Reconciling the Privacy Rule and Substance Abuse Record Confidentiality

by Pamela T. Haines, RHIA

According to the 2002 National Survey on Drug Use and Health, an estimated 22 million Americans age 12 and older were classified with substance dependence or abuse; that is 9.4 percent of the total US population. A new report from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment gives guidance to substance abuse (SA) programs on protecting the confidentiality of patient records. However, the need to know this information reaches farther than one might think at first glance.

Who Needs to Know?

It may be helpful to clarify here who is included under alcohol and SA programs. Regulation 42 CFR, part 2, 2.11 states that SA programs include the following:

> (a) Any individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or (b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or (c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers.

It further states that the above SA programs must be federally assisted in some way (e.g., through the Medicare or Medicaid programs or the recipient of funds provided by any US department or agency, or a local government unit that receives federal funds which could be [but are not necessarily] spent for the alcohol or drug abuse program). The regulations apply if the program is assisted by the IRS through allowance of income tax deductions for contributions to the program or through granting of tax exemption status. For a few exceptions related to federally funded entities (such as the armed forces), see 42 CFR, part 2, 2.12 (c).

The Privacy Rule and Implications for SA Programs

SA programs must follow all of the more protective requirements of the privacy rule if the program transmits protected health information (PHI) electronically in connection with one or more of the transactions listed in part 162 of the privacy rule.[1] At the same time, many of the permissive disclosures of the privacy rule are prohibited by 42 CFR, part 2. The following are paraphrased excerpts from the SAMHSA document:

- The general rules regarding uses and disclosures of PHI are very different between the privacy rule and 42 CFR, part 2. Generally, without authorization, SA programs must not disclose PHI unless it is first specifically permitted in 42 CFR, part 2, and then also by the privacy rule.[2]
- Disclosures for treatment, payment, and healthcare operations without patient authorization are permitted by the privacy rule, but not by 42 CFR, part 2, therefore part 2 applies.[3]
- The privacy rule defers to state law regarding parental consent for disclosure of a minor's PHI; 42 CFR, part 2, requires the minor's signature, even in states where parental consent is required.[4]
- The privacy rule requires written revocation of authorizations; 42 CFR, part 2, permits oral revocation. SA programs may want to at least document verbal revocation.[5]
- The privacy rule permits disclosures under subpoena without patient authorization (with certain satisfactory assurances); 42 CFR, part 2, prohibits disclosure under subpoena without patient authorization without a special good cause hearing.[6]
- The privacy rule permits disclosure to accreditation bodies under a business associate agreement (BAA); SA programs must ensure that the qualified service organization agreement (QSOA) requirements are included in the BAA or the

mandates of the audit and evaluation provisions in 42 CFR, part 2, are fulfilled.[7]

- Under a BAA, the privacy rule permits disclosures to business associates without authorization; 42 CFR, part 2, permits disclosures under a QSOA as well. However, there are a couple of provisions in the BAA that are not permitted under the QSOA; SA programs must meet the requirements of both regulations.[8]
- There are differences between the requirements for research in the privacy rule and 42 CFR, part 2. Additional guidance in this area is expected from HHS in the future.[9]
- The requirements of the privacy rule notice of privacy practices include significantly more detail than the notice required by 42 CFR, part 2.[10] SA programs must therefore combine the requirements of their notice with the notice of privacy practices.

While incorporating the more protective requirements of 42 CFR, part 2, into their policies and procedures, privacy officers in SA programs must also address all of the new administrative requirements in the privacy rule and include them in their work force training. At the same time, they also need to be alert and ready to engage in damage control to offset misconceptions about the application of the privacy rule to SA programs that employees may bring back to the workplace from seminars, conferences, and other training, as well as from the plethora of articles that interperet HIPAA.

As patients become more savvy regarding their privacy rights, SA programs, non-SA healthcare providers, and all recipients of SA programs' PHI alike need to become more aware that they could be held accountable for unauthorized disclosures or redisclosures of substance abuse PHI that they have received from an SA program.[11]

Notes

1. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. "The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs." Available online at www.hipaa.samhsa.gov/Part2ComparisonCleared.htm.
2. Ibid, 5.
3. Ibid.
4. Ibid, 6–7.
5. Ibid, 7.
6. Ibid, 9.
7. Ibid, 11.
8. Ibid, 10.
9. Ibid, 12.
10. Ibid, 12ff.
11. "Health Insurance Portability and Accountability Act of 1996." Public Law 104-191. 42 CFR, Part 2, 2.12(d) and 2.32. August 21, 1996. Available online at http://aspe.hhs.gov/admnsimp.

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