Disclosure of Medical Record Copies for Payment Purposes

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by the AHIMA 2006 Privacy and Security Practice Council

HIPAA promised administrative simplification through a variety of health information standards, including transactions and codes sets and the privacy rule. Transactions and code sets, which were implemented in October 2002, were designed to reduce the number of requests from payers for supporting documentation (i.e., copies of patient health records). Although this was perceived as a win for HIM professionals, this has not been the case for most.

Despite the simplification rule, many healthcare organizations continue to receive high numbers of payer requests for supporting documentation to process a claim. In addition, it seems that the requested information is expanding beyond what the healthcare organization believes is reasonably related to the claim encounter. Requests are being received for "any and all," "past, present, and future," and even in one example "records for the lifetime of the patient." These requests exceed the minimum necessary requirement.

There is often no acknowledgment of other federal and state regulations that may preempt HIPAA. When questioned about such requests, payers may cite the HIPAA privacy rule and the ability to request these records for payment purposes, but they rarely acknowledge the privacy rule's "minimum necessary" standard. Often, payers may lack a sound understanding of state regulations that may preempt HIPAA.

Defining Payment

In April 2003 covered entities (healthcare providers and plans) implemented the HIPAA privacy rule and the standard that a covered healthcare provider may, without consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations.[1] The rule defined a "payment" as the activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan or the activities undertaken by a covered healthcare provider or health plan to obtain or provide reimbursement for the provision of healthcare.[2] *Payment activities* include:

- Determinations of eligibility or coverage (including coordination of benefits or the determination of cost-sharing amounts) and adjudication or subrogation of health benefit claims
- Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related healthcare data processing
- Review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services[3]

With regard to payment and payment activities, both payers and healthcare providers are subject to HIPAA and the minimum necessary standard. The privacy rule states:

> For any type of disclosure that it makes on a routine and recurring basis, a covered entity must implement policies and procedures (which may be standard protocols) that limit the protected health information disclosed to the amount reasonably necessary to achieve the purpose of the disclosure. For all other disclosures, a covered entity must develop criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought; and review requests for disclosure on an individual basis in accordance with such criteria.[4]

The Department of Health and Human Services provides the following less-than-definitive guidance:

Covered entities are required to apply the minimum necessary standard to their own requests for protected health information. One covered entity may reasonably rely on another covered entity's request as the minimum necessary, and then does not need to engage in a separate minimum necessary determination. See 45 CFR 164.514(d) (3) (iii). However, if a covered entity does not agree that the amount of information requested by another covered entity is reasonably necessary for the purpose, it is up to both covered entities to negotiate a resolution of the dispute as to the amount of information needed. Nothing in the Privacy Rule prevents a covered entity from discussing its concerns with another covered entity making a request, and negotiating an information exchange that meets the needs of both parties.[5]

How to Safeguard Patient Records

Since HIM professionals are charged with safeguarding the privacy of patient health information as well as compliance with HIPAA and other federal and state regulations that affect the disclosure of patient health record copies, they should develop policies and procedures for the disclosure of patient protected health information (PHI) for payment purposes that:

- Address the need to recognize the minimum necessary standard, including when to seek further justification if the request seems excessive (e.g., any and all records)
- Clearly identify relevant federal and state regulations that affect the disclosure of PHI by the organization
- Clearly identify patient authorization requirements for requests for health information with special protection (e.g., HIV test results, mental health, AODA)
- Require HIM participation in contract negotiations between payers and the healthcare provider that address access to and disclosure of patient PHI for payment purposes
- Define parameters for what may be considered reasonably relevant or minimum necessary information with regard to the payer's request. For example, request for additional information:
    - Must be related to the injury or illness for which the services were provided (e.g., all records related to the diagnosis or injury from a given number of preceding months or years)
    - Must be made within an appropriate time period surrounding the patient encounter and must be reasonably related to payment of the claim (e.g., within a given number of months or years of the encounter)
    - May be justified through the payer's investigation of potential claim fraud
- Include a sample communication letter in response to a questionable payer request (see the sample letter [below])
- Identify resources available to assist with questionable payer requests, such as:
    - Privacy officer of payer organization
    - State insurance commissioner
    - Office for Civil Rights

Disclosures of patient PHI, beyond the minimum necessary, between payers and healthcare providers may be affected by the portability aspects of HIPAA that do not permit payers to deny coverage for a preexisting condition if the member was covered by some form of insurance during the entire interval. In October 2006 the San Francisco Chronicle reported that California state regulators fined Blue Cross of California $200,000 for illegally dropping a member who failed to disclose surgery performed 23 years earlier for acid reflux disease, surgery her doctor verified was unrelated to her current condition.

Questions for the industry to consider include:

- How far back may payers reasonably go to identify pre-existing conditions, and are they entitled to such information if the "preexisting condition" concept is not pertinent?
- How are payers gaining access to patient health information from decades earlier?
- Does this relate to requests for "any and all" healthcare records of the patient?

Sample Response Letter to a Questionable Request for Medical Record Copies by a Payer

[Date]

[Address]

Dear Payer:

[XYZ Healthcare Provider] has received your request to provide additional supporting documentation/health record copies for the claim identified below:

[Patient Name]
[Account/Subscriber Number]
[Medical Record Number]
[Dates of Service]

We recognize that HIPAA and [insert state if applicable] regulations allow disclosure of patient protected health information for payment purposes. However, we are limited by the HIPAA minimum necessary standard: *"When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request (45 CFR 164.502(b))."* We are also limited by federal and state regulations that provide additional protections for certain conditions.

It is our policy to honor only those requests for disclosure of patient health record copies that we believe are reasonably related to the services/encounters that have been billed. We feel that the request you have submitted does not meet our "reasonably related" standard or is not allowed under federal and state regulations for the following reason(s):

- The request for "any and all" health record copies is beyond what is reasonably related to what has been billed.
- The request for health record copies related to the injury or illness identified for the services/patient encounter is beyond what is reasonably related to the services/encounter that has been billed (greater than [XX months/years]).
- The request for health record copies greater than [XX months/years] from the date of service/encounter is beyond what is reasonably related to the services/encounter that has been billed.
- The request for health record copies related to the injury or illness is further protected by state and federal regulations that require a patient's written authorization prior to disclosure. [Organization may want to add check boxes for relevant federal and state laws].
- [User may insert applicable state law or regulation]
- [User may insert applicable federal regulation]
- There is no documentation in the health record to indicate that there is a payer-patient relationship between your organization and the patient.
- Other:

We will be happy to respond to your request for health record copies upon receipt of a written authorization from the patient or upon further receipt of information from your organization to provide justification for the request.

If you have any questions or concerns, please contact:

Thank you.

[Name/Title]

Notes

1. HIPAA Privacy Rule, 45 CFR § 164.506.
2. Ibid., § 164.501.
3. Ibid., § 164.501.
4. Ibid., §164.514(d)(1)(3)
5. US Department of Health and Human Services. "Health Information Privacy and Civil Rights Questions & Answers." Answer ID 216, "Does the Minimum Necessary Standard Apply to Disclosures Made to Another Covered Entity?"

Available online at http://healthprivacy.answers.hhs.gov.

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