far without you. Happy Holidays and best wishes for a peaceful and fulfilling 2019. See you in January.
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AND NOW WE'RE ON INSTAGRAM! @MDPSYCHOLOGY
Psychoanalysts get a lot of strange looks. And trust me: The looks get even stranger when people find out you’re a psychoanalyst interested in assessment. “It’s bad enough you can interpret my dreams,” I was once told. “But you do it by looking at inkblots? You are one weird dude.”

I took it as a compliment. Somewhere in the playful banter was respect for my scientific expertise. With wary teenage awe, my interlocutor was acknowledging that my dream and Rorschach interpretations were on the mark.

This issue of The Maryland Psychologist addresses just how much advances in psychological assessment offer our patients, their families, the broader mental health effort, and our society. I could not agree more! My effort in this column will be to ground my excitement and appreciation in what psychoanalysis, with its contemporary emphasis on multiculturalism and diversity, can uniquely contribute to our collective assessment efforts.

Psychoanalysis believes an understanding of the past can usefully inform the future. So, a story (from the work of Chilean psychologists Elizabeth Lira, Eugenia Weinstein, and their colleagues):

In its dying years, the Pinochet dictatorship, aware its dominion was ending, released psychologically devastated political prisoners back into their communities. Poverty, repression, and state violence remained pervasive; the regime’s hope was that communities witnessing, up close, how ex-prisoners had been devastated by severe, complex trauma would shut down any potential sproutings of collective resistance.

The psychoanalytic psychology community responded, setting up semi-clandestine clinics to offer treatment and hope to the returning prisoners. But the clinicians
were surprised. The ex-prisoners told the psychologists they did not want therapy. They wanted “IQ tests,” so they could understand what their imprisonment and torture had damaged, and what of their capacities had survived with intact potential. To their credit, the psychologists responded.

* * * * *

I did not become a psychologist intending to conduct assessments. I wanted (still want) to serve the communities I belonged to (still belong) – people of Latinx, LGBT, and working-class backgrounds – with the healing psychotherapy can bring. The available assessment tools at the time I trained were both powerful and problematic, saturated with pervasive race, ethnicity, socioeconomic status, gender and other biases the test developers and users disavowed. Too often, unreliable and invalid results were used as “scientific” justification to pigeonhole whole populations onto paths to nowhere good. I knew something was wrong, and I wanted no part of it.

What changed my mind? In a way, a US version of what Lira, Weinstein and their colleagues found.

Working as a Latinx psychologist in community mental health settings, I met family after family, patient after patient, who wanted to know what was going wrong in their lives and what could be done about it. They liked me as a therapist, but even more they wanted my diagnostic expertise. And, pragmatically, the jobs available to me wanted me to do “testing.” There was something inescapably legitimate – market-driven, in the best sense of the term – about the demand.

I have been very fortunate to have had supervisors and colleagues, as I trod the long road to becoming a clinical psychologist, with multicultural awareness and attunement, depth of assessment skills, and a passion for what good assessments can offer. And they taught me something that has stayed with me: Since racism, sexism, poverty, and trauma cause psychological damage to those they oppress, how can we not see those effects in test results? That is not about labeling; it is about using assessment as a tool that unearths important truths and leads to transformative understandings and individual and community empowerment.

To do that – the psychoanalytically informed assessment tradition offers, with solid scientific grounding - we have to meld what can be learned from nomothetic assessment data with full appreciation of a patient’s multidimensional and idiosyncratic emotional life, development, and sociopolitical/sociocultural context. In other words: Assessment is done by psychologists, who think and work integratively, bringing together the variety of kinds of relevant data as we frame our
findings and recommendations.

To approach this key point from a different direction: Multiple traditions inform clinical psychological assessment. One, originally deriving its conceptual basis from eugenics and other repugnant belief systems, focuses on categorization and on diagnosis in a narrow, rigid sense – somewhat crudely put, who is and is not “normal” or “exceptional.” Psychologists in the other tradition, colleagues who drew creative inspirations from psychoanalysis – people such as David Wechsler, Lauretta Bender, and the generation that pioneered the clinical use of the Rorschach – were more interested in understanding individuals as individuals, and how they could best be helped. This tradition, indeed, has given us data that have led to important breakthroughs in our collective breaking-down of prejudices and misconceptions and helped us understand the gifts, resilience, and potential of diverse populations.

Sometimes, the two traditions have been in fruitful dialogue and have helped each other evolve. Sometimes they have collided and clashed. I worry that we are in a time of such difficult disjuncture now. Two recent examples:

I am proud that there is a powerful trans movement – forging welcome advances in rights, family and social embrace, and trans community capacity-building at state and local levels, if not, currently, at the level of federal policy – and that APA has adopted guidelines for psychological work affirmative of trans and gender-nonconforming people. More and more, trans people seeking support for gender-affirming medical and surgical treatments turn to psychologists for our assistance.

Many psychologists want to use our assessment tools in our clinical efforts to be of service to our trans patients. The problem? Not one of our published test measures – even those (very) few with gender norms – has trans norms (for an authoritative review, see https://www.researchgate.net/publication/312247045_Affirmative_Psychological_Testing_and_Neurocognitive_Assessment_with_Transgender_Adults).

On a different front: This past summer, at APA, I was eager to look over the wealth of new Spanish-language tests that are being published. Credit card in hand, smiling, and hopeful, I visited the exhibitor booths and asked to see both test materials and technical manuals (I’m funny that way). I was ready to re-tool with up-to-date, robust measures.

But I was disappointed again. The measures I saw were user friendly and elegantly designed, but developed on populations with small n's and not representative of the diversity of US and immigrant Latinx populations I serve. Some used awkward translations of items into Spanish; proffered measures of predictive validity were wanting. I spoke with one salesperson, who sheepishly acknowledged the limitations. The company had difficulty getting people to participate in their test development studies. With the
lack of sensitivity to critical test development issues in the tests being sold and for the intended patient populations, I could see why.

What To Do?

I am in hearty favor of not throwing the proverbial baby out with the proverbial bath water.

Again thinking back to my foundational training, I was taught that psychological assessment measures have inherent weaknesses, so psychologists look for sources of convergent data across test measures and use our overall impression of clinical context in transforming test results into meaningful assessment findings. That still makes really good sense to me.

I hope you will join me in welcoming, with enthusiasm, all the innovations in assessment that are blossoming, reflecting advances in neuropsychology, behavioral assessment, our understanding of cognition, technical innovations in our understandings of reliability, validity, and other important facets of psychometrics, and – equally important – our commitment to “give away” psychology so it can serve the range of diverse, multicultural communities that can benefit from what we have to offer.

But, please – let’s also remember our past. Let’s re-affirm that understanding emotions cannot be done solely using self-report measures. Let’s resist the temptation to let bright, new, shiny assessment measures seduce us – let’s hold them to the rigorous scientific standards that make our assessment work worthwhile.

And by all means, let’s not let the imperfect development of our science and our profession keep us from placing all we have to offer at the service of the communities who seek out our assessment work. After all, isn’t that why we became psychologists in the first place, and what keeps us in our complicated, demanding, always engrossing, and not infrequently life-saving work? Neurodevelopmental and Neuropsychological Assessment of our Smallest NICU Survivors: Assessing Children with Severe Motor and Visual Impairments
Neurodevelopmental and Neuropsychological Assessment of our Smallest NICU Survivors: Assessing Children with Severe Motor and Visual Impairments

Gwendolyn J. Gerner, Psy.D.

There is increasing awareness in how we need to conceptualize diversity issues within the context of psychological practice, and this includes neurodevelopmental and neuropsychological assessment of our youngest and smallest Neonatal Intensive Care Unit (NICU) survivors. Preterm birth is defined as birth < 37 weeks gestation, with children born <=32 weeks gestation being at the highest risk of major neurodevelopmental consequences of preterm birth (e.g., intraventricular hemorrhage, post-hemorrhagic hydrocephalus, periventricular leukomalacia, retinopathy of prematurity) and associated elevations in rates of severe disabling conditions (e.g., cerebral palsy, intellectual disability, visual and hearing impairment). Based on the March of Dimes Report Card (2014-2016) for Maryland alone, the overall rate of preterm birth is 10.5% statewide, with rates increasing across most counties.

Psychologist are often tasked with providing care to children born preterm, as they frequently present in a variety of clinical settings due to concerns that range from severe developmental delays and sensory impairments to learning, attention, social/ emotional, and behavioral problems. Neurodevelopmental or neuropsychological assessment of these children are critical, as such evaluations provide diagnostic clarification and targeted treatment recommendations. While those children who have high frequency and low severity concerns (e.g., mild fine motor problems, attention problems, etc.) can generally be evaluated using traditional standardized measures, assessment becomes increasingly challenging when a child has one or more severe morbidities commonly associated with preterm birth, such as visual and severe motor impairments. Despite the presence of these visual and severe motor impairments, conducting early neurodevelopmental assessments remains critical, as the earlier we are able to provide more specific information about a child’s neurodevelopmental course within the context of severe motor and visual impairments, the more opportunity we have to capitalize on periods of peak brain plasticity and influence long-term outcomes.
As such, what are the factors we need to consider when providing psychological or neuropsychological assessments for young children who have visual and severe motor impairments following preterm birth? With regards to visual impairment, there are many different types of abnormalities of the visual system that can negatively impact the perception of visual stimuli presented during a standardized neurodevelopmental or neuropsychological evaluation. Some examples include retinopathy of prematurity, uncorrected refractive errors, nystagmus, optic nerve atrophy, visual field cuts, or oculomotor abnormalities. Additionally, cortical vision impairment (CVI) is more common among children born very preterm, especially those who sustained structural brain injuries of intraventricular hemorrhage, post-hemorrhagic hydrocephalus, hemorrhagic infarction, and/or periventricular leukomalacia (PVL). CVI can be diagnosed as early as age 6 months, but it is often not diagnosed until much later or not recognized at all. CVI requires a multi-disciplinary team to make the diagnosis, as factors such as imaging findings, visual evoked potentials, EEG, ophthalmology exams, and a functional vision assessment; however, psychologists and neuropsychologists completing evaluations for children born very preterm should be aware of some of the behavioral symptoms in case CVI has gone unrecognized and/or testing accommodations need to be made (Chorna et al., 2017). Symptoms of CVI may include preference for looking at lights, viewing objects in the peripheral fields through the corner of the eye, better perception of objects when they are moving (e.g., spinning toys) or when they move from the peripheral field, difficulty with highly dense and detailed visual stimuli, and preference for higher contrast and more saturated colors (e.g., white, black, red, yellow). It is important to ask targeted questions about such symptoms within the clinical interview. Furthermore, it is important to consider that there is some overlap with other more widely recognized developmental disorders that are more prevalent in children born preterm, including Autism spectrum disorder and emerging attention difficulties. As such, within the context of the case conceptualization, careful consideration should be given to whether symptoms are best accounted by visual impairment another neurodevelopmental disorder or a combination of both.

Diagnosis of severe motor impairments following preterm birth are made by a child's medical team during infancy through the toddler years; however, on some occasions less severe forms
or specific types of cerebral palsy may not be recognized until a child is older. Thus, informal and formal examination of motor skills is necessary, as well as a thorough developmental history regarding achievement of developmental motor milestones and current functions. In terms of the conceptualizing the impact of motor impairments on development, it is important to recognize that proper development of the motor system allows for exploration and learning about the environment. This is especially evident in a child's development of visual perceptual and problem-solving skills, as limitations on a child's ability to move decreases opportunities to learn about spatial relationships and access opportunities for cause-and-effect learning. Conversely, motor impairments also negatively impact a child's ability to demonstrate knowledge, including use of pointing or gesture to indicate a response choice and even ability to use speech to communicate knowledge. When severe motor impairments and visual impairments co-occur this has even greater impact on learning and development, as well as a child's ability to demonstrate knowledge.

Providing direct testing within the context of visual and motor impairments can be challenging and there are few measures neurodevelopmental and neuropsychological measures adapted and normed for visually impaired and/or severely motor impaired young children. An adapted version of Bayley Scales of Infant Development, Third Revision (BSID-III) for low vision and motor impaired populations exists; however, the norms utilized are from the original BSID-III (Visser et al., 2014; Morgan et al, 2018). Other more common measures were recently reviewed at length by Morgan et al (2018), breaking down the best measures for children with severe motor impairments based on psychometric properties for discriminating disability from no disability, prediction of later outcomes, and evaluating treatment changes. The tests that received the best ratings for discriminating disability from
no disability are the BSID-III, the Battelle Developmental Inventory, the Capute Scales (i.e., CAT/CLAMS), the Mayes-Motor Free Compilation (MMFC), and the Infant Psychological Development Scale. The Fagan Test of Infant Intelligence and the Capute Scales received the best overall ratings for ability to predict future outcomes. Finally, the Mullen scales of early learning demonstrated the best psychometric qualities for evaluating response to treatment. Therefore, different tests may address different needs within the context of a given referral question.

Use of the abovementioned measures may still require adaptations for visual and/or severe motor impairments beyond standardized administration. For instance, if a child is non-verbal or has speech that is unintelligible may need to use of eye gaze when providing responses. When evaluating children with problems with visual acuity or CVI, enlargement of stimuli and increase in contrast may be necessary, and advances in technology have made stimuli more easily accessible through tablets or if pictures of the stimuli are taken with a tablet. In other instances, stimuli may need to be exchanged for different stimuli based on characteristics that maximize visual processing and multi-sensory exploration. It may be helpful to conduct assessments in front of a black or white trifold board to limit complex visual information in the background for children with CVI. Finally, the most important accommodation is to increase wait-time for a response.

Ultimately, specialized training in the assessment of children with visual and severe motor impairments is critical before performing such evaluations; however, visual impairment may be less obvious prior to an evaluation and considering this as an underlying factor in a child’s performance difficulties is necessary. Furthermore, those evaluating children with histories of brain injury within the context of very preterm birth should also have specific knowledge about and experience with the neurodevelopmental complications in this population that map onto specific behaviors across early development.

References:


Congratulations to all of the 2018 MPA Awardees!

Outstanding Volunteer Contributions to MPA
Esther Finglass, Ph.D.

Outstanding Contributions to the Education and Training of Psychologists
Steven Feifer, Ph.D.

Outstanding Scientific Contributions to Psychology
David Jobes, Ph.D.

Grady Dale Jr. Award for Outstanding Contributions to Diversity in Psychology
Harriette Wimms Ph.D.

Outstanding Legislator of the Year
Del. Meagan Simonaire

Outstanding Lifetime Professional Contributions to Psychology
Edward Shearin, Ph.D.

Congratulations to all of the 2018 Poster Session Winners!

First prize of $250:
Subjective improvements in substance abuse disorder associated with 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT)
Kasey Cox - Loyola University Maryland

Second prize of $100:
Does Stress Hurt or Help Us? Gender Differences in the Relationship Between Stress Mindsets and Internalizing Symptoms
Hilary R. Hoagwood - American University

Third prize of a free MPAGS membership:
An Exploration of Mindfulness Factors in Aiding College Counseling Centers
Rachel Simms - Loyola University Maryland

and

Children's Utilization of Health Care and Parenting Stress as Predictors of Child Behavior Problems
Cierra Stanton - Loyola University Maryland
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Lessons Learned: Multiculturalism, Socioeconomics and Assessment

Linda McGhee, Psy.D., J.D.

A single case, years ago, heavily influenced my thinking and philosophy about testing. A young woman, from a minority culture, sought out testing because she had some learning, attentional and processing difficulties. Because she came from a family of very modest means and an inner-city, impoverished school system, she had not received testing or accommodations in her earlier years. She struggled in her undergraduate studies and wanted to pursue graduate school, but she needed accommodations to take standardized testing. Testing revealed such accommodations were clinically indicated, but as she had not been diagnosed earlier in life, the woman was unable to get the much-needed accommodations for graduate school. It was this sobering reality that has shaped my thinking about cultural and economic barriers to assessment. While diversity in all of its iterations is important, the intersectionality of culture, socioeconomics and assessment are the prime focus here.

The United States is a diverse nation and is becoming more so in recent history. The number of people from minority ethnic groups and their relative proportion in the population is increasing dramatically. In the years between 1990 and 2000, the Asian/Pacific Islander and Hispanic/Latino populations each increased by fifty percent.¹ In some urban areas (Washington, D.C., Detroit, San Francisco and Miami), ethnic minorities represent over 50 percent or greater of the population.² This trend is expected to continue. Sometime near the middle of this century, no ethnic group will have over fifty percent of the population.³ Clinical psychology has long held its focus to the internal psyche of the individual. A chief critique of our field has been its slow reckoning with culture and race. This is likely rooted in the same reluctance to engage meaningfully on matters of race and culture that exists in the society as a whole. In the last decades, the field of psychology has turned a more focused eye toward multiculturalism. Paul Pederson has gone so far as to name multiculturalism as the fourth force. He argues that each era of psychology represents a major movement in counseling, and that multiculturalism follows the eras of psychoanalysis, behaviorism and person-centered/humanistic psychology as the fourth force.⁴ Notably, a large portion of psychology’s multicultural focus has been centered on therapy as opposed to assessment.

Considerations of affordability have also been an issue in psychotherapy, but accessibility is particularly acute in testing. The median household income in the US is just over $55,000. Even though Marylanders have the highest U.S. median income with $78,000 (data from 2016), testing fees represent a large investment relative to earnings.⁵ Of course, affordability is taking place in the backdrop of rising income equality in the United States. Twenty-five percent of U.S. workers make less than $10 per hour, which
aggregates to a below poverty-line existence. Yet at the same time, the top ten percent of Americans by income control fifty percent of U.S. income, the highest proportion in U.S. history.⁶

The price of an educational or neuropsychological assessment varies widely but can range from just over one thousand to over four thousand in the Washington D.C. area. Typically, these fees are due at the time of the first appointment. Some insurance companies cover testing, but it is usually for a portion of the fee. It is often difficult to get insurance coverage or reimbursement for educational testing, i.e., testing for the diagnosis of learning disorders. Public school systems and the special educational bureaucracy often deny testing to children who desperately need it. Months-long waiting lists often greet those seeking within network testing. Thus, high quality assessments are often less available to those families with modest means. In addition, a full battery of test could involve up to 6-8 hours of assessment time, and extra time is often necessary to secure input from interested parties, and to review results. Therefore, parents and clients have to take significant time away from work or school in order to be tested, which may also impact family finances.

In the practice of psychology, the essential question is whether we, as clinicians, are appropriately considering culture/race and socioeconomics in our analysis of assessment cases. Yet, it is important to frame our psychological analysis in psychological theory.

While there are many theoretical frameworks by which to view diversity, Sue and Sue’s tripartite model is instructive in organizing thinking about the relative weight of culture in shaping functioning. When analyzing individuals presenting themselves for an assessment, the Sue and Sue model suggests that the client should be considered as a unique individual with idiosyncratic characteristics. The second level involves consideration of the groups to which the individual belongs. The third layer to consider are those experiences and events that are shared across humanity.⁷

With a theoretic framework by which to contextualize race, culture and socioeconomics, the next logical place to begin our quest to become more culturally-competent testers are our guiding tenets and ethical code. The APA’s Ethical Principles of Psychologists and Code of Conduct is instructive. A primary guiding principle is first, do no harm. Our practice of assessment of multicultural and economically diverse populations should place our clients in no worse shape than we find them. Respect for human rights and dignity is another guiding principle. There are ethical prohibitions against discrimination based on race, ethnicity, socioeconomic status (and religion, disability or sexual orientation). In addition, competency in addressing populations of diverse ethnic and economic backgrounds are also necessary. As it specifically relates to assessment, the Ethical Code indicates that the psychologist should consider the purpose of the testing, test factors,
test-taking abilities, and other characteristics of the person being tested, including situational, linguistic, personal and cultural factors. The Ethical guidelines also encourage psychologists to outline with clients and interested parties the limits of assessment. Section 9 of the Ethical Code addresses assessments in terms of competency, consent, test interpretation and uses of assessments.⁸ Beyond the ethical code, the latest iteration of the DSM, the Fifth Edition, explicitly sought to include “keys aspects of culture relevant to diagnostic classifications and assessment.” This is done in a myriad of ways in the DSM-5 including cultural considerations that are incorporated into disorder descriptions. The DSM-5 includes an Outline for Cultural Formulations, which is designed to aid clinicians in assessing culture and the blueprint for interviewing clients called a Cultural Formulation Interview. There are “cultural concepts of distress” also contained in the DSM-5 glossary, detailing psychological syndromes related to various cultures around the world. In addition, there are numerous journals and APA Section 45, which are devoted to multiculturalism as it relates to the practice of psychology.⁹

Given some knowledge of theoretical frameworks and ethical guidelines, how do you apply such knowledge to practical situations. Well, it starts with awareness. Awareness of one’s own cultural background and the acknowledgement of the importance of culture in understanding your clients. In addition, cultural competence consists of the acquisition of skills and capabilities that would enable one to navigate an increasingly diverse world. This process involves a great deal of self-examination, reflection and the knowledge that bias, prejudices and “isms” might work to color our perceptions and internal classifications of others. This self-examination should include clients from cultures that are similar to our own as there are presumptions (not necessarily born out) of shared experiences of individuals from similar cultures.¹⁰

Beyond self-examination, how do you improve your skills in culturally competent testing? Consider training on multiculturalism and culturally-aware testing. Resources include APA (Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations).¹¹ MPA seminars and training on multiculturalism, accessibility of services and assessment. In addition, consider supervision groups or individual supervision. If you are assessing multicultural and socioeconomically diverse populations, consider a testing supervision group. If there are none available, consider forming one. You could also seek out individual supervision periodically to discuss areas of concern, get insight or discuss strategies.

In terms of the testing environment what kind of practices are consistent with culturally and economically-aware assessments? Here are some practical guidelines that I have found to be useful over the years. Of course, some of these suggestions are applicable to all testing clients but may have particular significance with diverse populations.

**Pre-Assessment**
- **Referral Question/Clinical Interview.** Thorough clinical interview and background questionnaire in order to understand and refine the referral question. Review relevant information impacting culture and socioeconomics.
- **Education about Testing Process.** As some individuals from various cultural and economic backgrounds may have less exposure to what testing entails, a thorough explanation of the process is usually indicated. A favored approach is to ask respectfully what the clients know generally and if they have questions about various aspects of the assessment. Questions such as “Would you like for me to explain...?”, “Before we begin, do you have questions”?
- **Family History.** Awareness that family history may vary between cultural and socioeconomic groups as older family members may have learning, attentional or emotional issues that have not been diagnosed due to lack of access to testing. (Alternatively, some family
histories may have instances whereby certain members were pathologized incorrectly). In addition to questions about official diagnoses of family members, I sometimes ask if siblings, relatives have had academic, focus or emotional issues or problems in school, even if there is no diagnosis. Questions like “Anyone in your family have problems in school? Social difficulties? Did someone repeat a grade? Drop out of school?”

- Analyze whether testing is the appropriate means to answer the referral question. Are there other means? If the testing is appropriate, is it needed now?

- Detailed conversation about expectations of the testing, what does the client or parents see the results are being used for. Discussion should also incorporate school or work expectations and/or access to testing. Are there reasons that others want testing that may not be known or understood by the client, e.g., use of testing in the process of “counseling out” individual from a certain educational setting or assignment to a special program.

- Conversation with parents or client acknowledging and normalizing their fears of stigmatization. Helping them to work through concerns about stigmas is a process in which those labelling concerns are balanced against the benefits of early diagnosis and treatment of a child’s deficits.

- Speak to client/parents respectfully about the costs of the assessment. If you think affordability is a problem, ask. I typically ask if they would need services covered by insurance. Have knowledge of places where testing may be found at lower cost, including the client’s public school (even if they are in private school), local university training programs, local children's hospital, and low-fee clinically based programs. If the client is in a private school, encourage client/parents to discuss with school the possibility of testing fee support, which some schools offer commensurate with financial aid. But review implications of who is the client (and who owns the testing) when the school funds testing.

- What do you do if the client asks for a member of their own race or culture to perform the assessment? I have also been asked to discuss the relative merits of matching race in the testing environments. In my dynamic training, I was taught to use these queries as a part of the treatment. I generally ask them what their ultimate goals are. I also try to delve into the reasons behind for this request, as it often is a sign of anxiety over the testing. I do discuss relevant data and research about matching therapist of the same culture.

- If English language capabilities are not strong, consider referring to a tester who speaks and/or administers assessments in that language.
Testing/Testing Environment

- In my experience, some members of minority cultures may be sensitive to the scrutiny involved with testing. So, special efforts to make testing environment relaxed and as non-judgmental as possible. I take some time to get to know the clients by engaging in some small talk with the dual purpose of getting them to relax and to get information about how they are reacting to the testing environment. Sometimes, if the test client exhibits marked signs of anxiety, I often stop and inquire about it.

- Ascertain if language capabilities are consistent with prior representations. Also gather information on the number of languages spoken in the home and note which language was learned first. A related area is noting if the child is in a language immersion program as there are well-documented impacts of immersion on knowledge acquisition.

- Use a variety of instruments in order to have strong corroborating data. Limit placing strong weight on outlying data. Explain outlying data.

- Include tests that have attempted to increase cultural representation in normative sample (e.g., MMPI-2 and WISC-5).

- Consider and inquire about client’s exposure and proficiency of technology prior to using digitally-mediated testing, e.g., Q-Interactive, use of I-Pads and laptops.

- Consider nonverbal intelligence measures as these tests can reduce cultural influence inherent in some verbal assessments.

- If subject is anxious and is missing questions that I think they know, I score test as indicated by the instructions but sometimes re-ask questions to ascertain underperformance.

Disseminating Results/Post Test Environment

- Recognition that some family may be extremely wary of what the testing will produce and be very protective of information. I attempt to place the family at ease by thoroughly explaining the testing results. Often, the testing psychologist can assist with the dissemination of the report with the family, client, school and other interested parties.

- Beginning in adolescence, having an age-appropriate conversation with the client about the test findings.

- Speak to strengths as well as challenges in reports. Include in reports a discussion centered on how strengths could be used as building blocks in the academic and social environments.

- Awareness of the utility and emotional and sociological impact of some recommendations, e.g., red-shirting, repeating a grade or not attending college. That is not to say these issues are never discussed but understanding how certain groups might perceive such discussions or recommendations.

- Explain in report if client speaks other languages in the home. If English based language scores are depressed, note key information about whether English is the first language. Also, consider including non-verbal measures.

- Note information about key differences in school-systems from other countries, e.g., school year encompasses different months in Australia.

- Outline who is the client and who “owns” the results of the testing and whether and to whom clients should release report.

- Consider redacting sensitive information from reports being released to schools and to numerous outside entities.
References:
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MARYLAND PSYCHOLOGICAL ASSOCIATION
Psychological and Neurological Testing Codes are Changing, Effective January 1, 2019

Paul C Berman, Ph.D.
MPA Professional Affairs Officer

We have been through a number of Current Procedure Terminology (CPT) coding changes over the years involving the codes for psychotherapy.¹ It is now time for a significant change in CPT testing codes and on January 1, 2019 all of the codes for psychological testing and neuropsychological testing will change.

There are more than 10,000 CPT procedure codes published annually in the CPT Manual. Each CPT code is assigned a relative value unit, or RVU. RVUs are based on three main components:

- The time and the intensity of the work required by the practitioner;
- Practice expenses (mental health professionals have low practice expenses – desk, phone, computer, chairs, and Kleenex) while services which require expensive equipment (MRIs) or additional staff to assist in the service (nurses) have high practice expenses; and
- Professional liability.

The RVUs are then multiplied by Medicare's annual conversion factor (which changes year to year based upon budgetary issues) to arrive at the dollar amount Medicare will pay for each CPT code. While this is how Medicare rates are determined, commercial insurance companies benchmark their annual reimbursement rates against the fees established by Medicare.

¹ When I first started in practice, the CPT code for psychotherapy was 90844. In 1998, that code was replaced by CPT code 90806 (for a 45-50 minute therapy session). CPT code 90806 eliminated in 2013 and replaced by CPT code 90832 (for a 30 minute session), 90834 (for 45 minute session), and 90837 (for 60 minutes for more).
CMS has been pushing for changes to the testing codes
For a number of different reasons having to do with the technical underpinnings of the psychological testing codes, the Centers for Medicare and Medicaid Services (CMS) has been pushing to reassess the “work” related value for the psychological and neuropsychological testing codes. As a result, the APA Practice Organization devoted considerable resources over the last several years to ensure that the re-evaluation of the testing codes was done fairly and recognized the many hours of time spent throughout the testing process including reviewing documents, time required to decide which tests will be utilized, administering the testing, scoring the testing, integrating findings, and writing the report. APA Practice worked with the AMA multi-specialty sub-committee in charge of assessing and revaluing CPT codes. The re-evaluation process for each CPT code results in this AMA specialty sub-committee making recommendations to CMS about the specific “work” value which they believe should be assigned to each revalued CPT code. CMS is not required to take the recommendation of the specialty sub-committee so additional APA Practice Organization resources were also devoted to working with CMS to accept the revalued testing codes.

Conceptual Differences between the old codes and new codes
The new codes differentiate between:

1. Time spent administering and scoring the testing, and is sometimes referred to as “technical services”;

2. Time spent interpreting and integrating the testing data, decision-making, treatment planning, writing the report, and providing feedback to the client/family members/caregivers, and is sometimes referred to as “test evaluation services” or “professional services”;

3. Whether the test administration and scoring are completed by a psychologist/neuropsychologist or a technician; and

4. A single stand-alone computer screening test and a battery of neuropsychological or psychological tests.

Current Testing Codes are eliminated
January 1, 2019

All current CPT codes for testing (e.g., 96101, 96102, 96103, 96118, 96119, and 96120) will be eliminated on January 1, 2019 and replaced by seventeen new codes. I will discuss the changes to the testing CPT codes in this article. For additional information, please see the APA Practice website (www.apapracticecentral.org) which has several good single page explanations of the changes. In addition, the APA Practice Organization sponsored two webinars by former APA President Antonio E. Puente, Ph.D. and Neil H. Pliskin, Ph.D., who is a member of the AMA/CPT Health Care Professionals Advisory Committee on behalf of APA, and both webinars are also available on the APA Practice website.
New CPT codes for psychological and neuropsychological testing

   The same coding principles apply for psychological testing and neuropsychological testing but the specific codes utilized are different. I will start with psychological testing.

   Psychological Testing. CPT code 96130 is coded for the first hour spent providing “Test Evaluation Services” and CPT code 96131 is coded for each additional hour providing “Test Evaluation Services.” CPT 96131 may be used when at least 31 minutes is spent providing this service. This is considered the “cognitive work” required to provide “Test Evaluation Services” including preparation for the testing (deciding which tests will be administered), interpretation and integration of the testing results, treatment planning, clinical decision-making, report writing, and interactive (face to face) feedback to the patient, family members, or caregivers.

   CPT Code 96130 is coded for the first hour of this professional time. Billing will never include more than once CPT Code 96130. CPT Code 96131 is used for additional professional time providing “Test Evaluation Services.” Each unit of 96131 is also 60 minutes, but can be coded if the professional spends as little as an additional 31 minutes beyond the first hour. So, for 1 hour and 35 minutes of “Test Evaluation Services” provided by the psychologist, the coding would be 1 unit of 96130 and 1 unit of 96131; for 2 hours and 45 minutes the psychologist would code 1 unit of 96130 and 2 units of 96131; and, if the psychologist spent 3 hours and 15 minutes of time providing these services then the billing would still be 1 unit of 96130 and 2 units of 96131.

   Neuropsychological Testing. The coding for “Test Evaluation Services” for a neuropsychological testing follows the same principles as psychological testing but utilizes different CPT codes. CPT code 96132 is coded for the first hour of “Test Evaluation Services” and 96133 is coded for each additional hour (also with a minimum of 31 minutes).
2. “Test Administration and Scoring.”

The CPT codes for “Test Administration and Scoring” are also time-based codes. We will use one specific code for the first thirty (30) minutes of test administration and scoring and then a different code for each additional thirty (30) minutes. The CPT codes for “Test Administration and Scoring” are the same for psychological testing and neuropsychological testing. But there are different codes depending on whether the “Test Administration and Scoring” is performed by a psychologist or performed by a technician.

Test Administration and Scoring of Neuropsychological and Psychological Testing by a psychologist. CPT Code 96136 is the code used for the first thirty (30) minutes of test administration and scoring for psychological and neuropsychological testing when the work is performed by a psychologist and then CPT code 96137 is used for each additional thirty minutes of test administration and scoring (and requires a minimum of 16 minutes of time to use this code).

So, for example, a psychologist who spends 1.5 hours administering a WAIS, 1.5 hours administering a Rorschach, and .75 hours administering a TAT; and then spends .5 hours scoring the WAIS, 2.25 hours scoring the Rorschach, and 45 minutes “scoring” the TAT (e.g., identifying themes) would have a total of 3.75 hours of administration time and 3.50 hours of scoring time for a total of 7.25 hours. The CPT coding would then be: 1 unit of 96136 (30 minutes) and 13 units of 96137 (6.5 hours). The additional .25 hours of time not yet accounted for could not be coded because it does not meet the minimum 16 minutes for one additional unit of 96137. Therefore, we do not code the final 15 minutes of time.

Test Administration and Scoring of Neuropsychological and Psychological Testing by a technician. The timed coding system is the same whether the administration and scoring is completed by a psychologist/neuropsychologist a technician, but the specific codes utilized are different. The first thirty (30) minutes of psychologist or neuropsychological test administration and scoring by a technician is coded 96138 and each additional thirty (30 minutes) is coded 96139 (again, with a minimum of 16 minutes required to code 96139).
3. Other Coding Changes

There are two specific CPT codes for the assessment of aphasia and cognitive performance testing; four specific CPT codes for Developmental/Behavioral Screening and Testing; and one additional code for automated testing and automated results via electronic platform for a single psychological or neuropsychological test.

Assessment of Aphasia and Cognitive Performance Testing²

- CPT Code 96105: Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.

- CPT Code 96125: Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour by a psychologist or neuropsychologist. This code is used for time spent administering and interpreting the testing and preparing the report.

Developmental/Behavioral Screening and Testing³

- CPT Code 96110: Developmental Screening, scoring and documentation, per instrument

- CPT Code 96112: Developmental test administration, interpretation, and report by a psychologist or neuropsychologist, first hour only

- CPT Code 96113: Developmental test administration, interpretation, and report by a psychologist or neuropsychologist, each additional 30 minutes

- CPT Code 96127: Brief emotional/behavioral assessment, scoring, and documentation, per standardized instrument (e.g., ADHD scale, depression inventory, etc.)

Automated Testing and Result⁴

- CPT Code 96146: Test administration and automated result via electronic platform of a single psychological or neuropsychological test

Some additional comments:

The code changes will present billing problems for any testing that was started in 2018 and completed in 2019. I would suggest, if possible, that testing that is started in 2018 be completed in 2018. It is not possible to mix coding. Therefore, at the very least, if you do start testing in late December 2018 and complete the testing in 2019, then use codes for 2018 only or for 2019 only. You will, of course, still be able to send in a bill in early 2019 with codes for testing that was completed in late 2018, but the coding structure does not allow for mixing codes (e.g., if you administer some tests in 2018 and some in 2019, and interpret some in 2018 and some in 2019, there is no way to bill the base code and then additional time codes.)

I anticipate that there will be some billing problems and many questions following the start of the new coding on January 1, 2019. I will follow up with additional articles.

Please contact me with questions/concerns: pcberman@bermankilleen.com
Entire books are written about how to write psychological reports, and perhaps this is appropriate since some reports are as long as a short novel. But, I do not think so. I do think we can all agree, unread reports are entirely ineffectual. Length and language and the personal components of a report all lend to whether a report is read and understood. In my experience, no one wants to read a 40 page report, not even the person who wrote it, and I have read longer reports. Recently, in developing a Manual for a test, I was looking for case studies from the field using the instrument, and one psychologist I spoke to ask me if I wanted the complete reports, proudly adding that his reports were “very comprehensive” and typically ran between 40 and 60 pages. The only person who wants to read a report like this is an attorney who is preparing to cross-examine you!

Granted, we write reports for different purposes in different settings. There is also a natural tension between writing a report that relevant audience members will read in its entirety and preparing an archival document for future reference—however, the latter is why we have appendices!! Over many more years than I want to admit of both writing reports and teaching report writing to doctoral students, I have boiled it down to what I think are six key principles of writing a report that is readable, and that can help the client. I have been asked to share those with you.

1. Write individualized reports.

Understand that there is no such thing to the person you are writing about as a routine report. If we do not as psychologists understand this, who can? Use no fill-in-the blank templates or macros. If you feel this simply takes too long, checkout current dictation software. Dictation software over the last 4-5 years has become amazingly accurate, will learn your nuances and vocabulary quickly, and can keep up with you pretty much no matter how fast you talk. Dictation and a quick review and edit go pretty fast with minimal practice.

2. Write about people, not tests.

I hate to read a psychological report that is simply a test recital and especially one that fails to integrate all of the testing results with the history and interview into a complete picture of a person. Not every task needs to be described in detail and not every score needs to be reported in a table or narrative text. Use Appendices if you feel compelled to report at that level of detail—obviously the more salient and influential tasks upon which you draw important conclusions should be emphasized in the body of a report, but be clear and be succinct.
Tell the story of the person.

Who doesn’t like a good story!! And who better to tell the story of a person’s development and life and why they were seen than a psychologist. Storytelling is also one of the oldest, if not the oldest, means of effective transition of knowledge—and it is still very effective in getting across your findings and recommendations.

Be accurate.

Never confuse clients (templates will eventually catch up with you). Be certain that all of the scores you report or otherwise rely on are accurate and that you have checked everything for clerical errors. Having had a forensic practice for more than 35 years, I can hardly count the number of times I have found clerical and related errors in score reporting, ranging from table look up errors to addition errors or just transposition mistakes.

Have a great ending that addresses the referral question and gives both hopeful and helpful guidance to the reader.

If you do not address the referral question clearly, you simply have not done your job. If you want to argue the referral question was vague, then you haven’t done your job either. Be sure you are clear on the expectations for the psychological testing or assessments done before you evaluate, and know what the expectations of the referral source are specifically—and address them thoroughly. Hopeful and helpful guidance translates to a happy ending—and who doesn’t like that!

Write using proper grammar, spelling, and formal writing conventions.

Write like a competent, well-educated professional (which you are), and understand all of the above will affect your credibility, one way or another. You get to choose which way.

Changing our habits is hard, but writing effective reports does not have to be. Write reports people want to read and you will have improved your service to your client, and after all, isn’t that what we want, what we really, really want?

Author note: Cecil R. Reynolds is Editor-in-Chief, Archives of Scientific Psychology, Associate Editor, Journal of Pediatric Neuropsychology, and Emeritus Professor of Educational Psychology, Professor of Neuroscience, and Distinguished Research Scholar at Texas A&M University. He currently practices forensic neuroscience in Austin TX. Correspondence concerning this article should be directed to the author at crrh@earthlink.net. ©Cecil R. Reynolds. Used with permission. All other rights reserved.
Current practice patterns have shifted from comprehensive assessments to more focused psychological testing, for good reason. Particularly for those who focus on treatment to remediate symptoms, brief questionnaires like the OQ-45 or the MMPI-RF are helpful to gather assessment data. But, most of us do come up with complex cases, and I find personality testing using the Rorschach can be a help in formulating a reasonable treatment plan. After many years of using Exner’s CS, I made the switch to R-PAS 7 years ago and feel the change was worth making. In this brief article, I highlight some benefits to using R-PAS.

Without assessment information about the depth and range of psychopathology, it may be difficult to decide how much to use the therapy relationship to challenge and coach the patient to make change. I say this because we may not truly appreciate the psychic impairments that limit the patient’s capacity to make those changes with psychological help.

I have greatly benefitted from using an R-PAS index called the ego impairment index (EII) as I try to conceptualize how formulate a treatment plan. The index is highly sensitive to significant limitations in the patient’s personality. This is particularly helpful when the history is inconclusive (e.g. no evidence of serious impulse control problems, major depressive episodes or psychiatric hospitalizations). In my experience, the higher the score on EII the more therapy needs focus on coaching and supporting function in life, and less on probing and exploring underlying thoughts and feelings. What follows is a case example to illustrate the point. Case information is de-identified and presented with the patient’s permission.

The R-PAS profile for “John” showed that his high EII score gave evidence that he would have difficulty perceiving things accurately and was likely to suffer anxiety, even in the face of minor stresses. John presented a life-long avoidance of relationships, convinced that he was worthless. During childhood, there was significant language delay, which led the family to get help in a program for autistic children. The history also included treatment during college and graduate school to address depressed suicidal ideation, though he did not require hospitalization. I saw him as he was completing his graduate work for a Ph.D. in computer science.
Focal therapy (behavioral activation) was used to support coping with depressive symptoms. Based on patient preference, referral to psychiatry was not made. John's card III response, "a person very shabbily dressed with torn clothes", shed light on his social anxiety. Coaching him on social skills will be akin to helping him get a new wardrobe so he can present himself in a more confident manner. More effective social behavior may in turn impact his depressed self-attitude. We used self help books to coach social behavior. Interestingly, John gave me a book written by a famous football coach (Don Schula), to help us talk about how he likes, and doesn't like being coached in his therapy.

The Rorschach helped me to decide how to use the therapy relationship to coach him and support his learning social skills to use at work and in his personal life. After several years of weekly therapy, John is free of depressive symptoms, still struggles with self worth and needs support when he is stressed at work. He now has a girlfriend that he loves.

I will be conducting R-PAS training on May 24, 2019 for MPA. Here is a brief listing of some of topics that will be addressed at the training.

- New form quality tables were developed (form quality ratings for 40% of the objects in the R-PAS manual are different from CS); this addresses CS tendency to over-pathologize
- Assessment of narcissism now uses other codes besides the reflection response, because landscape reflections may not indicate narcissism
- Aggressive content, rather than aggressive movement, is now featured to study proneness to aggression
- Assessment of dependency is improved by using other content besides food
- Ambitence is now seen as normative as opposed to problematic (Rorschach considered this style of blending reflective thought with expressive engagement as adaptive)
- One texture response is not normative, though multiple texture responses are correlated with relationship loss
- A new set of norms is being built, with international data, using examiners who have been certified as competent in coding and administration skills
- Neuropsychological research, using FMRI, is helping us anchor Rorschach variables
Classifieds

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