# The CLINICIAN

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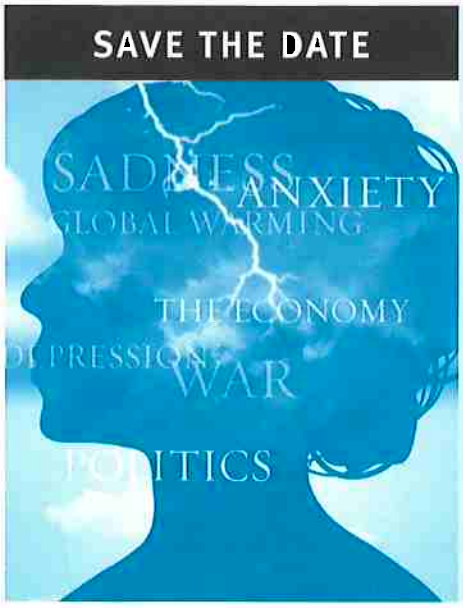
THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.


**The New York State Society for Clinical Social Work**
**40th Annual Education Conference**

## Out of Sorts: Meeting the Challenge of Working with Anxiety and Mood Disorders

Saturday, May 2, 2009
8:30 am – 4:00 pm
The Nightingale-Bamford School
20 East 92nd Street, New York, NY

Our unstable economy, politics, war and the threat of global warming leave underlying traces of sadness and anxiety upon the psyche and body of both therapist and patient, a feeling of "out of sorts" unconscious, difficult to articulate. Suicides/homicides occur too often when depressive symptoms and hidden rage remain the unspoken known in families, schools, the workplace, among friends, and within couples.

This conference will address the profound importance of connecting and listening to both the clinician's own and the patient's split off states of awareness.

Our keynote presenters, Jerome C. Wakefield, Ph.D., DSW, and Carol Tosone, Ph.D., are recognized for the significant contributions they have made to our field. Dr. Wakefield will be presenting a thought-provoking paper, "The Loss of Sadness: Is Normal Sadness Being Mislabeled as Depressive Disorder?" Dr. Tosone will present "Comparative Treatment Models for Panic Disorder: A Case Illustration."

The Education Committee is also pleased to bring you an intellectually-stimulating education program of eight workshops carefully selected to address the needs of social workers from a variety of settings. Various theories and techniques will be presented for working effectively with children, adolescents and adults individually, within families and as adult couples.

Brochures have been sent to all members and information is also available on our website, www.clinicalsw.org. Please be sure to register early to be assured the workshop of your choice.

We look forward to seeing you on Saturday, May 2, 2009.

*—Susan Klett, LCSW-R, Chair, Education Committee*
suzanneklett@aol.com

## President's Message

***Take Care So You May Take Care***

We are good at taking care of other people. We welcome them to our practices, generously assess from strength perspectives and realistically assess for challenges. We harness our knowledge of internal process and inter-personal relationships to support people so they can make changes that will make their lives better.

CONTINUED ON NEXT PAGE

### IN THIS ISSUE

# Legislative Committee

## *Licensing Update*

*by Marsha Wineburgh, DSW, Chair*

The Clinical Society is continuing to monitor and work with the Office of the Professions (OP) within the State Education Department to address the questions concerning the implementation of the psychotherapy licensing laws. As we have reported in earlier articles, the passage of our licensing law in 2002 has created three key problem areas: procedures for meeting experience requirements for individual licensure, addressing problems arising from the January 1, 2010 expiration of licensure exemptions for individuals in certain programs and issues around authorized settings for professional practice.

**Problem #1**

Most important for LMSWs who began working on their clinical experience requirements during and following the passage of the licensing law has been the determination made by the Department which impacts the setting and supervision requirements for acceptable clinical experience for LCSW licensure.

The Office of the Professions has made a determination to accept experience for licensure as a licensed clinical social worker (LCSW) that was completed in a private practice owned by the LMSW applicant and/or under a supervisor who was paid by the applicant provided the experience commenced prior to **February 2, 2009** and the application for licensure is submitted **no later that February 2, 2015**. The experience must satisfy all the requirements set forth in section 74.3 of the Regulations of the Commissioner of Education and must be otherwise in compliance with all applicable laws and regulations. **A form notifying the Department must be submitted no later than July 2, 2009**.

For information:
http://www.op.nysed.gov/swprivatepractice.htm

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## President's Message

CONTINUED FROM COVER

We offer information and make connections for people so that they receive the services that they need. Our focus is continually on the best interests of the people for whom we work.

*Jonathan Morgenstern, MSW, LCSW, Society President*

Perhaps we should be offering ourselves the same abundance of riches. We love our work, so it's important that we make sure we've created the best circumstances that allow us to continue doing what we love. We should be welcoming of ourselves, proud of our strengths and accepting of our challenges. While our own lives are positively impacted by our knowledge, training and experience, we should equally be willing to avail ourselves of the services of another who should be as generous to us as we are to others, offer us a safe haven where we can deeply replenish and reenergize. There is a balance to things, and we are well advised to keep our eye on maintaining the balance that best suits us, as our life also includes family, friends and interests.

So take care so that you may take care and so that you can continue doing and loving what you do. The Society will continue to be a community that supports its members in doing what they love. ■

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.


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**SOCIETY PHONE:** 1-800-288-4279

**EDITOR:** Ivy Miller. 301 East 45th Street, Apt. 8D
New York, NY 10017 | tel. 917-606-0424
ivy.miller@yahoo.com

**NEWSLETTER COMMITTEE CHAIR:** Helen Hinckley-Krackow

**DEADLINES:** January 10 and September 10

### Problem #2

The 2002 Social Work licensing laws exempted programs regulated, funded operated or approved by OMH, OMRDD, OASAS, OCFS, local social service or mental hygiene districts until 1-1-2010 to allow any person to provide services without being licensed. After that date, current law provides that only licensed professionals could provide services that are restricted under law, including psychotherapy. Agencies would not be able to delegate tasks to persons who are not licensed or exempt. Exemptions which survive the 1-1-2010 expiration date include students and an LMSW under supervision.

As the 2010 deadline approaches, there have been discussions as to whether agencies will be able to meet the requirement for licensed staff or if the agencies should have an extended or permanent exemption. The 2009-2010 Executive Budget, which awaits passage by the legislature, proposes to extend the exemption for 4 years, after which time only licensed, exempt, or otherwise authorized persons could provide professional services.

### Problem #3

The Office of the Professions and others are working to address questions about the unauthorized "corporate practice" of the social work professions. Under New York law, only licensed individuals may provide professional services, and any agency or entity providing such services must be legally authorized to employ licensed professionals.

Since the practice of clinical social work was not restricted prior to the enactment of the licensing law, for-profit and not-for-profit businesses provided services that are now, since the passage of the licensing law, restricted. The definition of an authorized setting for mental health services is being discussed and may include a process to register entities that are not currently approved by the Office of Mental Health or another government agency. This directly impacts on the settings and supervision requirements for acceptable clinical experience for LMSWs seeking clinical licensure going forward as well as ensuring that patients receive quality services.

There is also confusion regarding acceptable experience for the LCSW, which is defined in the Education Law as the *diagnosis and treatment of mental, emotional, behavioral, addictive and developmental disorders.* It may be difficult to ascertain whether some settings are providing experience delivering mental health services, including clinical social work, or are providing experience delivering services that do not qualify for licensure, including case management, supportive counseling and advocacy.

To some extent this confusion reflects an older conflict about what "clinical" refers to. For some professional organizations, it refers to any direct contact with a client. For the Clinical Society, its meaning is restricted to "diagnosis and treatment...". The Clinical Society fought for a second social work license (the LCSW) to ensure recognition of clinical social work as a mental health specialty, along with clinical psychology and psychiatry.

### LICENSED CLINICAL SOCIAL WORK SCOPE OF PRACTICE

The statute, Education Law (7701) defines the scope of practice of LCSW as "2...(a)... ...encompasses the scope of practice of LMSW and, in addition, includes the diagnostic assessment of mental, emotional, behavioral, addictive and developmental, disorders and disabilities, and of the psychosocial aspects of illness, injury, disability and impairment undertaken within a psychosocial framework; administration and interpretation of tests and measures of psychosocial functioning; development and implementation of appropriate assessment-based treatment plans; and the provision of crisis oriented psychotherapy and brief short-term and long-term psychotherapy and psychotherapeutic treatment to individuals, couples, families, groups, habilitation, psychoanalysis and behavior therapy; all undertaken for the purpose of preventing, assessing, treating, ameliorating, and resolving psychosocial dysfunction with the goal of maintaining and enhancing the psychological and social functioning and well being of individuals, couples, families, groups, communities, organizations, and society.

### Going forward

The Clinical Society will continue to monitor these issues carefully and update our membership. Let us know what your problems are either by e-mailing your chapter legislative chair or myself at **mwineburgh@aol.com.** ■

# Vendorship and Managed Care Committee

*Quarterly Report to the Members by Helen T. Hoffman, LCSW, Chair*

The VMCC continues to gather and disseminate information, to assist individual members and to explore what can be done to influence external forces. This quarter, the following issues were foremost for us:

**OptumHealth:** As OptumHealth takes over clients formerly served by Empire Value Options, NASW NYS, NASW NYC, and NYSSCSW (the Society) have sought to obtain a Provider Forum with Optum (formerly UBH), for orientation. On February 3, a meeting involving representatives of Optum, NASW and the Society took place in Albany. Doris Tomer represented the Vendorship and Managed Care Committee at that meeting. Helen Hoffman and Jonathan Morgenstern participated by teleconference.

After a discussion of the details of the transition, Ray Cardona of NASW introduced the subject of currently "flat" reimbursement rates. Optum answered the question in a measured, seemingly interested fashion, but made clear that their rates are "competitive with most managed behavioral health plans," and that their goal is to "provide our customers with a cost savings." There is no new news about the transition of Oxford patients to Optum, but this is expected to occur in the coming year.

**Medicare:** Virginia Lehman, our new Medicare Liaison, has been active in helping members with Medicare billing issues. A useful connection at National Government Services has been made. Members are invited to contact Ginny with Medicare questions or problems with payment at **lehmanV117@aol.com**. Where needed, she will be able to pass along requests for assistance to NGS.

In February, Doris Tomer will be going to Phoenix for a conference of the RUC (Relative Value Scale Update Committee of the AMA), during which a small informal group of psychiatrists, psychologists, social workers and nurse practitioners will explore what can be done to get the Medicare CPT codes for mental health reviewed. The first step has to be to gather data to show compelling, concrete evidence why the rates should be changed. This proposes to be an uphill battle requiring approval at several levels of the AMA even before approaching CMS for a rate change.

**New York Business Group on Health:** In the last year Helen Hoffman has attended five meetings of the Mental Health Task Force of the New York Business Group on Health (the Society is a dues paying member). This group, representing employers, insurance companies, pharmaceutical companies, providers, NAMI and the NYC Department of Health, is currently working on an initiative to get primary care physicians to screen, diagnose and treat patients with depression. The main value of our participation in these meetings, besides our gaining perspective, is to be more visible in the community and to network where possible with other participants.

**Timothy's Law/Parity Bill:** On February 8, Helen Hoffman spoke to the Queens Chapter as part of their monthly meeting on Timothy's Law and the Federal Parity Law. This was followed by a lively Q&A on other managed care issues. ■

*Society members are invited to seek answers to their insurance questions by contacting members of the Vendorship and Managed Care Committee listed below:*

| NAME | CHAPTER |
|---|---|
| **Helen Hoffman,** *State Chair*<br>helenhoffman@verizon.net | METROPOLITAN |
| **Michael Koetting**<br>mkoetting@aol.com | METROPOLITAN |
| **Virginia Lehman,** *Medicare Liaison*<br>LehmanV117@aol.com | METROPOLITAN |
| **Ruth Washton**<br>rwashton@verizon.net | METROPOLITAN |
| **Shirley Sillekens**<br>ssillekens@aol.com | QUEENS |
| **Colleen Downes**<br>Eve114@aol.com | STATEN ISLAND |
| **Susan Kahn**<br>shkahn@verizon.net | NASSAU |
| **Doris Tomer**<br>tomerd@juno.com | NORTHEAST |
| **Linda Plastrik**<br>lptunedin@aol.com | WESTCHESTER |

# Everything You Ever Wanted to Know About Medicare

**FROM THE VENDORSHIP AND MANAGED CARE COMMITTEE**

*by Helen T. Hoffman LCSW, Chair*

The Vendorship and Managed Care Committee has established a relationship with a special contact at National Government Services. We have been able to ask some specific questions and the answers may be of interest to Society members. The following are excerpts from the correspondence between Virginia Lehman, Medicare Liaison, and our contact at NGS:

**1. On the claim form, should the NPI # be solely in box 33?** The NPI of the billing provider/supplier or group is reported in Box 33A. If a group is billing, then the rendering provider's NPI number is reported in Box 24J. If a group is not billing then leave box 24J blank. [For those of us that have more than one practice, location, the NPI goes in both 32a and 33a. 32 is for the office the patient is seen in and 33 is the clinician's billing address. 32b and 32c are to be left blank, since Medicare Legacy numbers are no longer being used.]

**2. Claims from 2005 and 2006 cannot be processed.** This chart shows the date that claims from 2005 and 2006 had to be filed by:

| For Services Rendered Between: | Claims Must Be Filed By: |
|---|---|
| Oct. 1, 2004 and Sept. 30, 2005 | Dec. 31, 2006 |
| Oct. 1, 2005 and Sept. 30, 2006 | Dec. 31, 2007 |
| Oct. 1, 2006 and Sept. 30, 2007 | Dec. 31, 2008 |
| Oct. 1, 2007 and Sept. 30, 2008 | Dec. 31, 2009 |

**3. Is code 90847 appropriate/acceptable for family sessions?** [Generally, yes, CPT # 90847 is appropriate for family session with patient in session. CPT # 90846 is for family session without patient.] You have to read the description for the code in the CPT book. You need to choose the most appropriate code for the services you are rendering. We cannot tell what code you should use. Here is a link to the local coverage determination on our website: http://www.ngsmedicare.com/NGSMedicare/lcd/L26895_active_lcd.html

**4. The fee schedule for 2009 has two different lines/fees for 90806. Which one is correct or is one line for area 1 and second line for another area?** If you are referring to the second line that has a # in front of it (see below), these amounts apply when service is performed in a facility setting. It states this on the bottom of the page.

| | | | |
|---|---|---|---|
| 90847 | 120.87 | 114.83 | 132.05 |
| #90847 | 112.50 | 106.88 | 122.91 |

**And is it correct that clinical social workers are reimbursed 75% of physicians' fees?** Yes this is posted on our website under fee schedules (see below). website: http://www.ngsmedicare.com/NGSMedicare/PartB/Claims/FeeSchedules/ny/2009/CPandSWFeeSchedules.aspx

**Clinical Psychologists and Clinical Social Workers Fee Schedules:** National Government Services will no longer be publishing a separate fee schedule for clinical psychologists (CP) and clinical social workers (CSW). The reimbursement for CP is based on the fees published in the Medicare physician fee schedule (MPFS). The reimbursement for CSW is based on 75 percent of the fees published in the MPFS.

**Where would we find fees for Rockland County?** The fee schedule online shows the different areas. Rockland County is listed under Area 02, see below:

| New York Fee Schedules: | |
|---|---|
| **AREA 01** | MANHATTAN |
| **AREA 02** | BRONX, BROOKLYN, NASSAU, ROCKLAND, STATEN ISLAND, SUFFOLK, WESTCHESTER |
| **AREA 03** | COLUMBIA, DELAWARE, DUTCHESS, GREENE, ORANGE, PUTNAM, SULLIVAN, ULSTER |
| **AREA 04** | QUEENS |
| **AREA 99** | Albany, Oneida, Allegany, Onondaga, Broome, Ontario, Cattaraugus, Orleans, Cayuga, Oswego, Chautauqua, Otsego, Chemung, Rensselaer, Chenango, Saratoga, Clinton, Schenectady, Cortland, Schoharie, Erie, Schuyler, Essex, Seneca, Franklin, Steuben, Fulton, St. Lawrence, Genesee, Tioga, Hamilton, Tompkins, Herkimer, Warren, Jefferson, Washington, Lewis, Wayne, Livingston, Wyoming, Madison, Yates, Monroe Montgomery, Niagara |

**5. Is there any way of expediting payment?** [One member submitted claims for six sessions dated 8/24/08. She has been informed that this claim will be paid but she may have to wait 6-8 weeks.] If the claim is submitted on paper, there is a mandatory

CONTINUED ON PAGE 15

# Arts and Creativity in Clinical Practice Committee

## *Who, What, Where, When, Why and More*

### Who
We are clinical social workers with a background in the creative arts and/or interest in the creative process. Our members are often dually certified as social workers and arts therapists.

### What
We are a specialty group whose foundations are rooted in aesthetics, clinical theory and techniques culled from a diversity of psychotherapeutic approaches: object relations theory; ego and self psychology; Freudian psychoanalytic theory; Gestalt therapy and other therapeutic approaches.

### Where
As school, geriatric and agency social workers in private and institutional settings, we consciously employ both non-verbal and verbal modalities.

### Why
We believe the arts are a basic part of human communication and are driven by the union of cognitive and affective functioning (mind/body awareness). As clinical social workers, we adhere to the person-in-context view of psychotherapy.

### When
We try to meet on the third Sunday of the month from October to May for one hour and thirty minutes from 11:00 am to 12:30 pm (evaluation and networking go to 1:00 pm).

### What
We offer presentations given by members or invited guests, conduct study groups as needed, provide peer consultations and plan a yearly outing.

### Who Can Join
Meetings held by the committee are a membership benefit, and as such are offered free of charge. A background in the creative arts or interest in the creative process is helpful, but is not a requirement.

### Recent Programs
Our 2008 presentations included — September 28, "Creativity and Inhibition; A Self-Psychological Approach," Ashley Warner, LCSW; October 26, "Creative Co-presentation of the Use of Collage When Working With Families and Couples", Rita Gazarik, LCSW and Joy Sanjek, LCSW; November 23, "Tolerating and Containing through Creative Application of Learned and Intuitive Skills: A Dialectical Behavioral Therapy (DBT) Approach," Suzanne Klett, LCSW

### History
The first formal meeting of the committee was held January 1997. Our format is generally educational, often experiential or exploratory. In keeping with our professional viewpoint, we attempt to synthesize theory and practice in our presentations and activities. We encourage those who attend our events to present examples from clinical practice.

### Goals
We aim to give form and shape to clinical material that is often inaccessible to spoken language. Our purpose is to support each other's efforts in verbalizing the exploration of the time-space continuum between thought and action. The unfinished, rough, and unpolished idea is as welcome as the publishable case study; we value meaning and relevancy. Communication of process is as important as product. In the interest of furthering communication and outreach efforts, we are offering an on-line ACCP "bulletin board." ■

### INQUIRIES:


**Sandra Indig LCSW, ATR-BC, *Chair*** **212-330-6787**
psych4arts@hotmail.com

**Joy Sanjek LCSW, *Co-Coordinator*** **646-469-9733**
joyoveranger@bigplanet.com

**Sema Gurun LCSW, *Professional Relations*** **212-982-2489**
gurunsema@verizon.net

**Joanne de Rosa LCSW, *Membership*** **212-505-2258**
jdr505@verizon.net

*by Sandra Indig LCSW, ATR-BC, Chair*

## SPRING 2009 METROPOLITAN CHAPTER EVENTS
## *of the Arts and Creativity in Clinical Practice Committee*

### March 29 — Claudette Duff, ATR, LCSW

**"Art Therapy with the LGBT Community; Case Presentation,"**

An East Indian woman suffering from symptoms of PSTD due to early sexual abuse by a family member is relieved of her fear of intimacy. Through an eclectic use of art therapy theory and technique, her story unfolds as her past secrets are skillfully guided to the surface. A hands on, experiential segment is part of this workshop.

Claudette Duff, ATR, LCSW, is director and founder of Integrity Senior Services and is in private practice in Staten Island and Manhattan. She specializes in working primarily with the Lesbian, Gay, Bisexual, and Transgender community. Claudette is a Member-at-Large and Co-Chair of the Membership Committee of the Society.

### May 17 — Jacinta "Cindy" Marschke, Ph.D

**"The Creative Challenge: Making Dialectical Behavioral Treatment (DBT) Personal, Real and Dynamic"**

Because DBT draws heavily on cognitive behavioral theory and is highly structured, it presents a challenge to avoid a recipe-like, dry skill–building delivery and to insure that the content is personally meaningful to each participant. This presentation will focus on the creative strategies Dr. Marschke has used to deliver and facilitate integration of the DBT material.

Dr. Marschke is a long-time member of the Mid-Hudson Chapter and former Society president. She is in private practice in New Paltz and Kingston and consults two days a week with the Kingston Hospital Employee Assistance Program. She has been utilizing Martha Linehan's DBT model since 1994. Initially, the Mental Health Association of Ulster County asked her to adapt the model for parents of patients diagnosed with Borderline Personality Disorders. Subsequently she was hired to train clinicians and implement the model at Ulster County Mental Health, the local community mental health center. An article describing the application of DBT to non-patient populations appeared in Smith College Studies in Social Work in November 1997.

**Where and When:** 130 Fifth Avenue (at 18th Street), Suite 900, Manhattan; 11:00 am to 12:30 pm, Sundays (please leave 30 minutes for evaluation and networking).

**Reservations:** Please call Sandra Indig to verify address and to reserve a seat: 212-330-6787

# Free Association and Creativity Study Group (I and II)

*Presentation by Sema Gurun, LCSW / Review by Sandra Indig, LCSW, ATR-BC, Committee Chair*

"...I think psychoanalysis has provided a new form of thinking and relating for transforming inner experience into a two person relation and that has not existed before, but which is evolutionary... The individual is there for help. The species is there for free association." —Christopher Bollas, *Being Creative, Free association in psychoanalysis and the arts*, p. 5, http://www.freud.org.uk/bollas.html

*Sema Gurun, LCSW*

Over the course of two study groups held at the office of Joy Sanjek, coordinator of the committee, Sema Gurun, skillfully led her attentive audiences in examining links to creativity and the creative use of the process of free association in the therapeutic alliance. We were prepared for a rich and exciting discussion with focus on the role of the unconscious according to Christopher Bollas, MSW, psychoanalyst and Blake Morrison, playwright. Selected literature was made available prior to the meeting.

Borrowing from a conference titled "Being Creative" held on March 10, 2002, Sema brought in the centrality of creativity in psychoanalysis and in Freud's work in particular. To paraphrase from a summary given at that conference, the question of how an idea comes into mind reveals the influence of the multi-layered and dynamic nature of the unconscious. Bollas, in implying that a person is like a work of art, continues Freud's legacy wherein analyses of dreams, phobias or symptoms are treated as acts of unconscious creativity. Here reference was made to Bollas' most recent book, *Free Association*, published in the "Ideas in Psychoanalysis" series, in which he observes that an extraordinary form of unconscious communication in the analytic setting, free association, is a form of personal creativity.

Just as that phrase, free association is a form of personal creativity, inspired the conference Being Creative, a number of participants volunteered their own processes of creation by citing examples of their work and the circumstances of the creation and the emotions which infused them.

Among others in the group, I am multi-disciplined. Examples from practice with patients as well as personal work in the areas of painting, writing, and dance were given. We then took turns reading aloud a section from a printout from Bollas' web page, which summed up and clarified our discussion to this point:

> When I think of the way I work as a psychoanalyst I realize that being absorbed in what my patients say is very important and that the more they talk, indeed, just free talk and the less they try to say something profound or insightful, the greater the likelihood that we will both be engaged in unconscious creativity. And that means, to me, a giving over of oneself to the creativity of that form of unconscious composition found in what I [Bollas] call in this essay The Freudian Pair: the analysand free talking, the analyst in meditative listening. Not every session yields an insight derived from this kind of inter subjective creativity. In fact, I think those insights that do arrive out of the matrix of association are all the more significant because of the comparative rarity of psychic revelation, but I think something of what we are talking about today we may hold in common: a period of immersion or maybe without even knowing this going on in our respective "materials" whether produced by a patient, another composer, or the abandoned objects someone's life and out of this we create something. (Webpage on Bollas, P.3)

Sema provided us with a brief review of some of the history of object relations theories from the 40s through the 60s, including Anna Freud's enormous contribution, namely, the ego and its defenses. She spoke about Freud's regard for the dream as the most sophisticated form of thinking and the key role free association plays in its interpretation. In the same vein, Jung's work with his patients brought to light the role also played by narration or story telling in the associative process.

Aside from the repressive influence Victorian Vienna had on recovering memories blocked from consciousness, I was struck, in the here and now, by the often monumental struggle waged in the clinical setting to overcome resistance. It appears appropriate to mention the skill which the analyst brings to this task. Within the nexus of the therapeutic alliance, the analyst's subconscious or

**SANDRA INDIG, LCSW, ATR-BC**, is chairperson of the Arts and Creativity in Clinical Practice Committee. She is: an exhibiting painter and member of the Abingdon Square Painters, performs with Dances for a Variable Population, on staff and writes for the E-Zine, *Manhattan Arts*. She maintains a private practice in Manhattan.

pre-reflective unconscious (the intersubjective model, Stolorow, Atwood) may be a key determining factor in the ability of the patient to free associate. I concur that this may well be the underlying reason some clinicians have a higher rate of successful treatment in comparison to other practitioners.

Free association is the operative process in the creative act. Sema included the work of the surrealists as an example of the power of the life of the dream. The free associative approach was embraced by the abstract expressionists in the post modern period. Given the constraints of space, I have not delved into the thinking of Blake Morrison, the playwright, also discussed in this study group. However, I will paraphrase his ideas on creativity as a good lead-in to Sema's discussion of her creative process.

Morrison thinks of creativity as something we tend to complain we lack. People say things like, "But I'm not creative like you." Some will not say anything out of superstitious beliefs that to do so would rob them of their creative powers. Morrison sees it as a thing like sex or exercise, where the notion of excess does not enter in. Too much creativity? What an impossible idea. (http://www.freud.org.uk/morrison.html)

Sema Gurun does what is impossible or at least very difficult for some, that is, engaging in self-directed observation unimpeded by another's prompting, judgment, second guessing, and lack of fear of concrete goals.
In order to answer the hypothetical question,

How does the psychoanalytic concept of free association, as described by Freud, translate to the artist, writer, or musician, etc. in their work? I believe that we can accept as a given that creativity is best mobilized when the artist is able to freely associate within h/er mind without any super ego inhibitions holding back the imagination. Christopher Turner (as cited by Bollas) gave five elemental processes to creativity: perspiration, inspiration, surprise, play, healing. Sema added Edward Albee's wise nugget, "Creativity is magic. Don't examine it too closely."

She took us outside the context of the therapeutic setting and shared with us two sessions of painting recently experienced at the Art Students League. We followed her self-observing ego noting her work space, the people and objects around her, her model reading a book, and her association to her process, including the free association of symbolic connections.

Sema began with her first painting session with, for me, a very provocative statement, "It is not always easy to get the cartoon of the painting down. Much working through is necessary as I put a drawing on and whitewash it shortly after. I am thinking about the model: she is an older woman looking a bit like Emily Dickinson. She is holding a book on her lap; an excellent composition in itself. A friend has just given me a calendar. It is 12 paintings (12 months) of "The reading woman." What wonderful synergy! I am already stimulated by the reading woman composition. This will sustain me. I am looking at her thoughtful sad eyes as I draw her face with a brush dipped in a slab of raw umber. I wonder what country she is from, Eastern Europe perhaps. Her sitting position is non-sensual, almost 19th century. Something about her is reminding me of my mother. My mother was a reading woman too at one time. I rework the face again. This is slow for my usual a la prima style. She has an unsure look about her face, hard to know what she is thinking or feeling. Is she thinking about the story she read during her break, after the morning session, I wonder ... The face changes, as thoughts run concurrent to my brushstrokes; she resembles several objects I have known in my life. In the end, I complete the portrait and feel like keeping it. I put it on a shelf to dry. Next week I will look at it with interest."

Transferences are stirred in the second painting session as she recalls a teapot bought for her mother and the loss of her mother as well as a very special love alliance. In the narrative, Sema relates that the teapot which she had given to her mother as a gift became hers once again upon her death. She had, in some sense, been reunited with her object as well as being reunited, for a brief time, with her boyfriend.

She tells us, "One day as I remember the teapot's origin as I am washing it, I uncontrollably, but almost on purpose, hit it against the faucet and break two of its parts (the lid and the spout). Alan and I break up again a year after we are reunited. Was the breaking of the teapot an unconscious prediction on my part? Was it an unexpressed rage at Alan? Was it Alan or my mother I was putting to rest by the break?"

Back in our clinical setting, it is in the inborn talent of the clinician to pick up on the cues and clues of the patient's ambiguous life experiences, and to help him or her delineate them into a more concise and cogent narrative. It may well be the greatest task that lies between the two objects and, perhaps, the most creative process since the formation of life. ■

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**Sema Gurun, LCSW**, is an interpersonal-international psychotherapist and works in multi-modal styles with her international patients in several languages. She believes that intersubjectivity and all that it conveys in the nexus of the therapeutic relationship is the healing process. Her private practice is in Manhattan.

Sema presented the two papers discussed above at the ACCP Committee study group meetings on November 4, 2007 and May, 11, 2008 respectively. On March 8, International Women's Day, she will present her paper, "Culture and Identity: the shift in the roles of modern woman" to the Turkish American Women's League. On April 3, she will present "Therapy and Culture" at the Family and Couple Practice Committee. She is also public relations person for the ACCP Committee.

# Borderline or Bipolar

*by Brian Quinn, LCSW, Ph.D.*

Karen, age 28, has a history of depression, mood instability, self-mutilation, temper outbursts, feelings of emptiness, sensitivity to rejection, and difficulty being alone. She has made three suicide attempts. Diagnosed with borderline personality disorder at age 22, she has been treated by three psychiatrists and two therapists, one of whom had provided supportive therapy and another who had done dialectical behavior therapy. She has not had a sustained response to any of the four antidepressants she has been prescribed. She is currently taking 375 mg per day of the antidepressant Effexor along with 15 mg per day of the atypical antipsychotic Abilify, yet she still meets diagnostic criteria for a major depressive episode. In spite of being quite bright and a talented artist, she has not been able to work for a number of years.

Karen clearly has a number of prototypical borderline personality traits, but clinicians need to be very cautious about diagnosing borderline personality disorder in the presence of an active mood disorder (Goodwin & Jamison, 2007). The principle of a diagnostic hierarchy, formalized by the German psychiatrist and philosopher Karl Jaspers, suggests that a disorder lower on the hierarchy should not be diagnosed when one higher on the hierarchy can account for the symptoms. Mood disorders sit near the top of the hierarchy (second only to organic illness and perhaps substance abuse) since they can lead not only to depression and mood instability but to many of the symptoms seen in other disorders. The diagnostic hierarchy concept was largely abandoned with DSM-II, which encouraged clinicians to make multiple diagnoses even if one is the symptomatic expression of another.

Various forms of bipolar disorder are especially likely to produce borderline-like traits. Some women with bipolar II disorder (depressive episodes alternating with a muted form of mania called hypomania), for instance, can have extremely rapid shifts in their moods — every few days or less. Instead of discrete, rapid alternations in mood, many patients with bipolar II disorder have depressive mixed states, which are characterized by the simultaneous occurrence of many symptoms of depression and a few manic or hypomanic symptoms (Akiskal and Benazzi, 2003). Patients in depressive mixed states can be highly anxious and irritable, have labile moods, be suicidal, and may engage in impulsive, risky behaviors. This symptom picture can easily be mistaken for borderline personality disorder. Even when bipolar II patients are relatively symptom free, they tend to have the mood lability and intense emotional reactions typically associated with borderline personality (Henry et al, 2008). Finally, there are many depressed patients without a history of hypomania who have "features of bipolarity," such as a family history of bipolar illness, not typically found in those with unipolar depression.

The presence of a key feature such as a family history of bipolar illness or a collection of other features makes it likely that the patient has a "bipolar spectrum illness" — even if their symptoms do not fulfill the rather strict and narrow diagnostic criteria for bipolar illness described in DSM (Ghaemi, 2008). Individuals with bipolar spectrum illnesses often have histories of pronounced irritability, emotional over-reactivity, stormy interpersonal relationships, and impulsive, self-destructive behavior. In a small but important study of patients diagnosed with borderline personality disorder at the Cornell-Westchester Hospital, famed for its expertise in treating these patients, Deltito et al (2008) found that, more often than not, the patients exhibited clear evidence of bipolarity. Perugi et al. (2006) found a high rate of a variant of bipolar disorder — cyclothymic temperament (chronically unstable mood) — among patients diagnosed with narcissistic, borderline, and histrionic personality disorders.

Some clinicians have suggested that borderline personality traits are a complex form of post-traumatic stress disorder with prominent dissociative defenses. Bipolar patients do have a higher rate of childhood abuse and post-traumatic stress disorder than the general population, so this formulation should be considered in the assessment of any borderline or bipolar patient.

How can the clinician determine whether a patient has a bipolar disorder in addition to or instead of borderline personality disorder or post-traumatic stress disorder? Some differences in the nature of depressive symptoms may be helpful in sorting out bipolar disorder from borderline personality. Goodwin and Jamison (2007), for instance, suggest that the depressive episodes in bipolar disorder tend to be spontaneous, stable, and discrete episodes with clear onset and offset, whereas borderline depressions tend to be much more variable and reactive to social stimuli. However, as previously noted, bipolar II patients in general and those with rapid-cycling or mixed episodes in particular can have highly variable mood and be emotionally over-reactive. So, mood instability alone is nonspecific and carries little diagnostic weight.

The symptoms that most clearly define bipolar illness are the presence or past history of mania/hypomania. There are seven cardinal symptoms of mania and hypomania that can be remembered with the mnemonic DIGFAST (Ghaemi, 2008).

**D – distractibility (difficulty maintaining focus on tasks)**
**I – insomnia (a decreased need for sleep, not the inability to sleep)**
**G – grandiosity**
**F – flight of ideas (racing thoughts)**
**A – activity (increased goal-directed activity)**
**S – speech that is pressured, loud, rapid or increased talkativeness**
**T – thoughtless, impulsive or risky behaviors such as sexual indiscretions, reckless driving, spending sprees or sudden traveling**

According to DSM, the presence of three of these symptoms in someone with euphoric mood or four in someone with irritable mood is diagnostic of hypomania and bipolar disorder, although these numbers are somewhat arbitrary. Borderline and bipolar patients may both be emotionally unstable, emotionally over-reactive, irritable, and impulsive, but only bipolar patients will have had an episode with several of these core hypomanic symptoms (Benazzi, 2008).

*When asked, Karen revealed that in the midst of long periods of depression marked by lethargy, and problems keeping her mind on school or her art work, she would have sudden, brief periods where she would feel very energetic and excited about painting. At such times, she felt creative and focused. She would paint for hours, forget to eat and often stay up late. Typically socially anxious and filled with self-doubt, she would, at these times, feel much more confident and outgoing.*

Hypomanic episodes, however, are not always easy to identify. First of all, patients spend the vast majority of time they are ill in the depressed phase of the illness (Judd et al., 2003) and will rarely seek help during their highly pleasurable hypomanic episodes. Second, hypomanic episodes are brief and fleeting, typically lasting one to three days, and are often forgotten, denied or dismissed by the patient as periods of normal mood (Goodwin and Jamison, 2007). If a clinician neglects to ask a patient and his or her close family member's specific, probing questions about a history of DIGFAST symptoms, hypomanic episodes will be overlooked. (A clinician needs to ask family members about a history of hypomanic symptoms to offset the patient's tendency to forget and deny them.) The clinician can best identify hypomania by asking about episodes of increased goal-directed activity and productivity and a reduced need for sleep rather than changes in mood. These behavioral manifestations of hypomania are easier for the clinician to identify and for the patient and his or her relatives to remember than subjective changes in mood.

Keep in mind that hypomanic episodes do not lead to significant social or occupational impairment and, in fact, as in Karen's case, often lead to beneficial increases in productivity. Hypomania may be the only disorder in DSM that can lead to temporarily improved functioning. For this reason, clinicians often feel uncomfortable labeling periods of improved functioning as a phase of bipolar illness.

How can the clinician gain some degree of certainty that these periods are in fact hypomania and not just normal happiness and enthusiasm? One way is to check out how often these periods occur. As Akiskal (1996)

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**Brian Quinn, LCSW, Ph.D.** author of *Wiley Concise Guides to Mental Health: Bipolar Disorder and The Depression Sourcebook*, 2nd ed., is private practice in Huntington. He specializes in working with people with mood disorders and substance abuse. He earned his master's degree in social work at the University of Chicago and his Ph.D. in clinical social work at New York University. He has a post-graduate certificate in psychoanalytic psychotherapy from Beth Israel Medical Center in New York City. He has given seminars on the diagnosis and treatment of bipolar disorder at several graduate schools of social work, the New York and Delaware State Society for Clinical Social Work, and to thousands of clinicians nationwide in seminars sponsored by professional education seminar companies.

# Membership Committee

*by Gloria Robbins, LCSW, Chair*

Claudette Duff and Gloria Robbins have been the Membership Committee Co-Chairs, but for personal reasons, Claudette recently had to take a leave of absence. We worked very well together and accomplished much.

We had a number of conference calls which culminated in a membership retreat on October 18 in New York City at the office of Helen Hinckley Krackow. All chapter Membership Committee chairs or representatives from the chapters were present. Three related topics were addressed: Communication, Membership, Advertising and Marketing. Many creative and innovative ideas were generated.

The next step involved each chapter meeting by January 15th and committing to an action plan with the dates the plans would be put into action. The reports are still coming in and there will be a follow up sometime soon to learn how each chapter is following through on their commitments.

The Membership Committee is dedicated to and realizes the importance of generating new membership. All chapters have been very cooperative and we all work well together. May we continue to grow in membership and strength. ■

# Independent Practice Committee

*by Co-Chairs Sandra Jo Lane, LCSW and Sheila Peck, LCSW*

Beginning in March, the Independent Practice Committee will offer a program developed by its members to any Society chapter or committee that requests it. The presentation will integrate and present a variety of aspects of practice that are sometimes neglected in the 21st century business milieu.

The intention of the committee is to provide members with some business-savvy ideas to help them start, develop and build their practices. Clinicians will learn more about creating effective marketing strategies for attracting and retaining clients and will consider what holds them back from achieving their practice potential. The program will also offer some useful handouts for participants to take home.

We ask that chapters or committees submit requests for the presentation by the end of April. Contact Sandra Jo Lane or Sheila Peck in order to arrange a suitable date. Consider that this might be a useful topic for a chapter fundraiser.

The program will be a minimum of two hours in length. Here's an outline:

1. **Networking & Marketing** – Janice Gross
2. **Money: Part I** – Sandra Jo Lane
3. **Money: Part II** – Gloria Robbins
4. **The Business of Practice** – Ariane Sylva
5. **Niches & Pitches: Practice Building Nuts & Bolts** – Sheila Peck

See you in September (or later). ■

**CO-CHAIRS**

Sandra Jo Lane, **SJLSunshine@aol.com**, 631-586-7429
Sheila Peck, **Sheila2688@aol.com**, 516-889-2688

# Chapter Reports

STATEN ISLAND ▸ MID-HUDSON ▸ QUEENS ▸ NASSAU ▸ WESTCHESTER

## Staten Island Chapter

*by Mary Fitzpatrick, President*

The Staten Island Chapter is a small but very vibrant chapter. We meet one Sunday a month in a member's home, which makes for a very comfortable and enjoyable as well as educational experience.

The first half of our meetings is devoted to relevant topics on the local and state level. We hear from all our committee chairs regarding updates on what is current and important. There is always an open forum for discussion related to our roles as clinical social workers in this very difficult time in our Society.

We have developed a very successful interactive goggle group exclusive to our members. We hope to link in with other chapters at some point. Like them, we would like to attract more members, particularly younger ones, and are exploring ways to do that. Since we are small, people get to know each other quite well, which is ideal for clinicians who are in private practice and may be feeling isolated.

Once a year in the spring, we have a half-day conference that is open to mental health community. It is usually well attended and well received. This year's conference is titled, "Reflections of The Narcissistic Mother in the Daughter's Maternal Transference." The speaker is Laura Arens Fuerstein, Ph.D., who is releasing a book, *My Mother, My Mirror*, on April 2.The conference will be at the Staaten on Staten Island on Saturday, April 25, from 9:00 am to 12:30 pm. For information, e-mail Mary FitzPatrick at **fitzrodal@aol.com**.

In conclusion, the chapter is small, but has very dedicated, committed and experienced clinical social workers who are there to help each other and anyone else who reaches out to them.

## Mid-Hudson Chapter

*by Rosemary Cohen, President*

The Mid-Hudson Chapter's Board meets bimonthly, except during the summer months, and presents four annual workshops during the fall, winter and spring. All mental health professionals and students are welcome at the workshops, and CEU's are available.

On March 7, Carolyn Bersak, DSW, presented her workshop, "The 'Fatal' Counter-Transference or, The Therapist and the Triangle," on couples treatment and infidelity, at Vassar Brothers Medical Center in Poughkeepsie. In April, Gary Siegel, LCSW, will present the second part of his workshop, "The Wellsprings of Emotion," to explore clinical interventions based on emerging neuroscience research of the brain, at Benedictine Hospital in Kingston.

Our Peer Consultation Group meets with both members and non-members on the second Friday of each month. It divides its two-hour sessions between practice management issues and clinical case consultation. Mentorship groups are planned for meetings in Poughkeepsie and in Kingston.

The chapter members' Clinical Study Group had its initial meeting on February 21 to discuss Dr. Irving Yalom's novel, *When Nietsche Wept*, and the film of that name.

The chapter members' interactive listserv, an e-mail group, was launched in November 2008. The listserv facilitates communication among the entire chapter membership, and allows for messages to be posted privately as well, to and from individual members. Members have posted messages to the listserv regarding clinical referrals and reimbursement rates, Vendorship and Managed Care, and Legislative committee updates. A new chapter brochure will be ready for distribution beginning March 7.

## Queens Chapter

*by Fred Sacklow, President*

The Queens Chapter has had five educational presentations to date. Robert S. Pepper, LCSW, Ph.D., CGP, a Queens Chapter member, spoke about the work he does with groups. Nina Kandel, LCSW, CASAC, informed us about the mechanics of identifying the DWI client. Ed Pettrosky, Psy.D., gave a PowerPoint show on understanding and diagnosing ADHD. Robert and Nancy Hazelton, LCSW, discussed EAP work with trauma victims. Most recently, Helen T. Hoffman, state chair of the Vendorship and Managed Care Committee, reported on the current state of working in a managed care environment and the effect on practice since the passage of some new parity laws.

On March 8, Helen Crohn, DSW, presented "Working with Clients with Sexual Problems." On April 19, Susan Dowell, LCSW, will present "Hypnosis for the Non-Hypnotic Therapist;" on May 17, Estelle Rauch, LCSW, will present "Couples Therapy: Object Relations Theory;" and on June 14, Felicia Ivey-Toure, M.A., LMHC, CASAC, will present "Identifying, Developing and Maintaining Attainable Treatment Goals for Challenging Clients."

All meetings take place at Holliswood Hospital, where there is ample parking. We hold a very enriching networking session before each presentation beginning at 11:00 am. Presentations run from 11:30 am until 1:00 pm. If you have any questions please contact me at **Freds99@aol.com**.

Please be aware that we now have a listserv for the Queens Chapter. Soon all members will be added. I look forward to seeing you in person at our meetings and talking to you in cyberspace.

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**UPDATE:** We are proud to announce that long time member and Queens Chapter Secretary Hanna Turken, LCSW, reports that her paper, "Why Should I Love Thee When I Have So Many Reasons to Hate Thee," will appear in the next issue of *Clio's Psyche: Understanding the Why of Culture, History and Society*. In addition, her paper, "The Never-ending Challenge to the Therapist's Neutrality: A Therapeutic Crucible in Promoting Mutual Growth," has been accepted for presentation at the next ICAPP conference.

## Nassau Chapter

*by Sheila Peck, President*

The Nassau Chapter has been an especially busy place this year. In addition to a myriad of exciting programs, there have been a number of changes in our board. The "joint," such as it is, has really been "jumpin'."

First, let's bid a farewell — a truly fond one — to those who have left us. Don't worry — no one has died — they've all gone on to better things and events for which they need the time that was formerly ours.

Program Chair Jane Magenheimer left us for a women's choral group (national champion in its field, no less), and Lorraine Fitzgerald has just taken over her spot. Recording Secretary Margaret Murphy stepped aside for purposes of enjoyable grandmothering, and new board member Linda Wright stepped in. Member Evelyn Kuntz approached us with some exciting ideas for monthly networking dinners and implemented these while also joining the board.

So, while we miss Jane and Margaret, we're glad to have our new members, although we have an idea that Legislative Chair Manny Plesent would welcome another male board member with much gratitude. And when grandmotherly activities lessen, Margaret is planning to rejoin us.

Here's some of what else has been happening in Nassau: We started our presentations in October with the annual New Member Brunch, where Melissa Atkinson, LCSW, presented "The Healing Power of Humor." In November, Roberta Shafter spoke to us about "Family Context in Healing from Sexual Abuse."

December brought our annual clinical conference. This year, the presenter was Carl Bagnini, LCSW, noted teacher and Society member, who talked with us about "Strange Bedfellows: Intimacy and Infidelity," at a conference that was attended by almost 100 clinicians.

We started the New Year with "Interventions in Working with Addictions," with Eileen Wolfe, LCSW, presenting. In February, we "imported" a speaker from Washington, DC. Alison Malmon told her own true story, "Changing the Conversation about Mental Health on Campus." In March, Lorraine Fitzgerald will present on "The Rights of the Dying and an Overview of Hospice."

Also scheduled for 2009 is our annual Book Brunch; this year's topic is "Hurry Down Sunshine" by Michael Greenberg, and the talk will take place on May 3 in Great Neck.

Our End-of-Year Brunch will be some time in June, and we plan to schedule a few more networking dinners, which have become quite popular.

New Program Chair Lorraine Fitzgerald and her committee are already working on next year. The plan for the clinical conference has to do with terminations of all kinds. We'll keep you posted.

By the way, our programs are open to members of any chapter — all free of charge except for our annual program. Some of you Manhattanites think we're all the way out in the sticks (whatever sticks you may mean), but we're actually only a 45-minute car or LIRR trip away. Not far away at all for such worthwhile programs. Please do join us. And let me know if you have any questions; contact me at **sheila2688@aol.com**.

## Westchester County

*by Martin J. Lowery, President*

The major activity of the year, the annual conference, will take place on Saturday, April 25, at the Maryknoll Center in Ossining. The speaker is Dr. Sue Johnson, co-founder of Emotionally Focused Therapy (EFT). Her presentation, "The New Science of Love and Bonding: A clinical map for couple therapy," will focus on the latest science of adult bonding and delineate how the framework of EFT impacts the therapist's perspective, goals, focus and interventions. For information call Roberta Rachel Omin, LCSW, at 914-941-8179 or goodomin@optonline.net.

In addition, the chapter's most significant new initiatives have been (1) listserv development, as we seek to refine more effective means of communication to support and build members' clinical social work practices; and (2) formation of a "Membership Steering Committee," whose goal is to develop and implement a chapter plan to attract and retain members. Exciting possibilities have surfaced for both initiatives that will gradually be realized as those who generously volunteered shepherd them along.

The various other chapter committees continue to meet monthly to support members with interests in family practice, group therapy practice, mentorship/private practice, peer consultation, child/adolescent, and spirituality and therapy.

At the January General Membership Meeting, Martha Lopez, LMSW, currently Director of the Office of Hispanic Affairs for Westchester County, engaged the participants in a discussion around a presentation titled, "The Immigrant Experience: Living in Fear and Alienation." The enthusiasm that was stirred has led to a search for a way in which both the chapter and the Office of Hispanic Affairs might cooperate in bringing the issue to a larger audience. ■

# Everything You Ever Wanted to Know About Medicare

CONTINUED FROM PAGE 5

28 days payment floor period. The payment will not be released for payment until after the 28 days. It cannot be expedited.

**6. Is it possible for the Society to receive one copy of the 2009 ICD-9 manual?** [There have been some questions re: codes which may no longer be in use. Instead of individual members calling NGS separately, if we had a manual we could check this out ourselves.] ICD-9 manuals are not provided by NGS or Medicare. You need to purchase them from any major bookstore or online.

**7. Is there any possibility of NGS/Medicare opening up electronic submissions to MAC users, most likely involving new software on the part of NGS?** There are no plans to add software for MAC users.

**8. A member was informed that her name and provider address, which were the same as those submitted on a previous claim that was reimbursed, were in error and that she would have to redo the claim. Will she have to redo this?**
If the claim is rejected because her name and address are not clear on the 1500 form then she has to resubmit the claim.

**9. Area 01: Some think that claims in area 01 should be sent to Medicare Part B, NGS, P.O. Box 4751, Syracuse, NY 13221-4751. Others think there is now a different zip code.**
The zip code is not changed. Area 01 is Manhattan and that is part of the downstate counties, so that address is correct.

| | |
|---|---|
| Claims (i.e., 1500 forms) | National Government |
| NY–Downstate | Services, Inc. |
| counties/13202 | P.O. Box 4751 |
| (previously 803) | Syracuse, NY 13221-4751 |

Link to all the mailing addresses:
http://www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/POBox_ContactInfo_PartB.aspx

**10. United Behavioral Health has contracted for one year with the New York State Empire Plan and is called Optum. Will Medicare do automatic crossovers with Optum or must providers, once reimbursed by Medicare, then submit directly to Optum for Medigap reimbursement?** The beneficiary has to set up any crossovers (if it is available). Please tell providers to have the patients call 1-800-Medicare to find out if a crossover can be set up. If it is not available, then the provider will have to submit directly to Optum for reimbursement.

**11. If a patient can afford to pay a provider who is a Medicare provider, and that provider's fee is higher than the Medicare designated fee, can the provider bill for the difference?** No. **Also, can a provider bill for missed sessions? And if so, can these sessions be billed at the provider's regular (higher) fee?** No.

**12. Is it correct that we need not put any information in box 17? (1500 claim form)** Box 17 is for the Referring Physician information. This information is not needed for the services your specialty renders. Here is the link to our website for the 1500 claim form instructions. The provider should be accessing these instructions to help them complete the form correctly.
http://www.ngsmedicare.com/NGSMedicare/PartB/EducationandSupport/ToolsandMaterials/instructions0805.aspx

**13. Will the scanner reject claims if there is a comma between the last and first name on the 1500 claim form?**
The scanner should not reject because of a comma between the last and first name, but if claims are handwritten it is a problem because the handwriting must be perfect. I have seen handwritten claims where the comma looks like part of the name. So long as providers are handwriting claims they will continue to have problems with claims being rejected. There is software available that providers can purchase to print out claim forms.

**14. Is AJ (designation for clinical social worker) required after the CPT service code?** No, the AJ modifier has not been valid since 05/02/2005.

**15. Are LMSW's eligible for Medicare Part B reimbursement?**
No, Medicare does not recognize LMSW's.

**The links below give very specific information on filling out the form:**

**For information on filling out the CMS-1500 form:** http://www.ngsmedicare.com/ngsmedicare/PartB/EducationandSupport/ToolsandMaterials/instructions0805.aspx

**For a sample copy of the CMS-1500 form:** http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf

**For the CMS-1500 with the legend**
http://www.ngsmedicare.com/ngsmedicare/PartB/EducationandSupport/ToolsandMaterials/CMS-1500%20Form%20with%20legend.pdf

**Members are invited to send their questions to Virginia Lehman, Medicare Liaison for the New York State Society for Clinical Social Work, at LehmanV117@aol.com.** ■

## Borderline or Bipolar?

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has pointed out, hypomania is recurrent, happiness is not. Repeated episodes of increased goal-directed activity along with a maintenance or increase in energy in the context of reduced need for sleep, particularly if spontaneous, represent hypomania. A clinician should also be sure to check for what immediately follows periods of increased energy and productivity. Nearly always, periods of reduced need for sleep and increased activity are short-lived and quickly followed by oversleeping, lethargy, and a marked absence of goal-directed behavior (so-called anergic or shut-down depressions).

*Karen also revealed that after one, two or three days at most, she would suddenly lose interest in painting and just about everything else, as well. She would spend more time in bed, once again become socially anxious, and lose her ability to concentrate.*

In cases where a patient with apparent borderline personality has clearly not had a hypomanic episode, the clinician is uncertain whether certain behaviors represent hypomania, or where therapist and psychiatrist disagree about a past history of hypomania, it is useful to examine the patient's symptoms, course of illness, family history, and response to antidepressant medications for "features of bipolarity." ■

*In the next segment of this article, I will describe these features of bipolarity in some detail so that clinicians can more accurately identify those borderline or depressed patients with a bipolar spectrum illness.*

**REFERENCES**


Akiskal, H. (1996). The prevalent clinical spectrum of bipolar disorders: beyond DSM- IV. Journal of Clinical Psychopharmacology, 16(2 Supp 1), 4S-14S.

Akiskal, H. and Benazzi, F. (2003) Family history validation of the bipolar nature of depressive mixed states. Journal of Affective Disorders, 73(1-2), 113-122.

Deltito, J., Martin, L., Riefkohl, J., et al. (2008). Do patients with borderline personality disorder belong to the bipolar spectrum? Journal of Clinical Psychiatry, 69(4), 533-545.

Ghaemi, S. (2008). Practical guides in psychiatry: Mood Disorders. Philadelphia: Lippincott, Williams & Wilkins.

Goodwin, F. and Jamison. K. (2007). Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression. New York: Oxford University Press.

Henry, C., Van den Bulke, D., Bellivier, F. Et al. (2008). Affective lability and affect intensity as core dimensions of bipolar disorders during euthymic period. Psychiatry Research, 159(1-2), 1-6.

Judd, L. et al. (2003). A prospective investigation of the natural history of the long-term weekly symptomatic status of bipolar II disorder. Archives of General Psychiatry, 60, 261-269.


## IN MEMORIAM

**Arlene Litwack**

On February 18, 2009 our Society, AAPCSW, and PPSC lost one of our most revered members to cancer. Arlene Litwack contributed to the field of clinical social work in her teaching, workshops, lectures and supervision. Her work was most noted in the area of grief, chronic illness, and the impact of death on identity. She presented at our Annual Conference for the last five years. The loss of Arlene saddens us all.

## ANNOUNCEMENT

**New Mailing Address for All Submissions to**

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