Title: Minimum Necessary Protocols for Routine Disclosure of PHI and EPHI (External Disclosures)

Prepared By: Compliance Liaison

Purpose:

To define the standard practices which limit the disclosure of information to the amount reasonably necessary to achieve the purposes of the disclosure. This policy relates to the routine and/or recurring disclosures of consumer Protected Health information (PHI) and Electronic Protected Health Information (EPHI) to ***outside entities*** in connection with treatment, payment, and healthcare operational activities.

Scope:

This policy applies to all employees (including full-time employees, part-time employees, contractual providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH) and all consumers served by HBH.

Information:

1. It is the policy of HBH, as related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996:
   - When using and/or disclosing PHI and EPHI for payment, treatment, and operations purposes, HBH must make reasonable efforts to limit the amount of consumer PHI used and disclosed to that which is minimally necessary to accomplish the intended purpose of the use and/or disclosure.
   - The Health Insurance Portability and Accountability Act of 1996 does not require authorization by the consumer for disclosure of his/her PHI for purposes of treatment, payment, or healthcare operations. In addition to adherence to HIPAA legislation, HBH also follows applicable State law MCL 330.1748 (Confidentiality) and MHC 330.7051 (Privileged Communications) regarding the disclosure of PHI when Michigan law is more restrictive than HIPAA.
   - Information may be provided to third party payors (e.g., Medicaid, Medicare, Blue Cross, etc.) as required by contracts and/or subscriber agreements with the payor.
   - A copy of the consumer's PHI may be provided to another designated individual if the request is in writing and signed by the consumer or his or her legal representative (guardian). The release must clearly identify the specific information that is to be disclosed, the designated individual, and where the copy of the PHI should be sent.
   - The consumer has the right to request that restrictions be placed on the use and/or disclosures of his/her protected health information in connection with uses and disclosures for treatment, payment, and operations and when disclosing to family members. If the consumer requests, HBH shall restrict disclosure of PHI if the PHI pertains solely to a healthcare service for which the consumer (or a party other than a health plan), has paid HBH in full. (See also "Recipient Rights – Confidentiality and Disclosure of Information Procedure" RR.2.07).
2. HIPAA defines *"Protected Health Information"* broadly as any health information, including consumer demographic information, that is created or received by a provider and:
   - which relates to past, present, or future physical or mental health condition of a consumer, the provision of healthcare to the consumer or payment related to the provision of healthcare to the consumer; and,
   - that identifies or can be reasonably used to identify a consumer (i.e. first or last name, social security #, case #, date of birth, address, etc.)
3. Since PHI is defined broadly, in a practical sense, nearly all information relating to consumers will be considered protected health information subject to the HIPAA privacy rule when accessing, using, disclosing, and/or storing it. Examples of documents/information containing protected patient information include, but may not be limited to:
   - The entire contents of the consumer's case record

- Service Activity Logs
- Progress Notes
- Billing Information
- EOBs (Explanation of Benefits)
- Lab/Test Results
- Prescriptions
- Consumer information appearing on a computer screen/monitor

4. The HIPAA rule requires all providers of healthcare and behavioral healthcare to implement standard policies and procedures that limit the information disclosed to the amount reasonably necessary to achieve the purpose for the disclosure. Part of HIPAA includes an Administrative Simplification section which defines the provision for protecting the security and privacy of individually identifiable healthcare information, including behavioral healthcare information. While HBH is not required to make an individual determination for each disclosure, standard protocols are noted below as guidelines for common situations, relative for example, to information that may be disclosed for the purpose of Treatment, Payment, and Operations (TPO), particularly for the purposes of billing for services.

5. For the purpose of this policy, the HIPAA privacy rule defines these terms broadly as follows:
   - **Treatment** means the provision, coordination, or management of healthcare and related services (including coordination and management by a provider with a third party; consultation between healthcare providers relating to a patient; or referral of patient for healthcare from one provider to another).
   - **Payment** means activities undertaken by a provider to obtain payment or be reimbursed for healthcare services provided to the consumer. This includes, but is not limited to:
     - Determining eligibility or coverage
     - Billing and collections
     - Claims adjudication
     - Review of services related to medical necessity or justification for charges
     - Risk adjustments
     - Utilization Management (UM) activities
     - Disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).
   - **Healthcare Operations** relates to certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, are limited to the activities listed in the definition of "healthcare operations" at 45 CFR 164.501, and include:
     - Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs
     - Reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, credentialing, certification, and licensing activities
     - Conducting or arranging for medical review, legal services, and auditing services (including compliance reviews, accreditation reviews, governing body site visits, licensing audits, fraud and abuse detection, and compliance programs, etc.
     - business planning and development (such as cost management activities)
     - business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

6. Some uses and disclosures that are considered treatment, payment, or operations and, therefore, do not require an authorization are:
   - Use of consumer information (including medical records from previous providers) by physicians, therapists and other staff for treatment purposes
   - Disclosure of consumer information to insurance companies for payment purposes
   - Use of consumer PHI by finance staff for billing and operations
   - Disclosure of consumer information to health plans for coverage/eligibility determinations, medical necessity/appropriateness review, justification of charges, utilization management review, pre-certification, or pre-authorization

7. Disclosures to another provider for Treatment, Payment, or Operations: In addition to uses and disclosures of PHI for the agency's own treatment, payment, or operations, the privacy rule also allows HBH to disclose PHI in certain cases for other providers' treatment, payment, and operations as follows:
   - **For Treatment:** Disclosures may be made, as necessary, to another healthcare provider outside of the agency for treatment of the patient.
   - **For Payment:** Disclosures may be made to another healthcare provider or health plan, so that the other provider or plan can obtain payment for services.
   - **For Healthcare Operations:** Disclosures may be made to another healthcare provider or health plan for the other entity's healthcare operations, if both the agency and the other healthcare provider have a relationship with the consumer.

8. This policy covers the routine day-to-day external disclosures of consumer PHI/EPHI in order to remain compliant with HIPAA requirements (i.e., disclosure of demographic information, billing activities, documentation of the services provided to the Pre-paid Inpatient Health Plan (PIHP), and disclosure of consumer PHI such as records from a particular date of service to insurance companies in connection with insurance company verification of services).

9. At the beginning of services all consumers are provided a "Notice of Health Information Practices" pamphlet (90-082) which explains the uses for PHI and will be requested to sign an "Acknowledgement of Receipt of Notice Form" (90-063) evidencing that they received the Notice. Additionally, on an annual basis the Notice is included in the Person-Centered Plan (PCP) (see also "Notice of Health Information Practices Procedure" ORI.2.03)

10. Uses, Accesses, and Disclosures relative to protected health information, restrictions on "Need to Know" Rule, "Minimum Necessary" Rule, and Disciplinary Actions:
    - HBH employees shall not use, access, acquire, or disclose any consumer PHI for personal purposes. HIPAA breach notification (45 CFR subsection 164.402) prohibits any impermissible acquisition, access, use, or disclosure of PHI which compromises the privacy, confidentiality, or security of any consumer's PHI. This includes accessing consumer's electronic and/or paper records. HBH's electronic medical record (EMR) system tracks all accesses into consumer's records. HBH makes a good faith effort to monitor accessing activities through on-going audits in an effort to assure that all electronic protected health information (EPHI) is safeguarded against improper use, access, and/or disclosure by staff (see also "Monitoring Employee Access to EMR/EHR Procedure" ORI.2.09). HBH has strict penalties/sanctions when audit findings evidence that an employee has violated the HIPAA and/or breach regulations.
    - Employees are trained initially and annually in HIPAA and other Corporate Compliance topics. This includes two (2) basic HIPAA Rules related to "Need to Know" and "Minimum Necessary". In clear terms, "Need to Know" means that unless staff has a valid reason (treatment, payment, or operations) to see a consumer's PHI, they are prohibited by federal law from accessing, using, or disclosing such information. "Minimum Necessary" refers to using, accessing, or disclosing only the absolute minimum amount of information necessary for the intended work-related purpose (treatment, payment, and operations). These rules must be strictly adhered to by all employees at all times.

- HBH personnel and disciplinary policies do not mandate a lesser sanction/disciplinary action before HBH may terminate an employee for a HIPAA violation. HBH has the discretion of terminating an employee for a first offense if the seriousness of the offense warrants such action. An employee should expect to lose his/her job for willful or grossly negligent violations to HIPAA regulations, Federal Laws, or State Laws protecting integrity, confidentiality, and security of protected health information.
- Employees should also be aware that violations to HBH's privacy, security, and compliance policies and standards may constitute a criminal offense under HIPAA, federal laws, or state laws. Any employee who violates such a law may expect that HBH will provide information concerning the violation to the appropriate law enforcement personnel and will cooperate with any law enforcement investigation and criminal prosecution.
- Further, these violations may also constitute violations of professional ethics and may be grounds for professional discipline and/or loss of licensure. Any employees subject to professional ethics guidelines and/or professional discipline should expect that HBH will report such violations to the appropriate licensure/accreditation agencies and to cooperate with any professional investigations or determinations/actions.

Policy:

A. Disclosures Specifically Required by Health Plans, PIHP, Collection Agencies, etc.:

Information may be provided to third party payors (e.g., Medicaid, Medicare, Blue Cross, etc.) as required by contracts and/or subscriber agreements with the payor. HBH can rely upon a health plan's representations regarding the information that is needed for a claim, including representations that are contained in a policy, a provider agreement, or in a health plan newsletter or bulletin. For example, to the extent that the health plan makes representations that the information is necessary, the following information may be provided as part of a claim to a health plan:

- Date(s) of service
- Consumer demographic information
- Information regarding the insurance contract number, plan number, group number, etc.
- Diagnosis and/or procedure codes
- Information regarding medical history
- Referral or pre-certification information
- Other information requested such as portions of the medical record related to the dates of service

B. Non-specific Requests by Health Plan:

1. There may be situations where HBH must make a disclosure of PHI that has not been specifically requested by the third party payor. For example, HBH may need to determine what information should be submitted to support a claim or defend an audit. In these situations, HBH must determine what information is minimally necessary to achieve the results for which the information is being requested. ***Information beyond that which is minimally necessary is not to be disclosed.***
2. For example, if a particular date of service is being questioned, it may be necessary to submit excerpts from the date of service in question, as well as information from previous or subsequent visits that support medical necessity, plan of service, etc.

C. Disclosure Parameters:

1. For the purposes of claims submission, information required or requested by the health plan or third party payor should be submitted.
2. Employees can rely upon representatives from health plans regarding the information that is required.
3. If HBH needs to submit additional information, employees should determine what information is necessary to support the service/claim in question and submit only the information that is minimally necessary.
4. If the employee has a question as to the amount of information that should be provided for a certain disclosure, they should contact the HBH Privacy Officer, Recipient Rights Officer, or the Executive Director.

Definitions/Acronyms:

EOBs – Explanation of Benefits
EPHI – Electronic Protected Health Information
HBH – Huron Behavioral Health
HIPAA – Health Insurance Portability and Accountability Act
PCP – Person Centered Plan
PIHP – Pre-paid Inpatient Health Plan
PHI – Protected Health Information
TPO – Treatment, Payment, and Operations
UM – Utilization Management

Forms:

90-063 Acknowledgment of Receipt of Notice Form
90-082 Notice of Health Information Practices Pamphlet

Records:

N/A

Reference(s) and/or Legal Authority

Health Insurance Portability and Accountability Act of 1996 @ http://www.hhs.gov/ocr/privacy/
MCL 330.1748 @ http://www.legislature.mi.gov/(S(m3xihnzthbdztt55lfxzei45))/mileg.aspx?page=getObject&objectname=mcl-330-1748
MCL 330.7051 @ http://www.legislature.mi.gov/(S(tvkudx55tffdzw55b1hz4cuz))/mileg.aspx?page=getobject&objectname=mcl-330-1750
ORI.1.14 Minimum Necessary Policy for Internal & Non-Routine Disclosures
ORI.2.03 Notice of Health Information Practices Procedure
ORI.2.09 Monitoring Employee Access to EMR/EHR Procedure

Change History:

Change Letter	Date of Change(s)	Changes
A	01/24/03	Added "Access Alliance of Michigan (AAM), Collection Agencies, etc:" to first heading under "policy on page 1, #4 on page 2 was "Document on Disclosure Log", added "AAM" & "EOBs" to Definition/Acronym section, added "(90-082)" to 1st sentence on page 2 and to "Forms" section, added to "Information" section: "Treatment, Payment, and Operations" detail, and also "PHI" definitions".
B	07/08/05	Added the first bullet and three sub-bullets in the "Information" section to reflect required HIPAA Privacy language due to AAM's formation of the OHCA (Organized Health Care Arrangement), added website references & hyperlinks, added "MCL' to Acronym section added 90-063 (Acknowledgment of Receipt of Notice Form) 2 places, added hyperlinks, .
C	03/22/11	Added the last six (6) bullets in "Information" section
D	04/29/14	Reviewed and revised to comply with recent HIPAA/HITECH revisions – added 4th & 5th bullets in #1 in "Information:" section, in "Information" section removed "CMHC Reports from #3, replaced "Access Alliance of Michigan" & "AAM" with "PIHP" throughout document (3 places), added references to "ORI.2.09" (2 places), in "Acronym" section removed "AAM" and added "UM" & "PIHP", in "References" section added "MCL 330.1748" & "MCL 330.7051", repaired hyperlinks, made numerous grammatical and wording changes throughout document without changing sentence content, formatted some sections with bullets, numbering, etc.
E	06/24/16	Changed "health care" to "healthcare" throughout document (27 places), added reference to ORI.2.03 "Notice of Health Information Practices Procedure" (2 places), in "Acronym" section removed "OHCA" and added "PCP", in "Information" section #9 added last sentence, made numerous small wording/grammatical changes/corrections throughout document without changing sentence content.