CURRENTS

An Electronic Newsletter for the NASW Washington State Chapter September 2012 Volume 2, Issue 5

Index

Leadership Address: STEPS TO A GREAT CAREER IN SOCIAL WORK Documenting for Medicare: Tips for Clinical Social Workers

PURPOSE OF DOCUMENTATION

Medicare uses documentation to:

- Evaluate a clinical social worker's ability to plan and assess a patient's treatment
- Monitor patient's care
- Demonstrate communication and continuity of care among providers
- Assist with accurate and timely claim review and payment
- Provide appropriate utilization review and quality care evaluation; and
- Collect data for research and educational purposes

GENERAL GUIDELINES

Although a Medicare Administrative Contractor (MAC) determines documentation requirements for its providers, there are general paper and electronic guidelines required by all MACs. The general guidelines may include the following:

- Recording the start and stop time of each session
- Documenting patient's name at the top of each page
- Dating all entries
- Signing all entries in the record with your name, degree, and other significant credentials
- Recording the type of procedure provided such as individual, family, or group therapy and the appropriate Current Procedural Terminology (CPT) code to identify the procedure

- Recording the diagnosis with the appropriate International

Medicare requires providers to document all activities and interventions performed for a Medicare beneficiary. These services include office visits, telephone calls, consultations, and referrals. Documenting services for a Medicare beneficiary is an important tool validating that services were performed. It also reveals the ongoing professional activities of a clinical

Classification of Diseases (ICD) Code:

- Documenting an emergency back-up plan for records when using electronic tools

AREAS TO DOCUMENT

To help avoid overpayment requests and pass a record audit, it is helpful to document the following areas in a Medicare record when performing psychotherapy services:

- A diagnostic assessment
- A treatment plan
- Progress notes
- A closing or discharge summary

DIAGNOSTIC ASSESSMENT

A diagnostic assessment, also known as a psychosocial evaluation, should be documented in each Medicare record. The diagnostic assessment assists in establishing medical necessity and should reveal evidence that the treatment services are warranted. Services are considered medically necessary if they:

- Are proper and needed for diagnosis and treatment of patient's mental health condition
- Are provided for the diagnosis, direct care, and treatment of patient's mental health condition
- Meet the standards of good mental health practice
- Are not for the convenience of the patient or the clinical social worker

The diagnostic assessment includes, but is not limited to, the presenting problem, an interval history, a mental status examination, and a treatment plan.

TREATMENT PLAN

A treatment plan describes how the patient's problems identified in the diagnostic assessment may be improved or resolved. The treatment plan is developed to be consistent with the diagnosis and should contain objective, measurable goals and a time frame for obtaining those goals. The patient should participate in the treatment plan which is signed by both the clinical social worker and the patient.

PROGRESS NOTES

Progress notes are an important and ongoing part of Medicare documentation and record psychotherapy interventions that occur in each session. Progress notes should reveal the therapeutic interventions used such as behavior modification, insight-oriented or cognitive behavior techniques. They also demonstrate the patient's response to treatment including strength, limitations, and progress. Dates of subsequent, missed, and cancelled appointments are always recorded. Coordination of care with the primary care physician, and other significant health care providers, guardians and caretakers is also recorded.

QUARTERLY SUMMARY

For long-term Medicare patients receiving psychotherapy services, it is helpful to document a quarterly summary which includes:

- A review of the goals of therapy
- Progress as a result of therapy
- An updated treatment plan

PSYCHOTHERAPY NOTES

Progress notes that are psychotherapy notes deserve special attention. For electronic transactions, HIPAA defines psychotherapy notes as "notes recorded by a mental health professional which document or analyze the contents of a conversation during a private counseling session, group, joint, or family counseling session and are separate from the rest of the individual's medical record." Clinical social workers and other providers are exempt from submitting psychotherapy notes without a patient's authorization when the notes in question fit this definition. Psychotherapy notes exclude the following:

- Medication and prescription monitoring
- Counseling session start and stop times
- Types and frequencies of treatment
- Results of clinical tests
- Any summary of patient's diagnosis, functional status, treatment plan, symptoms, and progress to date.

ERRORS

Existing documentation cannot be embellished at a later time and should be corrected as soon as possible. If an error is made in an electronic record, a dated addendum should be added to the record to explain the error and signed.

For paper records, do not erase nor white out. Instead, draw a single line through the error, mark it "error," date and initial it. If space does not permit, an addendum may be written to explain the error. A clinical social worker should be prepared to explain the error if the record is audited by Medicare and be aware of the requirements and special safeguards required to protect an electronic health record.

CLOSING SUMMARY

A closing or discharge summary is necessary when services are completed or patient is terminated. It includes a summary of the problems and treatment provided including achievement of goals, referrals, and reason for closing or discharging patient. Proper documentation of a Medicare record can help clinical social workers to achieve successful Medicare audits and help avoid Medicare overpayment requests. Important components of a Medicare record include a diagnostic assessment, a treatment plan, progress notes, and a closing or discharge summary.

RESOURCES

Coleman, M. 2005. *Psychotherapy Notes and Reimbursement Claims*. Washington DC: NASW Press. Available Online at: http://socialworkers.org/practice/clinical/csw0805.pdf Centers for Medicare and Medicaid Services. (2005). Psychotherapy notes. *Medlearn Matters* [Online]. Available at: www.cms.gov/Outreach-and-Education/
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Proper documentation of a Medicare record can help clinical social workers to achieve successful Medicare audits and help avoid Medicare overpayment requests.

Social Workers and Skype—Part II, Telemental Health Law

By Sherri Morgan, LDF Associate Counsel, and Carolyn I. Polowy, NASW General Counsel

Introduction

Any discussion of "telemental health" (TMH) services inevitably leads to a discussion of the health professions' licensing limitations and barriers that are inconsistent with current and expanding uses of information and communications technology that connect people via the Internet. Social workers who seek to provide distance counseling through electronic means, such as videoconferencing or Skype, are faced with an array of differing licensing laws in 50 states, the U.S territories and the District of Columbia, as well as international regulatory considerations. Part I on this topic was published in November 2011 and addressed professional and legal standards regarding the use of videoconferencing technology in the provision of social work services that included privacy, security and clinical considerations (Morgan, S. and Polowy, C., 2011). It raised cautionary considerations regarding Skype's security and identified standards applicable to videoconferencing in clinical treatment. Part II addresses current issues in court decisions referencing Skype technology and licensing laws affecting online practice and cross-state or cross-national boundaries.

Examples of Skype in Reported Legal Cases

Skype is identified by name in about 100 reported legal cases, providing a few examples of Skype's broad acceptance as a source of evidence for valid consideration by courts in cases where social workers may be involved. In one case a court in California allowed a child welfare social worker to be questioned as to whether she had attempted to facilitate communication via Skype between a child and an absent parent in Mexico. The court found that the social worker's attempts at facilitating communication with the distant parent by telephone were reasonable even though she did not utilize Skype (*Bernardo M. v. Superior Court*, 2011). In family courts some judges have ordered the use of Skype by parents to facilitate communication between parents and children who were located at a distance from one another (*[Redacted] v. [Redacted],* 2009; *Mack v. Mack*, 2011; and *Smirniotopoulos v. Paul*, 2011), and the courts considered the parents' efforts in making the Skype communication available to their children as a factor in the judicial decisions regarding parental rights.

In at least one federal case, a court utilized Skype to conduct a hearing involving a defendant who was situated in Guyana (*United States v. Moe*, 2008). It is also noteworthy that the content of Skype communications was considered as possible evidence of child sexual abuse in one California case (*W.S. v. D.S.,* 2011 Cal. App. Unpub. LEXIS 6440). Other cases involved an alleged threat against a judicial officer via Skype (*SEC v. Bilzerian*, 729 F. Supp. 2d 19 (D.D.C. 2010) and identity theft using Skype (*United States v. Jordan*, 544 F.3d 656, *662 (6th Cir. Tenn. 2008)).

These cases illustrate the potential for the disclosure of Skype session content in subsequent legal proceedings as well as the potential misuse of Skype by online clients that could trigger a social worker's reporting requirement. Reporting requirements might arise, for example, from a duty to warn of a threat

made by electronic means or child sexual exploitation perpetrated via Skype or other videoconferencing technology. Clinical social workers who utilize Skype or other videoconferencing technologies for confidential client interactions need to be aware that the electronic record of the sessions and the content (if recorded or tracked) provides an evidentiary record that may be sought later for a variety of legal purposes.

Medicare Standards

The regulatory bodies that have addressed "telemedicine" or "telepsychiatry" or "telemental health" have developed standards thus far that do not necessarily encompass Internet technology as the means for conducing psychotherapy. Medicare has detailed requirements for videoconferencing that envision the use of a professional office or clinical facilities and health care professionals at each end of the transaction to ensure that professional standards are met and assistance is available to the client/patient. Medicare standards were originally based on a professional "consultation" model, whereby a psychiatrist in one locale can evaluate a patient at another facility that may lack a psychiatrist or lack the type of specialist needed in a particular case. The originating site is not a patient or client's home (CMS, 2011; Center for Telehealth & eHealth Law, 2011). This is far different from a privately practicing clinician regularly conducting psychotherapy sessions with the client who is situated in their own home.

Federal Telemental Health (TMH) Expansion

One area of mental health practice where the use of communications and information technologies has been particularly encouraged and supported is within the U.S. military and Veterans Affairs. "Many federal agencies, including the U.S. military and the Veteran's Health Administration consider TMH a legitimate and accepted mode of care and are continuing to expand its use" (National Center for Telehealth & Technology, 2011).

The National Defense Authorization Act for Fiscal Year 2012 specified that for practice within the scope of federal duties, health care professionals who are working under military or defense jurisdiction and providing services to military employees or contractors (including civilian employees of DoD) do not need to be licensed in the same state where the services are provided (10 U.S.C.A. 1094(d)).

Notwithstanding any law regarding the licensure of health care providers, a health-care professional described in paragraph (2) or (3) may practice the health profession or professions of the health-care professional at any location in any State, the District of Columbia, or a Commonwealth, territory, or possession of the United States, regardless of where such health-care professional or the patient are located, so long as the practice is within the scope of the authorized Federal duties, 10 U.S.C.A. 1094(d)(1).

This amendment clarified existing interpretations of military health care practice and expanded the scope so that it covers services outside of federal facilities as long as the services are part of "federal duties". However, there is still a lag in implementation of compatible reimbursement procedures, since Tricare (the military employees' health insurer) does not pay for telemental health services that the patient receives in the home (Gould, J., 2012).

Other federal agencies involved in facilitating telemental health practice include the Health Resources and Services Administration (HRSA) which focuses on medically-underserved communities within the United States. Many of these are rural areas where access to appropriate specialty care is limited. HRSA published an extensive analysis of healthcare licensing structures in the U.S. as a report to Congress in November 2010. The report poses models for adoption of core licensing requirements across states and a common licensure application. The medical and nursing professions have emerged as leaders in this area, providing examples that other professions may consider (see also Morgan, S. and Polowy, C., 2007).

eHealth Laws in Other Countries

The practice of telehealth may be facilitated by laws that expand the geographic scope where a professional may practice. Australia has adopted a national licensing authority that includes national boards from a number of health professions, including psychology. In order to respect state (or territorial) rights, each state or territory passed the Health Practitioner National Regulation Law. One of the purposes of the national law is "to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction" (Health Practitioner National Regulation Law, 2009).

The Australian Association of Social Workers is working to achieve professional recognition to establish the registration requirements for social workers in that country. Once social workers are included in the Australian Health Practitioner Regulation Agency, they will be able to practice across state and territorial boundaries within Australia in a manner similar to other health professions.

State Laws

State laws on telemedicine or telemental health practice present an uneven patchwork of statutory and regulatory approaches.

- Telehealth Within a State

A number of states have specific telemedicine or telehealth provisions; however, even in states that have defined telemedicine, the law generally requires practitioners to be licensed in the state where the patient is located at the time of service. This is a limiting factor that does not adequately address the capabilities of electronic health care practice. Below is an example of the telemental health law that has been in effect in Kentucky since 2000:

335.158 Duty of treating clinical social worker utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth."

(1) A treating clinical social worker who provides or facilitates the use of telehealth shall ensure:

> (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and
>
> (b) That the confidentiality of the patient's medical information is maintained as required by this

chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.

(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:

(a) Prevent abuse and fraud through the use of telehealth services;

(b) Prevent fee-splitting through the use of telehealth services; and

(c) Utilize telehealth in the provision of clinical social work services and in the provision of continuing education.

(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.

- "Telemedicine" License

A few states have developed a more accommodating approach to interstate electronic practice through the creation of a special "telemedicine" license which permits out-of-state physicians to practice electronically within the state, but prohibits them from practicing in-person unless a full license is obtained. Examples include Louisiana (La. R.S. 37;1276.1; 37:1271) which has created a special "telemedicine" license for out-of-state physicians wherein they agree not to open an in-state office, not to meet with Louisiana patients and not to receive calls in Louisiana. This is a limited type of license and physicians who want to see patients in the state or open an office there would need to obtain a regular license to practice medicine. Montana also has a limited "telemedicine" license available only to out-of-state practitioners (Mont. Code Ann. 37-3-301). These provisions do not include social work practice and they are offered as examples for consideration. A number of other states have similar provisions, including Alabama ("Special Purpose License"), Minnesota and Tennessee, although this is an area of law that is changing rapidly, so this list should not be considered comprehensive.

- Exemptions for Temporary or Occasional Out-of-State Practice

Many states have exemptions from health care licensure requirements for brief practice within a state by out-of-state practitioners (who are otherwise licensed to practice in their home state). These may range from 10 – 90 days and may include various limitations, such as licensure board notification, registration and/or approval. These temporary/guest licensure provisions may be sufficient for the delivery of telemental health services to clients who have relocated and are in need to transition care in the new state or for a practitioner who primarily provides telehealth and in-person services within the home state, but who has occasional brief interventions with out-of-state clients or client groups or client family members (see ASWB Social Work Laws and Regulations Database, www.aswb.org). The means by which a state counts the permissible number of days of exempted practice varies by state. For example, some states may allow 30 days of continuous practice, while others may allow the days to be counted on an annual basis so that a total of 30 days of unlicensed practice

per year may be spread across several months or there may not be any interpretation of the rule.

- Telehealth Reimbursement

California's new telehealth law (California Assembly Bill 415, 2011), effective January 1, 2012, amended several provisions of existing law and added a new section in the state insurance code, authorizing payment of telehealth services and leaving it to the discretion of the health care provider as to whether telehealth services are appropriate.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) No health insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth**,** subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups.

(d) No health insurer shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract between the policyholder or contract holder and the insurer, and between the insurer and its participating providers or provider groups.

(e) Notwithstanding any other provision, this section shall not be interpreted to authorize a health insurer to require the use of telehealth when the health care provider has determined that it is not appropriate (Cal. Ins. Code § 10123.85, 2012).

Other states will need to address insurance reimbursement in order to facilitate access to telehealth services. A valuable resource for state by state telehealth information is available online in a wiki format from the American Telemedicine Association, where new legislation is posted on an ongoing basis (http://www.americantelemed.org/i4a/pages/index.cfm?pageID=3604).

Model Social Work Practice Act

The most recent version of the Model Social Work Practice Act (Association of Social Work Boards (ASWB), 2011, p. 7) defines electronic practice as follows:

Section 107. Electronic Practice
The practice of Baccalaureate Social Work, Master's Social Work, or Clinical Social Work to an individual in this jurisdiction, through telephonic, electronic, or other means, regardless of the location of the social worker, shall constitute the practice of social work and shall be subject to regulation under this Act.

In its commentary on this provision, ASWB reaffirms the preference for social work services to be delivered in-person while recognizing the increasing reality of electronic practice and the need for further study and regulation in order to protect the public (ASWB, 2011).

In addition to defining electronic social work practice as occurring in the physical location of the client, the commentary on the temporary practice exemption (ASWB, 2011, p. 23 – 24, Section 301(h)(1)) also addresses

electronic practice and takes the position that a temporary practice provision is preferred over a limited telepractice license. This approach does not address the practice of social workers who engage primarily in telepractice and who seek to provide services that may be national in scope.

Analysis and Conclusions

Health care regulators and health care insurers are beginning to focus more attention to developing workable standards for the practice of telemental health; however, the pace of technological innovation in electronic communications and rapid adoption by clients and practitioners makes it challenging to fashion requirements that create a reasonable balance between protecting the public and facilitating access to care. Social workers who are engaged in telemental health practice need to be technologically sophisticated enough to be aware of the limitations on its use and to utilize appropriate safeguards to protect clients' confidentiality and to meet clinical needs according to professional standards. Unlicensed practice in a state where a social worker is providing electronic services is unlikely to be covered by professional liability insurance, even if electronic practice is covered (NASW Assurance Services, 2012).

While the adoption of a specialized or limited "telemental health" license is appealing one of the weaknesses to this approach is the potential for states with less rigorous licensure and social work supervision standards to reduce the quality of services provided electronically in other states. If licensure in only one state is required in order to obtain a "limited-practice" telemental health license in other states, then the need for uniformity among state standards is substantially increased.

For the present time social workers must carefully review the licensing law in the state in which they are physically located and the law in any states where their clients may be located at the time telemental health services are delivered. Notification and/or registration (if not full licensure) in the state where the client is located are generally required unless the social worker is employed by military or federal agencies. Advocacy on a state-by-state basis is needed in order to support the passage of legislation and/or regulations that will encompass the methods of service delivery in which practicing social workers are already engaged. The interstate practice of social work and other health and mental health care is already a smaller discussion in an arena that is now international in scope (see Hiller, J., McMullun, M., Chumney, W., and Baumer, D., 2011, for a comparison of U.S. and E.U. health privacy laws and policies). Emerging issues within that realm include how to meet legal requirements when electronic records are stored in "cloud computing" facilities that may be located outside of U.S. soil.

NASW and the Legal Defense Fund will continue to monitor, propose, analyze and comment on solutions to social work licensure issues that may present barriers to practice or limit clients' access to services while advocating for high standards of practice.

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REFERRENDUM ON MARRIAGE EQUALITY

The Washington State Chapter Board of Directors approved to support R 74 at its meeting on Saturday September 8.

R 74 is a REFERRENDUM ON MARRIAGE EQUALITY. Here is a link to Washington United for Marriage, one of the organizations supporting R 74, **Washington United for Marriage**.

APPROVE R74
washingtonunited for marriage

You can participate in many ways in supporting R 74. You can make a contribution directly to Washington United for Marriage by **Donating Here** or you can sign up to participate on a phone bank effort to call voters to urge them to support R 74. The Washington State Chapter is looking to coordinate a night we have Washington State Chapter members participate in a phone bank opportunity to call Washington voters. Please look for that information in the next week on how to participate.

Thank you for your support of R 74.

Upcoming Workshops

September 28, 2012 - North Seattle Community College, Seattle, WA
From Principles to Problem-Solving: Ethics for Social Workers
Brian Giddens, ACSW, LICSW

October 12-13, 2012 - Bellevue Red Lion, Bellevue, WA
Clinical Supervision Workshop
Marshall Jung, DSW

October 27, 2012 - North Seattle Community College, Seattle, WA
Compassion, Fatigue, & Vicarious Trauma
Mary Jo Barrett, MSW

December 1, 2012 - North Seattle Community College, Seattle, WA
LICSW/LASW Licensure Exam Prep Workshop
Jonathan Beard, LICSW, CPRP

February 23, 2012 - TBA, Seattle, WA
LICSW/LASW Licensure Exam Prep Workshop
Jonathan Beard, LICSW, CPRP

March 8-9, 2013 - TBA, Seattle Area, WA
From the Beck Institute on CBT
Julie Hergenrather

March 22, 2013 - TBA, Seattle Area, WA
From Principles to Problem-Solving: Ethics for Social Workers
Brian Giddens, ACSW, LICSW

February 23, 2012 - TBA, Seattle, WA
LICSW/LASW Licensure Exam Prep Workshop
Jonathan Beard, LICSW, CPRP

October 26, 2013 - TBA, Seattle Area, WA
The Mini Mental State Examination
Thomas Starkey

Click here to Register!

Useful Resource

The Tobacco Quitline (1-800-QUIT-NOW) is once again available to the uninsured and underinsured in Washington State. Anyone who lives in our state is now eligible for at least one call to the quit line.

We have one-year's funding to make the quit line available to people without insurance thanks to the state legislature and the Centers for Disease Control and Prevention. Since launching in 2001, the quit line has helped more than 160,000 Washington residents. People who call the quit line double their chances of quitting successfully.

Quit line services can include counseling and nicotine replacement therapy, including gum or patches. Services are available to people who are:

- Age 18 or older and live in Washington state.
- Uninsured, or underinsured and have an insurance plan that does not cover cessation benefits.
- Pregnant.
- On Medicaid, or on a Medicare program that does not offer cessation benefits.
- Eligible for health care services provided by Indian Health Services.
- Or have a referral from the Veteran's Administration, or have an insurance plan which covers the

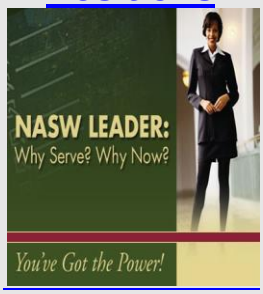
quit line tobacco cessation program.

For additional information please visit our Tobacco Quitline Services website.

Or view the August 1, 2012 Department of Health news release.

To order quit line cards for an office, clinic or program please send the full address and a contact name to: Joella.pyatt@doh.wa.gov.

Call for Nominations for FY 2013 NASW-WA Leadership Positions



NLIC FY 2013 Election Positions

Time To Serve

Have you wanted to serve the Social Work profession? Have you wanted to be part of the Washington State Chapter of NASW Board of Directors?

You can!

The Washington State Chapter of NASW is recruiting Social Work leaders to serve on its Board of Directors beginning July 1, 2013. The WA State Chapter Nomination Leadership Identification Committee (NLIC), chaired by Taylene Watson, is beginning its identification of WA State Chapter members to serve on the Board of Directors as Treasurer Elect, region representatives, vice president of policy areas, and student representatives. The positions the NLIC is recruiting for are:

Board Positions

Treasurer Elect (July 1, 2013 - June 30, 2015)

V.P. Social & Political Action (July 1, 2013 - June 30, 2015)

V.P. Professional Development (July 1, 2013 - June 30, 2015)

BSW Student Rep. (July 1, 2013 - June 30, 2014)

MSW Student Rep. (July 1, 2013 - June 30, 2014)

Region Positions (July 1, 2013 - June 30, 2015)

Central Washington Region Representative.

Inland Empire Region Representative

Mount Baker Region Representative

North Puget Sound Region Representative.

If you have an interest to serve your professional organization, please consider one of the above positions and complete the **NLIC application** which can be found on our website (make the red NLIC application the link). The WA State chapter is looking for social Worker members that want to ensure

the fiscal stability of the organization. The NLIC is recruiting members that want to bring new program and service ideas to the organization. We want energetic and knowledgeable Social Workers to participate and serve the Washington state chapter.

Please complete the NLIC Nominations Appointment application and return it to the WA State Chapter office by February 1, 2013.

NASW-WA State Chapter has CE ONLINE!

NASW WA Chapter has developed ONLINE CE for the 24/7 convenience of licensed Social Workers, Marriage and Family Therapists, and Mental Health Counselors**.**

Select **ONLINE CE** from an OnDemand Catalog or participate in a live webcast.

To view **ONLINE CE** workshops, go to our website, **NASW-WA Website**, click on the CE Institute button on the home page that says:

Social Workers, Smartphones and Electronic Health Information

By Sherri Morgan, LDF Associate Counsel, and Carolyn I. Polowy, NASW General Counsel

Introduction

Social workers are increasingly relying on mobile communications devices such as Internet-enabled mobile phones ("smart phones"), laptop computers and tablet computers in the course of carrying out professional social work duties. Some of the common issues that arise in the use of these devices include:

- Is it okay for me to email information to my clients?
- Am I required to use an electronic health record for clients?
- I've started storing my client files on a remote server through an IT vendor that provides password access to the records. Is that sufficient protection for clients' confidentiality?

This article will provide highlights of current and emerging issues for social workers who use mobile electronic devices in practice and suggests steps for consideration and action.

Background

Clinical treatments for a variety of emotional conditions and mental disorders are now offered through the medium of smart phone applications as well as computer-based videoconferencing, text and email. Examples of clinical smart phone applications include treatment of anxiety

disorders, phobias and alcohol dependence and using dialectical behavioral therapy (DBT) coaching and biofeedback (Boschen, M.J. and Casey, L.M., 2008; Cuijpers, P., Marks, I.M., and van Straten, A., et al., 2009; Dimeff, L.A., Rizvi, S.L., Contreras, I.S., et al., 2011; *and* Maier, E., Reimer, U. and Ridinger, M., 2011). Many other uses in behavior modification and management of medical conditions have been developed and are being tested, including remote monitoring of patients with chronic health conditions (Boulos, M.N, et al., 2011).

According to a study by the Office of the National Coordinator for Health Information Technology (ONCHIT), most mobile phones did not meet more than 40 percent of the HIPAA security standards without additional modifications (Mosquera, 2012). The ONC expects to develop best practices for securing smart phones by the fall and make them available online with a focus on providing guidance to small and medium-sized health care entities.

Password Protection

Securing an electronic device, particularly a mobile device, with password protection is a basic and easy step to accomplish. Strong passwords are those that would not be easy to guess, are sufficiently long (minimum of 8 characters) and sufficiently complex (combination of letters, symbols, uppercase and lowercase, and numbers). Setting the device to go into a password-protected mode after a short period of inactivity will deter simple attempts to breach the device and it is one component of a good security protocol. It is important to regularly clean any touchscreens to remove fingerprint traces of the device password (Wagner, 2010).

Encryption

Encryption software is one of the essential technology tools for a health provider to employ when using electronic devices and modalities for creating, receiving, transmitting and storing confidential client records and information. Affordable encryption technology is commercially available for securing the data contained on smartphones, laptops and tablet computers and for transmitting secure emails and text messages. If encrypted data are lost or stolen it is far less likely to be accessed by a third party in a useable format than unencrypted data. The HIPAA regulations specify that if encrypted patient health information is subject to a privacy breach, the health care entity is exempted from breach notification requirements. This is due to the decreased likelihood that encrypted data may be accessed in a useable manner (Morgan, S. and Polowy, C., 2010b).

Encryption software may be purchased online and downloaded directly to the device or it may be pre-installed on the device (see Wagner, 2010 for a discussion of default encryption software on the iPad).

Data Wiping

Software is available to remotely locate and erase the data from your device (Mosquera, M., 2011). This tool is useful as long as the device is connected to the Internet, such as via WiFi or an active GPS connection; however, if those connections are not available (such as when the battery dies), this feature will not be operable. Regardless, this is a simple application to upload and activate and it may be helpful in the immediate aftermath of a loss or theft to track the missing device.

WiFi Networks

Small health care practices, such as clinical social workers' offices, may use a WiFi network to connect computers to the Internet and many of these systems are not secure. Unless specific actions are taken, it is likely that a WiFi network is broadcasting a portion of its' identifying signal that may enable a hacker to access the system without authorization. The service set identifier (SSID) has default settings that may be changed by a savvy consumer. A number of steps are recommended to increase the security of WiFi networks, such as disabling the broadcast of the SSID and re-setting the administrative passwords and "upgrading the WiFi network security to Wi-Fi Protected Access (WPA) or Wi-Fi Protected Access II (WPA2)… which are two security protocols and security certification programs … to secure wireless computer networks. The Wi-Fi Alliance defined these in response to serious weaknesses researchers had found in the previous system, WEP (Wired Equivalent Privacy)" (Bradley, T., 2012; Mosquera, M., 2011).

What about Email?

The terminology of the HIPAA privacy and security regulations does not focus on email; however, the regulations do require that entities subject to HIPAA develop a plan to identify vulnerabilities to the privacy and security of individually-identifiable protected health information (PHI) and to address those vulnerabilities (Morgan, S. and Polowy, C., 2005). For use of email which includes information beyond simple appointment reminders, encryption is a valuable technology. For some situations, even electronic appointment reminders may breach client privacy, such as when a person does not want their spouse to be aware they are receiving clinical services and they share email passwords at home or have a shared email account.

Thus, a best practice would be to provide clients with an "opt-in" option for accepting emails or to only respond to emails that are initiated by the client. For client-initiated emails, it may still be appropriate to first confirm that the client consents to receipt of a return email. Emails may be considered part of the client's record, so social workers should always be aware that electronic communications may be subpoenaed, accessed by auditors, requested by the client or otherwise disclosed and used in a variety of legal or administrative proceedings. Although emailing is an efficient means of communication, the same care should be taken in framing an email response as with any other client-related correspondence.

Am I required to have an Electronic Health Record for my clients?

Financial incentives are available to physicians and certain categories of practitioners, including hospitals, for the adoption of electronic health record technology; however, these benefits are not currently offered to independently practicing clinical social workers (CMS, 2010). Some health plans and health insurance companies may begin requiring reimbursement claims to be filed electronically, so private clinical social work practices will find it increasingly difficult to avoid the adoption of electronic claims filing processes unless they utilize a self-pay-only model. Filing electronic health claims is not synonymous with the adoption of electronic health records for clients' clinical charts. Many small practitioners maintain a paper-based office, but use a third-party billing service that submits electronic claims on their behalf. This billing model still

requires that the clinical social work practice adhere to all HIPAA privacy regulations, for both paper and electronic records.

Smart Phone Access to Health Records

Models for allowing emergency providers to access patient records are being developed and legal standards permit such access, including access to electronic health databases (Morgan, S. and Polowy, P., 2011). The methods of securing access in a mobile environment are under study and some considerations include retaining data on the patient's mobile device with password protection and biometric authentication (accessible even for unconscious patients) (Gardner, R., Garera, S. and Pagano, M. 2009). Health information technology scientists are attuned to the need for maintaining information as confidential while permitting access in appropriate and necessary circumstances only to the personnel who require access. Extensive policy analysis has been conducted to evaluate the best approach to preserving patient privacy while supporting mobile and in-home care (Kotz, D., Avancha, S. and Baxi, A., 2009) and this is an area of law and health care practice that is evolving rapidly.

Cloud Computing and Health Privacy

Use of secure, off-site computer servers to store data for rapid access via the Internet has increased exponentially as mobile electronic devices proliferate. Health care practitioners who seek to harness the potential for this technology to store and access patient information must carefully evaluate the business that offers such services. Data servers that are not located on U.S. soil may subject the provider to a risk of non-compliance with HIPAA. In order to meet HIPAA requirements the provider may need to be able to determine where the confidential "data is physically stored, how many copies have been made, whether or not the data has been changed or if the data has been completely deleted when requested" (Admin, 2012). A cloud data company providing storage services for health-related purposes should be willing to sign a HIPAA business associate agreement, requiring that information be maintained in accordance with HIPAA privacy and security standards (see Morgan, S. and Polowy, C., 2010a).

Analysis and Conclusions

Working with new technology as a consumer does not automatically provide sufficient expertise or knowledge to apply the same technology in social work practice. To meet professional standards, social workers much conduct sufficient inquiries into the applicable legal, technological and administrative safeguards that assure clients' confidentiality will be protected and that they will be able to access their information readily (National Association of Social Workers, 2005). New service delivery methods also require that social workers develop the professional competence necessary to provide effective client interventions. Encryption is a standard expectation for the use of electronic health information; however, new applications for mobile health data are expanding at such a pace that each adoption of a new program or device must be evaluated for potential vulnerabilities so that the promise of its potential for new health care delivery models may be realized responsibly.

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2012 Medicare Updates for Clinical Social Workers

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For 2012, the Center for Medicare and Medicaid Services (CMS) has announced several changes impacting clinical social workers who are Medicare providers. Clinical social workers should note these changes to keep their Medicare practice running smoothly and effectively. Updates include:

SGR REDUCTION: In February, Congress averted the 27.4 percent Sustainable Growth Rate (SGR)

reduction which took effect March 1, 2012. As a result, there was no increase in Medicare reimbursement for psychotherapy services for 2012.

PSYCHOTHERAPY ADD-ON: The five percent add-on psychotherapy increase clinical social workers have received by Medicare for the past several years was discontinued on March 1, 2012 by Congress. Thus, clinical social workers can expect to receive a five percent deduction in Medicare reimbursement.

MEDICARE COPAYMENT FOR MENTAL HEALTH SERVICES: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) phases out the 50 percent copayment for mental health services beginning in 2010 and expanding to 2014. For 2012, the Medicare co-payment for mental health services is 40 percent.

PRACTICE EXPENSE ADJUSTMENT: 2012 is the third year of a four-year transition to the practice expense resource based system which includes clinical labor, supplies, and equipment used to perform psychotherapy services. Clinical social workers can expect a three percent reduction in reimbursement for practice expense.

PSYCHOANALYSIS CODE: New work value for the psychoanalysis Current Procedural Terminology (CPT) code was delayed until the family of psychiatric codes could be resurveyed and revalued for work and practice expense values. The family of psychiatric codes is being reviewed during 2012.

ELECTRONIC FUND ENROLLMENT: Medicare is enforcing its electronic fund enrollment for all providers. Section 1104 of the Affordable Care Act mandates federal payments to providers only by electronic means. As part of CMS's revalidation efforts, all clinical social workers currently receiving electronic funds transfer (EFT) payments are required to submit the CMS-588 EFT form with a Provider Enrollment Revalidation application or at the time any change is being made to the provider enrollment record by the clinical social worker.MSW, LICSW, CTrs. All Rights Reserved.

PHYSICIAN QUALITY REPORTING SYSTEM: The 2012 Physician Quality Reporting System (PQRS) offers an incentive payment of 0.5 percent of the total estimated Medicare Part B physician fee schedule to clinical social workers and other Medicare providers who report quality measures. Currently PQRS is optional. Clinical social workers who are not currently using PQRS should begin using the measure program in 2012. This prepares them to report PQRS for the year 2013 or be subject to a 1.5 percent penalty in 2015 for not reporting quality measures. Examples of quality PQRS measures clinical social workers can report include the following:

- **Major Depressive Disorder (MDD):** Diagnostic Evaluation – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period.
- **Major Depressive Disorder (MDD):** Suicide Risk Assessment – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.
- **Elder Maltreatment Screen and Follow-Up Plan:**

Percentage of patients aged 65 years and older with documentation of a screen for elder maltreatment and documented follow-up plan.

Additional Information about the PQRS is available online

Versions 5010: Version 5010 enforcement was extended from January 1, 2012 to June 30, 2012 to allow the industry additional time to upgrade their computer systems. Information about Version 5010 is available online.

ELECTRONIC HEALTH RECORD: At this time, clinical social workers and other non-physician practitioners continue to be ineligible for electronic health record incentives. A coalition of non-physician practitioners has been developed to address this with Congress.

HEALTH AND BEHAVIOR ASSESSMENT AND INTERVENTION CODES: CMS continues to restrict payment to clinical social workers when services are performed using the Health and Behavior Assessment and Intervention CPT Codes. NASW continues its advocacy efforts with CMS to change this.

ICD-10-CM: CMS has proposed a delay in the implementation of the International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) from October 1, 2013 to October 1, 2014 to allow the industry additional testing time for a smooth, permanent transition.

SKILLED NURSING FACILITIES: Clinical social workers in independent practice are only reimbursed for mental health services under Medicare Part B. For 2012, CMS continues to enforce its policy for the collection of overpayment for mental health services provided in a skilled nursing facility (SNF) by clinical social workers. SNFs provide Medicare Part A services.

DENIAL OR REVOCATION CLAIMS: Effective July 16, 2012, previously denied Medicare claims for psychotherapy services furnished during a period of denial or revocation may be resubmitted to CMS within one year after the date of reinstatement or reversal.

BENEFICIARY: Effective July 16, 2012, the term "recipient" will be removed from CMS Medicaid regulations and replace with "beneficiary" which will mean all individuals who are eligible for Medicare or Medicaid services.

INTELLECTUAL DISABILITY: CMS has replaced the term "Mental Retardation" with "Intellectual Disability" or Individuals with Intellectual Disabilities (IID) in all CMS regulations.

Additional information about 2012 Medicare updates is available in the *Federal Register*, November 28, 2011, Vol. 75, Number 228 and *Federal Register*, May 16, 2012, Vol. 77, Number 95. Available online.

Clinical social workers should note these changes to keep their Medicare practice running smoothly and effectively.

Center for Workforce Studies & Social Work Practice Recent Publications

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- *Social Work Salaries by Gender*
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- *Social Workers in Hospice and Palliative Care*
- *Social Workers in Hospitals and Medical Centers*
- *Social Workers in Mental Health Clinics & Outpatient Facilities*
- *Social Workers in Private Practice*
- *Social Workers in Psychiatric Hospitals*
- *Social Workers in Schools*
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Social Work Practice Perspectives: Available here.

- *2011 Medicare Changes for Clinical Social Workers*
- *Adolescent Depression and Suicide Risk: How Social Workers Can Make a Difference*
- *Advocating for Clinical Social Workers: Highlights of 2010*
- *Creativity and Aging*
- *Dangerous Rites of Passage: Trends in College Alcohol Consumption*
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New Practice Standards For a complete list of practice standards, click here.

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Have a fun, safe, and Happy Halloween!