SOCIAL WORK, PSYCHOTHERAPY NOTES, AND RECORD ACCESS IN NEW YORK STATE

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Social Worker

Social work is a profession that helps individuals, families, and groups change behaviors, emotions, attitudes, relationships, and social conditions to restore and enhance their capacity to meet their personal and social needs.

http://www.op.nysed.gov/prof/sw/

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Unlicensed Social Workers

New York State Education Law establishes the requirements for licensure as a Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW).

Unlicensed social workers can provide certain services.

Services that are defined as not requiring licensure include but are not limited to:

1. Serve as a community organizer, planner, or administrator for social service programs in any setting.
2. Provide supervision and/or consultation to individuals, groups, institutions and agencies.
3. Serve as a faculty member or instructor in an educational setting.
4. Plan and/or conduct research projects and program evaluation studies.
5. Maintain familiarity with both professional and self-help systems in the community in order to assist the client in those services when necessary.
6. Provide advice and guidance and assist individuals or groups with difficult day to day problems such as finding employment, locating sources of assistance, and organizing community groups to work on a specific problem.

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Unlicensed Social Workers (cont.)

7. Consult with other agencies on problems and cases served in common and coordinating services among agencies or providing case management.
8. Conduct data gathering on social problems.
9. Serve as an advocate for those clients or groups of clients whose needs are not being met by available programs or by a specific agency.
10. Assess, evaluate and formulate a plan of action based on client need.
11. Provide training to community groups, agencies, and other professionals.
12. Provide administrative supervision.
13. Provide peer services.
14. Collect basic information, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining the need for services

http://www.op.nysed.gov/prof/sw/swpracfaqs.htm

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Licensed Master Social Work (LMSW)

Licensed master social work practice:

1. The practice of licensed master social work means the professional application of social work theory, principles, and the methods to prevent, assess, evaluate, formulate and implement a plan of action based on client needs and strengths, and intervene to address mental, social, emotional, behavioral, developmental, and addictive disorders, conditions and disabilities, and of the psychosocial aspects of illness and injury experienced by individuals, couples, families, groups, communities, organizations, and society.
2. Licensed master social workers engage in the administration of tests and measures of psychosocial functioning, social work advocacy, case management, counseling, consultation, research, administration and management, and teaching.
3. Licensed master social workers may **only** provide "clinical social work" services (diagnosis, psychotherapy, and assessment-based treatment planning) **under supervision** of a Licensed Clinical Social Worker, licensed psychologist or licensed physician who is board-certified in psychiatry.
4. The Education Law and Commissioner's Regulations require appropriate supervision, which in some instances may require direct or on-site supervision, in the opinion of the supervisor. Whether or not the supervisor is on-site, the supervisor shares with the LMSW responsibility for the professional services provided to each client. Therefore, the supervisor may need to be on-site to conduct joint client intakes and directly observe the LMSW practicing clinical social work.

http://www.op.nysed.gov/prof/sw/article154.htm
http://www.op.nysed.gov/prof/sw/swpracfaqs.htm

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Licensed Clinical Social Work (LCSW)

Licensed clinical social work practice:

1. The practice of clinical social work encompasses the scope of practice of licensed master social work and, in addition, includes the diagnosis 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 and 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 mental, emotional, behavioral, and social functioning and well-being of individuals, couples, families, small groups, organizations, communities and society.
2. Diagnosis in the context of licensed clinical social work practice is the process of distinguishing, beyond general social work assessment, between similar mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities within a psychosocial framework on the basis of their similar and unique characteristics consistent with accepted classification systems.
3. Psychotherapy in the context of licensed clinical social work practice is the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior which are intellectually, socially, or emotionally maladaptive.
4. Development of assessment-based treatment plans in the context of licensed clinical social work practice refers to the development of an integrated plan of prioritized interventions, that is based on the diagnosis and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, disabilities and impairments, and social problems.

http://www.op.nysed.gov/prof/sw/article154.htm

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Psychotherapy Notes - HIPAA

- The HIPAA Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are **separate from the rest of the patient's medical record**.
- Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.
- Psychotherapy notes also do not include any information that is maintained in a patient's medical record. See 45 CFR 164.501.

https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html

Psychotherapy Notes – HIPAA (cont.)

Question: The HIPAA definition addresses psychotherapy notes and how they do not include things like start and stop time, symptoms or progress to date. These notes are the clinician's personal notes about the session and at CCDR have to write down some of that information as it is required for billing purposes. So where are we supposed to keep track of that needed information? It doesn't seem to make sense to have to use different notebooks to keep track of certain information as that is still personal notes.

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Psychotherapy Notes – HIPAA (cont.)

From the Commentary in the HIPAA Privacy Rule:

Comment: Some commenters claimed that psychotherapy notes contain information that is often essential to treatment.

Response from HHS:

- We conducted fact-finding with providers and other knowledgeable parties to determine the standard practice of psychotherapists and determined that only some psychotherapists keep separate files with notes pertaining to psychotherapy sessions. These notes are often referred to as "process notes," distinguishable from "progress notes," "the medical record," or "official records." These process notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. We were told that process notes are often kept separate to limit access, even in an electronic record system, because they contain sensitive information relevant to no one other than the treating provider. These separate "process notes" are what we are calling "psychotherapy notes." Summary information, such as the current state of the patient, symptoms, summary of the theme of the psychotherapy session, diagnoses, medications prescribed, side effects, and any other information necessary for treatment or payment, is always placed in the patient's medical record. Information from the medical record is routinely sent to insurers for payment.
- . . . the rationale for providing special protection for psychotherapy notes is not only that they contain particularly sensitive information, but also that they are the personal notes of the therapist, intended to help him or her recall the therapy discussion and are of little or no use to others not involved in the therapy. Information in these notes is not intended to communicate to, or even be seen by, persons other than the therapist.
- The final rule makes it clear that any notes that are routinely shared with others, whether as part of the medical record or otherwise, are, by definition, not psychotherapy notes, as we have defined them. To qualify for the definition and the increased protection, the notes must be created and maintained for the use of the provider who created them i.e., the originator, and must not be the only source of any information that would be critical for the treatment of the patient or for getting payment for the treatment. The types of notes described in the comment would not meet our definition for psychotherapy notes.

Psychotherapy Notes – HIPAA (cont.)

- Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes.
- Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes. (§ 164.508(a)(2))
- An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes." (§ 164.508(b)(3)(ii)).
- A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient.

Psychotherapy Notes – NYS PHL

- NYS does not define "psychotherapy notes" but uses the term "personal notes."
- Section 18 of the Public Health Law permits providers to deny access to personal notes and observations. The law defines personal notes and observations as "a practitioner's speculations, impressions (other than tentative or actual diagnosis) and reminders, provided such data is maintained by a provider."

Denial of Access - HIPAA

- § 164.524(a)(3) Reviewable grounds for denial. A covered entity may deny an individual access, provided that the individual is given a right to have such denials reviewed . . . in the following circumstances:
  - **(i)** A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
  - **(ii)** The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
  - **(iii)** The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.
- § 164.524(a)(4) Review of a denial of access. If access is denied on a ground permitted under paragraph (a)(3) of this section, the individual has the right to have the denial reviewed by a licensed health care professional who is designated by the covered entity to act as a reviewing official and who did not participate in the original decision to deny. The covered entity must provide or deny access in accordance with the determination of the reviewing official under paragraph (d)(4) of this section.

Denial of Access – NYS PHL

(§ 18(3) Limitations on access. (a) Upon receipt of a written request by a qualified person to inspect or copy patient information, a practitioner may review the information requested. Unless the practitioner determines . . . that (i) the requested review of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right to access to the information, or (ii) the material requested is personal notes and observations . . . .

So Which Denial of Access Rule Prevails – HIPAA or PHL?

- **Q.** PHL §18(3) provides that a health care provider may deny access to all or a part of the information and may grant access to a prepared summary if the provider determines that the review of all or a part of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information.

  HIPAA at 164.524(a)(3)**(i)** provides where the PHI does not make reference to another person a licensed health professional may withhold access to the individual if the access requested is reasonably likely to endanger the life or physical safety of the individual or another person. Which standard prevails?

- **A.** NYSDOH states that the HIPAA standard prevails. The HIPAA standard "endanger the life or physical safety" of the individual or another person is a more stringent standard than the PHL §18 standard "substantial" and "identifiable" harm.

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HIPAA or PHL?

- **Q.** HIPAA provides at 164.524(a)(3)**(ii)** that where the PHI makes reference to another person, and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person, the licensed health professional may deny access.

  PHL §18(3) provides that a health care provider may deny access to all or part of the information if the provider determines that the access would cause substantial and identifiable harm to the subject or other person which would outweigh the qualified person's right of access. Which standard prevails?

- **A.** HIPAA prevails if the disclosure would cause substantial harm to the subject but not the other person, because the threshold for the harm to the subject in order for the exception to apply is "endanger the life or physical safety" of the individual.

  PHL §18 prevails if disclosure would cause substantial harm to the other person.

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HIPAA or PHL?

- **Q.** HIPAA at 164.524(a)(3)**(iii)** provides that where the request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that disclosure is reasonably likely to cause substantial harm to the individual or another person, the licensed health care professional may deny the individual access. Which standard prevails?
- **A.** PHL §18 prevails because both HIPAA and PHL §18 have a "substantial harm" threshold.

Contrast Between HIPAA & PHL

HIPAA at 164.524(a)(3)**(i)** has the stricter "endanger the life or physical safety standard, but at 164.524(a)(3)**(ii)** and 164.524(a)(3)**(iii)** have the "substantial harm" standard.

When the facts fall into the 164.524(a)(3)**(i)** situation, the stricter HIPAA "endanger the life or physical safety" preempts the PHL "substantial" harm standard.

When the facts fall into the 164.524(a)(3)**(ii)** and 164.524(a)(3)**(iii)** situations, the "substantial" harm standard is the same as the PHL §18 "substantial" harm standard so PHL §18 prevails.

https://www.mssny.org/App_Themes/MSSNY/pdf/Practice_Resources_HIPAA_-NPI_Health_Insurance_Privacy_Rule_Privacy_Preemption_Analysis.pdf

Questions?
Comments?
Concerns?

Contact
Robert G. Trusiak

Robert G. Trusiak, Esq.
300 International Drive, Suite 100
Williamsville, NY 14221
716/352-0196
robert@trusiaklaw.com