Leslie S. Tsukroff, Inc.
Business Management Consulting for Mental Health Practitioners
68 North Bridge Street
Somerville, New Jersey 08876
973-879-1678
LTsukroffLCSW@Hushmail.com
https://www.LeslieTsukroff.com

April 2021 Newsletter

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1. Now registering! Audit-Proof Progress Notes: An In-Depth Look at Documentation & Record-Keeping in Private Practice. Sunday, April 18, 2021.
2. The Cures Act
3. Send your ethics and practice related questions to LsTsukroff@aol.com for the May Newsletter

NOW REGISTERING!
Audit-Proof Progress Notes: An In-Depth Look at Documentation & Record-Keeping in Private Practice
Sunday, April 18, 2021

With the implementation of the Interoperability, Accessibility and Information Blocking provisions in the 21st Century Cures Act (what is being referred to as "Open notes") going into effect on April 5th, you don't want to miss this valuable workshop that will help streamline your documentation methods, protect your practice and demystify writing Progress Notes once and for all.

All participants will receive a customizable Progress Note Template for FREE- a $15.00 value!!

Date: Sunday, April 18th
Time: 9:30 AM-11:30 AM EST
Cost: $50.00
Format: Zoom, Live-interactive Webinar
CEUs: *Social workers completing this course receive 2 Clinical Practice continuing education credits.*

Register and for workshop description, objectives & CE information *https://www.leslietsukroff.com/copy-of-are-your-ready-for-an-audit-1*

The Cures Act

What we know about the 21st Century Cures Act Final Rule Part I

What is it?

The 21st Century Cures Act Final Rule is a new law that goes into effect on April 5, 2021 that gives patients greater access to their medical records and control of their health care. The final rule clarifies the mandates around the interoperability requirements outlined in the Cures Act

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that Congress signed into law on December 13, 2016. This new law is often referred to as "open notes" and "information blocking" in the literature.

Who is responsible for drafting and enforcing this law?

This law was written and will be enforced by the ONC (The Office of the National Coordinator for Health Information Technology). Thus far, it has been modified and there have been extensions to compliance dates. The law has various implementation dates, and April 5, 2021 is the first date impacting clinicians. I will keep you abreast of information pertaining to implementation dates slated for the last quarter of 2022.

Who does the new law affect?

The law impacts **all** health professionals and not just covered entities under HIPAA. If you are a healthcare provider, this law applies to you.

What is information blocking?

When a health care provider (or health IT developer, health information network, or health information exchange) engages in intentional actions that prevents and/or delays their patient's access to, exchange of, or use of electronic health information (EHI). Examples of "information blocking" include but are not limited to: making it difficult for patients to find out how to gain access to their medical records; being slow to respond to a patient's request for a copy of their medical records; preventing patients access to their medical records; failing to respond to an adjunctive treatment provider's legitimate request for information contained in the patient's medical record.

What does this law say?

This law states that those mental health clinicians who are using an electronic medical record (EMR)/ electronic health record (EHR) that is certified by the ONC, must make their patient's medical records readily available and easily accessible upon request and without charge. Typically, an ONC certified program will have the capability of providing the patient the ability to log into a secure portal to access specific information (**see** "**What information must I make available to my patients?")** contained in their medical record anytime and without providing the clinician a request for release of information form.

What? I have to allow patient's access to *my notes*?

This is not a new concept. Patients have the legal right to access their medical records under state and federal laws and our respective professional codes of ethics. This new law does not impact existing laws on a patient's right to access their records but it does further enforce this right. Current state laws or federal laws, such as HIPAA still stand.

Refresher- rights to access

Under section 164.524, the HIPAA Privacy Rule gives patients the legal right to "access, inspect, and copy" their PHI (information contained in their medical record).
https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-524.pdf

NJ state licensing laws require mental health practitioners to provide patients access to their medical records. For example, the NJ SW Licensing Regulations state:

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"N.J.A.C. 13:44G-12.4 RELEASE OF CLIENT RECORD ….."
"b) At the written request of the client or authorized representative, a social worker shall provide the client record or a summary thereof, within 30 days of the request directly to: 1) The client or the client's guardian.." https://www.njconsumeraffairs.gov/regulations/Chapter-44G-State-Board-of-Social-Work-Examiners.pdf

Professional ethics codes, such as NBCC's states: "70. NCCS shall respond to requests for access to or copies of records within a practical timeframe."
https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

What am I legally permitted to withhold from patients under this new rule?
The Cures Act does not automatically provide patients with access to the clinician's psychotherapy notes, as long as the what the clinician is labeling "psychotherapy notes" meets the following HIPAA definition 164.501: Notes that are "recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record" . "Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." https://www.govinfo.gov/content/pkg/CFR-2004-title45-vol1/pdf/CFR-2004-title45-vol1-sec164-501.pdf

The Cures Act does not grant patients access to their medical record if the Information was "compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding."

Do I have to purchase and use an ONC certified Electronic Health record?
No, at this time, if you are currently not using an ONC certified program, you are not required to begin using one.

What information must I make available to my patients?

There are 8 types of clinical information that health care providers must make available under the Cures Act; however, only the first 5 pertain to mental health practitioners, while the remaining 3 are geared towards medical professionals:

1. consultation notes
2. discharge summary notes
3. history & physical
4. procedure notes
5. progress notes
6. imaging narratives
7. laboratory report narratives

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8. pathology report narratives

Explanation. Clinicians are required to provide patients access to information recorded in their medical record concerning: their reported and observed symptoms; termination/closing; assessment (bio-psycho-social); diagnosis; prognosis; interventions used; treatment plan; progress notes.

Are there exceptions?
There are 8 overriding areas, called "exceptions" that address a heath care provider's actions that may not be deemed as interference under the information blocking rule. These outline legitimate reasons a healthcare provider, health IT developer, health information network, or health information exchange might comply with the laws in the information blocking rule. For a more detailed explanation, visit https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf

In this newsletter, I will address 2 of the 8.

Infeasibility Exception
"It will not be information blocking if an actor does not fulfill a request to access, exchange, or use EHI due to the infeasibility of the request, provided certain conditions are met."

What if I keep paper records or am using a non-ONC certified Practice Management System?
If you are not using an ONC Certified product, you most likely do not have the technological capacity to provide patients with immediate access to their medical records; therefore, you are not obligated to provide this information in real time. But, because this rule is consistent with other existing laws/codes around a patient's right to access their medical records it is unlawful (and unethical) to "block" their access without valid reasons (exceptions). Mental health professionals keeping paper records or using a non-ONC Certified system cannot provide instant access to the medical record, but are still required to provide patient's access to their medical records if they request it.

The Preventing Harm Exception
"It will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met." This aligns with existing laws and ethical guidelines designed to protect the patient from accessing information in the medical record that might negatively impact the life, safety or health of the patient or another identifiable person. Like HIPAA, state professional licensing regulations and professional codes of ethics, The Cures Act allows mental health providers to withhold all or part of the patient's record, if in their professional judgment, they believe that granting a patient access to the medical record would adversely affect the patient's health or welfare.

What we don't know, yet

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- Will mental health clinicians be required to start using an ONC certified medical records system in the future?
- Will the common practice management systems clinicians utilize move towards ONC certification?
- What will happen to clinicians who engage in "information blocking"? The ONC has not published penalties for mental health practitioners/medical professionals who violate this law.

What does this really mean for practitioners who are not using ONC Certified Programs?
As previously mentioned, patients have had the right to access their medical records way before this rule was drafted. This rule doesn't change much for those who don't have the technological capabilities to provide patients with their medical records upon their creation. However, some experts believe that this new rule gives federal regulators more power to hold accountable those practitioners who delay or get in the way of a patient who has a legitimate right to their medical record. The bottom line, practitioners should ensure that they are following all ethical and legal guidelines around record-keeping and patients' request for their medical records.

Coming in the May Newsletter

Your ethics and practice related questions. Each month, I will feature answers to your burning questions. Please, be careful to provide general questions so as to protect the confidentiality of all involved. Submit questions to LsTsukroff@aol.com