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Transition to ICD-10 to Begin on October 1, 2014

Starting on October 1, 2014, all insurance companies will be required to accept only diagnoses for illnesses, including mental illnesses, based upon the 10th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Services provided before October 1, 2014, should continue to be billed using the current ICD-9 diagnoses, which correspond almost perfectly with the DSM-IV diagnoses. Services provided on or after October 1, 2014, should be billed with the ICD-10. CPT codes are not influenced by the change in the ICD.

Currently insurers must accept ICD-9 diagnoses, which were almost completely identical to the DSM-IV diagnoses. There are a few insurance companies that still require authorizations, and it is anticipated that the authorization requests after October 1, 2014, should include the ICD-10 diagnosis.

Many psychologists have relied on the DSM-IV to determine their diagnoses, even though insurers

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Bill Authorizing Courts to Appoint Psychologists as Insanity Evaluators Signed by Governor

Governor Corbett has signed House Bill 21 which will allow courts the option to appoint psychologists as evaluators of persons for insanity pleas. By coincidence, House Bill 21 has become Act 21 of 2014. Previously, Pennsylvania law only permitted courts to appoint physicians to testify on the determination of insanity. However, the passage of House Bill 21, introduced by Representative Glen Grell (R-Cumberland), has altered that standard.

Pennsylvanians will benefit now that the courts have the discretion of choosing from a wider pool of qualified professionals. It is estimated that perhaps as many as 100 psychologists in Pennsylvania have proficiency in forensic psychology and many of those psychologists could be available to offer such opinions. This estimate is based on a survey by the Association of State and Provincial Psychology Boards, the national association of state psychology licensing boards; it found that about four percent of psychologists had a proficiency in forensic work, thus allowing us to extrapolate that four percent of the more than 5,000 licensed psychologists in Pennsylvania have a similar proficiency. However, many of these may have proficiencies restricted to forensic areas other than insanity determinations.

The enactment of this law will end the anomaly whereby the courts could only appoint physicians to do the insanity evaluations, although the defense had the option of presenting testimony from other experts, including psychologists.

Nothing in this law alters the standards for an insanity defense in Pennsylvania. Insanity determinations are rare and probably constitute less than one percent of all

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Advocacy Day Is Upon Us

For more information and to register for Advocacy Day visit our website at www.papsy.org. If you have any questions about Advocacy Day, please contact Rachael Baturin at rachael@papsy.org.

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Advisory Committee on Violence Prevention Issues Report: Recommends Change in "Duty to Protect" Laws in Pennsylvania

In January 2013, the Senate of Pennsylvania adopted a resolution directing the Joint State Government Commission to establish an advisory committee to study "the issue of violent crime, which is balanced so that it encompasses a wide range of background and viewpoints." Some of the topics it addressed included the relationship of violent crime to mental illness, access to weapons, and school security, including school bullying.

In December 2013, the Joint State Government Commission completed its report on the role of mental illness and guns on community violence. Its 34-member advisory committee included several psychologists: Drs. Laura Crothers, Paul W. Kettlewell, Peter Langman, Edward Michalik, and Walter Rhinehart. It also included a research psychologist, Dr. Edward Mulvey. PPA and the public in general owe a great debt to those who participated in this advisory group.

The final report, which can be accessed at http://jsg.legis.state.pa.us/resources/documents/ftp/publications/2013-365-VPAC%20Report%201.1.14.pdf, is a detailed and evidence-based review of mental illness, violence, and gun ownership. Some of the topics covered in the report dealt with involuntary psychiatric hospitalization, the duty to warn or protect, ownership of firearms for those who have been subject to involuntary psychiatric hospitalization, and improved safety measures for schools.

The group did not recommend changes in the involuntary hospitalization statutes of Pennsylvania, only noting that these should be reviewed in detail to determine if changes were needed. However, it did recommend that Pennsylvania should codify its current duty to protect or warn laws. The current standard, as found in the Supreme Court case of *Emerich*, is vague and has been open to multiple interpretations. The proposed language is consistent with good public policy, in that it would require a warning or protective actions if there were imminent danger of serious physical injury. The protective actions could include

> communicating the threat to all identified or identifiable victims, notifying a law enforcement agency . . . [or] taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalizations if appropriate, or changing the nature of therapy if doing so would likely to diffuse the threat (p. 74).

It also recommended some changes in gun ownership laws for those who have lost the right to gun ownership because of a past involuntary psychiatric hospitalization. Currently, under Pennsylvania law, a person who is involuntarily hospitalized will be disqualified from gun ownership. However, the task force also recommended a pathway for those to have their right to gun ownership restored if they no longer pose a threat to public safety.

Finally, many of the recommendations involved school safety, including those dealing with security and an adequate response in the event of a school shooting or other tragedy. However, the Advisory Committee "strongly opposes arming school administrators, teachers or other non-law enforcement personnel." In addition, the Committee also recommended that student assistance programs should be fully funded and adequately staffed and efforts should be made toward ensuring a safe and secure school environment.

It is now expected that members of the Pennsylvania legislature will take these general recommendations and craft bills to implement them. PPA will monitor and provide input on these legislative efforts.

Motivated Moral Reasoning in Psychotherapy

John D. Gavazzi, PsyD, ABPP, and Samuel Knapp, EdD, ABPP

In the research literature on psychology and morality, the concept of *motivated moral reasoning* is relevant to psychotherapy. Motivated moral reasoning occurs when a person's decision-making skills are motivated to reach a specific moral conclusion. Research on motivated moral reasoning can be influenced by factors such as the perception of intentionality of others and the social nature of moral reasoning (Ditto, Pizarro, & Tannenbaum, 2009). In this article, we will focus on the intuitive, automatic, and affective nature of motivated moral reasoning as these types of judgments occur in psychotherapy. The goal of this article is to help psychologists remain vigilant about the possibilities of motivated moral reasoning in the psychotherapy relationship.

Individuals typically believe that moral judgments are primarily principle-based, well-reasoned, and cognitive. Individuals also trust that moral judgments are made from a top-down approach, meaning moral agents start with moral ideals or principles first, and then apply those principles to a specific situation. Individuals typically believe moral decisions are based on well-reasoned principles, consistent over time, and reliable across situations. Ironically, the research reveals that, unless primed for a specific moral dilemma (such as serving on jury duty), individuals typically use a bottom-up strategy in moral reasoning. Research on self-report of moral decisions shows that individuals seek justifications and *ad hoc* confirmatory data points to support the person's reflexive decision. Furthermore, the reasoning for moral decisions is context-dependent, meaning that the same moral principles are not applied consistently over time and across situations. Finally, individuals use automatic, intuitive, and emotional processes when making important decisions (Ditto, Pizarro, & Tannenbaum, 2009). While the complexity of moral reasoning depends on a number of factors, individuals tend to make moral judgments first, and answer questions later (and only if asked).

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Psychotherapy is a unique social relationship where individuals directly or indirectly bring moral concerns, dilemmas, and conflicts into the consultation room.

Psychotherapy is a unique social relationship where individuals directly or indirectly bring moral concerns, dilemmas, and conflicts into the consultation room. Consistent with the research on motivated moral reasoning, many patients utilize faulty moral decision-making strategies, often to justify inappropriate behavior. A first step in using motivated moral reasoning in psychotherapy is to recognize it when it occurs.

Consider a simple case of road rage. *Similar to the Fundamental Attribution Error,* the patient ascribes an intention to harm onto the offending driver without taking much situational data into consideration. Furthermore, even though the patient has no information about the other driver's intent, the patient creates a moral narrative in which the other driver intended to inflict harm or is incompetent to operate a vehicle safely. In either case, the patient justifies aggressive driving to teach the other driver a (moral) lesson. Was the other driver's intent really to harm the patient? Given that the driver's intent is unknown, is the moral outrage and aggressive driving justified? The therapeutic interventions can help patients find alternative strategies to handle their frustrations (rather than searching for confirmatory evidence to support aggressive driving) and to help patients recognize that a moral injustice did not occur. Perhaps the other driver was rushing to get to the bedside of a seriously ill family member.

Psychotherapy is also a place where patients address specific moral dilemmas. During therapy patients contemplate significant life decisions, such as ending a pregnancy, engaging in an extramarital relationship, or moving forward with a divorce. Knowing that individuals typically engage in bottom-up moral decision-making and the decision may have already made prior to therapy, one strategy is to slow down the decision-making process and appeal first to the patient's moral values. After the patient clearly identifies the moral values involved, the psychologist can help a patient use a thoughtful and well-reasoned decision-making process consistent with expressed moral values.

Psychologists also need to be wary of their own motivated moral

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MOTIVATED MORAL REASONING

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reasoning in psychotherapy. Because of the power imbalance, psychotherapy is a place where the psychologist's motivated moral reasoning can become particularly problematic. The psychologist has a fiduciary responsibility to use a patient-centered approach. When a moral dilemma arises in psychotherapy, a psychologist may intuitively assess the patient's dilemma. The psychologist may quickly conclude what is in the patient's best interest without understanding the patient's moral model or working through the moral dilemma collaboratively. Instead of recognizing the patient's sense of moral agency and responsibility, the psychologist can misuse motivated moral reasoning to influence psychotherapy in a paternalistic manner.

Intrusive advocacy is a specific way in which psychologists can interfere with the patients' autonomy and moral decision-making skills (Pope & Brown, 1996). With *intrusive advocacy*, psychologists advocate (or continue to advocate) for a moral course of action to patients, even after patients have made a moral decision. As one example, a psychologist may continue to prompt a patient, who was sexually abused by another psychologist, to file a complaint with the State Board of Psychology. In spite of the patient's repeated declarations of not wanting to file a complaint, the psychologist might repeatedly attempt to force his or her moral will onto the patient. The psychologist may reason that if the patient does not make a report, then others may be harmed in the future. While this reasoning may be true, the psychologist owes a primary duty to the patient, not necessarily to future patients. The psychologist's insistence to file a complaint likely reflects the psychologist's moral disgust with the situation more than the patient's sense of harm or urgency. Intrusive advocacy may disrupt the therapeutic relationship, leading to a negative outcome.

Within the psychotherapy relationship, both psychologists and patients are vulnerable to the pitfalls of motivated moral reasoning. If psychologists do not understand the importance of motivated moral reasoning, then opportunities may be lost and errors in judgment may occur in psychotherapy. When psychologists understand the complexities of motivated moral reasoning, a strong relationship of trust can be grounded in respect for the patients' morals and values. Additionally, psychologists may better recognize and incorporate the patients' values into psychotherapy, potentially leading to better outcomes in psychotherapy.

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HHS Issues Standards for Confidentiality Breaches

Samuel Knapp, EdD, ABPP Director of Professional Affairs
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Dr. Edward Zuckerman

The Department of Health and Human Services (HHS), which oversees the implementation of the HIPAA Privacy Rule, has issued special standards for health professionals to follow if there is a breach in confidentiality. According to HHS,

> Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted . . . which compromises the security or privacy of the protected health information (45 CFR §164.402).

It does not include accidental access to protected health information by a business associate or an employee. This expands the previous definition of "unauthorized disclosure" to include "acquisition" (even without viewing the protected health information or PHI), "access" (viewing the PHI even if no use was made of it) as well as "use" or basing actions on the PHI. Also, the previous breach standard required evidence of harm; a standard removed in the final regulation because of problems with its interpretation.

HHS reports that most breaches occurred because of theft (such as stolen laptops), hacking, or employee error.

HHS reports that most breaches occurred because of theft (such as stolen laptops), hacking, or employee error. Every year, several PPA members have had a data security breach. We have not kept records of the sources of the data loss, but their experiences appear to mirror the national data reported in that most of the breaches were due to theft and some to lost (or misplaced) records. For example, several psychologists have had their laptop computers stolen from their cars and a few psychologists had their offices robbed. A few psychologists have lost charts, disks, or flash drives with patient data on them. The burdens imposed on psychologists because of a breach speak to the importance of encrypting patient information. If the laptop had encrypted information, then it would only be necessary to investigate and document the breach; not to go through the breach notification process.

Here is what is involved: When a breach occurs to less than 500 persons, psychologists must notify the HHS within 60 calendar days of discovery of the breach and send a first class letter (or email) to each individual whose privacy was compromised. If the psychologist cannot locate 10 or more persons, then they must put a conspicuous notice in a local print or broadcast medium in the geographical area where the breach occurred. The notification letter must include a brief description of what happened, the type of information disclosed, any steps individuals should take to protect themselves, a description of what is being done to investigate the breach and to mitigate the impact of the breach (if possible), and contact information so individuals can find out more information. These procedures could be avoided if the PHI had been encrypted. The HHS website (http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html) contains information on how providers should respond if there are breaches of more than 500 persons, and it also includes forms for notifying HHS of any breach.

HOUSE BILL 21

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homicides, although attorneys will often seek private evaluations to determine if a reasonable basis exists for their clients to claim insanity. Recognizing psychologists as evaluators of the insanity defense is consistent with the scope of practice of psychologists and the recognition of psychologists in a variety of forensic areas.

The enactment of HB 21 is part of a long-term "small steps" strategy whereby in every session of the Pennsylvania Legislature, PPA will try to identify and address at least one area where an archaic state law unnecessarily restricts the practice of psychology. As a result of these efforts psychologists are able to testify at the hearings of persons convicted of drug and alcohol offenses, evaluate drivers suspected of impairment, evaluate impaired physicians or nurses, or evaluate professional fire fighters. Although each of these changes had little impact in and of themselves, they have gradually established a pattern which recognizes the specialized skills of psychologists.

The first bill to permit courts to appoint psychologists was introduced in 2010 by Representative Kathy Manderino at the request of PPA. When Rep. Manderino retired, PPA then asked Representative Glen Grell to introduce a similar bill in 2011, which he did. That bill passed the Pennsylvania House of Representatives in 2012, but failed to pass the Pennsylvania Senate.

TRANSITION TO ICD-10

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must only accept ICD-9 diagnoses. This has not been a problem before because the DSM-IV has a coding system that is almost identical to that of the ICD-9. However, the ICD-10 differs substantially from the DSM-V not only in terms of the numbering system, but also in terms of the exact definitions of some mental diseases.

The World Health Organization (WHO) developed the International Classification of Diseases in an effort to standardize the reporting of diseases across the world. The rest of the world currently uses the ICD-10 and will start using the ICD-11 when it is released in 2015 or 2016. Eventually the United States will be using the ICD-11, although there is no due date set yet for the United States to adopt the ICD-11.

All countries may modify the ICD; the National Center for Health Statistics has modified the ICD for the United States so the particular ICD used will be given a CM suffix (CM means clinical modification). The ICD-9 was developed in the 1970s and is out of date in terms of the specificity of its diagnoses and detail. For example, the ICD-10-CM contains 70,000 diagnoses compared to 17,000 for the ICD-9-CM (although the proliferation in codes is less pronounced for mental disorders than other disorders). Nonetheless, the ICD10 contains about twice as many diagnoses as the DSM-V. A website for the Centers for Medicare and Medicaid Services refers to the ICD-9 as "outdated and obsolete, and . . . inconsistent with current medical practices" (CMS; http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD10FAQs.pdf). One final difference is that the ICD-9 uses a numerical code with 3 to 5 digits, but the ICD-10 will use an alphanumeric code with 3 to 7 characters.

The information on the diagnostic categories for mental illnesses found in the ICD-10 can be found in the "blue book" developed by WHO (http://www.who.int/classifications/icd/en/bluebook.pdf).

The ICD-10 has more information per code than the ICD-9 did. There is not always a one-to-one correspondence between the ICD-9 and ICD-10, so it is not always possible to make a decision based on a simple crosswalk between the two systems.

How should psychologists prepare themselves for this transition? Some billing programs will offer a crosswalk when the diagnostic criterion are identical or nearly identical, and offer options when the ICD offers more specificity. The DSM-V does include a crosswalk between the DSM and ICD-9 and ICD-10 codes, although differences in the categorization can make this difficult to navigate at times. The Clinicians Tool Box, a website by Dr. Edward Zuckerman (http://www.theclinicianstoolbox.com/) advertises a simplified cross-walk procedure. Finally, the Centers for Disease Control has a FAQ on the ICD-10 transition which can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.

The New Confidentiality[1]

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Electronic means of communication raise new issues concerning ways to protect confidentiality when storing or transmitting patient information. For example, psychologists might ask what special confidentiality provisions would apply to the use of a professional answering service, faxes, web based scheduling system, or to the storage of records in the cloud? At times these issues become so complex that one psychologist said she felt like she had to be both a computer expert and a legal scholar.

This article contains some general information on how to evaluate threats to confidentiality and take appropriate precautions. We will not review issues dealing with the delivery of telehealth services, as these have been considered elsewhere (see articles on the PPA website concerning telehealth services).

Some confidentiality issues predate HIPAA. For example, it is always good practice to seek the permission of patients to leave messages on their telephones, send email messages, or to send confidential snail mail to their addresses. Many psychologists include a simple line on their intake form that allows the patient to check whether or where it is appropriate to leave phone messages or send mail. Also, it has always been good practice to send only the information needed to fulfill the purpose of any request. HIPAA institutionalized this rule and uses the term "minimally necessary" to describe it. For example, a billing service only needs some basic information such as date of service, diagnosis, procedure code, etc. I am hard pressed to determine a situation where they would need full access to the patients chart. Unfortunately, I have heard anecdotally of psychologists who have overinterpreted this "minimally necessary" rule and tried to parse out elements of the patient's chart to determine which portions were essential and which were less essential to send to a subsequent treatment provider. The Privacy Rule does not require such intense scrutiny when sending out records to other covered entities. Although psychologists should avoid sending out information where it is obviously irrelevant to the purpose of the request, they should feel free to send information which could reasonably be seen as relevant.

Even before HIPAA, prudent psychologists trained their clinical and nonclinical staff in the rules concerning confidentiality and the protection of patient information. This training is especially important now that large amounts of patient data, such as data sent electronically for billing purposes, can be compromised through employee error or misconduct. For example, employees could, if they wanted, access patient billing information from remote locations if they had the necessary password and login code.

Of course psychologists may continue to need to send information to patients or third parties by phone, fax, email, or postal mail as long as appropriate release forms have been signed and as long as the mode of communication is reasonably safe. The question often becomes how to determine if the new modes of communication are safe. Of course no form of communication is, or could ever be, completely safe. The standard that psychologists should use is whether they have anticipated reasonably foreseeable threats; not that their protections have to be 100% perfect.

Answering Services

Often psychologists use an answering service or have a voice mail system where patients can leave messages. Confidentiality with traditional answering machines primarily required the psychologists to avoid playing messages where patients could hear them. However, Internet-based voice mail services vary in the degree of privacy they afford subscribers. Psychologists should check their contracts to determine the amount of privacy awarded. Some psychologists hire or contract with companies to provide answering services. Because the use of these services would reasonably be expected to involve some sharing of protected health information, psychologists should have business associate agreements with these companies.

Faxes

Psychologists may send information to patients or third parties by phone, fax, email, or postal mail if patients have signed the appropriate release of information forms. Faxes involve transmission through telephone wires where the risk of interception is extremely low. However, psychologists can minimize accidental violations of confidentiality when using faxes by being scrupulous about dialing the correct number and ascertaining if the information received will be handled in a manner that protects patient privacy. For example, a psychologist can send information to the office of a physician with some assurance that it would be handled appropriately. However, when sending information to other offices, psychologists may need to double check on who

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[1]*Appreciation goes to Dr. Edward Zuckerman and other members of the PPA Ethics Committee who reviewed an early version of this article.*

THE NEW CONFIDENTIALITY

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would be on the receiving end of other fax numbers.

In one actual case that came before the Department of Health and Human Services (HHS), a physician's office accidentally faxed confidential information to the wrong number. HHS, among other sanctions, required the physician's office to include a prominent notice on the cover page that this was confidential information (HHS, 2013). Therefore we recommend that psychologists include a brief cover message on every fax indicating that this information is confidential.

Email Encryption

HIPAA does not require psychologists to encrypt emails, although we strongly recommend doing so. If the confidential information of a patient is compromised through a breach of privacy (even an accidental breach), psychologists will have to file a Breach Notification Form and will also have to send notices to the persons whose privacy was violated. Furthermore, the reporting of the breach to HHS may trigger a more extensive audit of the privacy protections of the psychologist (see article on Breach Notification). However, if the emails were encrypted, then the psychologist would be assured that their interception did not violate patient privacy and would not have to make a Breach Notification. It is not always clear how to choose an encryption service. However, if a vendor states that they meet government standards (such as HITECH or Sarbanes-Oxley- a federal law dealing with banking security among other topics), then it is likely that they do.

Cloud Storage and Appointment Books

Some psychologists find it convenient to use a computer-based appointment system or to store their records in the cloud. Traditionally many of these services and service providers have been considered conduits or an entity that merely transfers information from one source to another. However, a recent decision by HHS challenged the assumption that cloud storage was exempt from HIPAA and now most cloud storage vendors do offer business associate agreements. Looking for a company that offers a business associate agreement may be one way to ensure that compliance. Google Calendar is not HIPAA compliant, although one psychologist protects patient confidentiality by using ID numbers for her patients.

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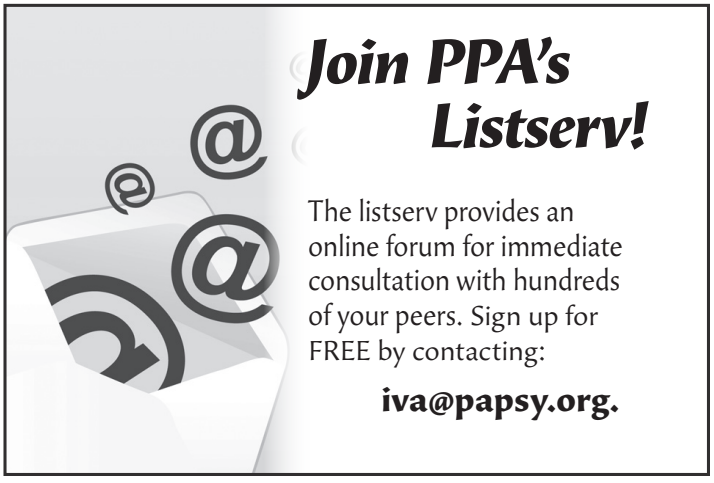

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Harrisburg, PA
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August 15, 2014
The DSM-5 and ICD-10 Transition
Frazer, PA
Marti Evans (717) 232-3817

Podcast
A Conversation on Positive Ethics with Dr. Sam Knapp and Dr. John Gavazzi
Contact: ppa@papsy.org

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.papsy.org/index.php/collaboration-communication/.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

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