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HIPAA Standards Benefit Unrealized Relating to Requests for Supporting Documentation

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The Health Insurance Portability and Accountability Act (HIPAA) promised administrative simplification through a variety of health information standards, including Transactions and Codes Sets (T&CS) standards and the Privacy Rule.

The T&CS standards, which were implemented in October 2002, were designed to reduce the number of requests from health plans for supporting documentation (i.e., copies of patient health records). This expected benefit has not been realized.

Despite the simplification rule, many health care provider organizations continue to experience high numbers of health plan requests for supporting documentation (health record copies) to process a claim.

Moreover, health care providers have begun to raise concerns regarding what they perceive to be conflicts between the health plan's requests for information and the HIPAA mandate to provide only the "minimum necessary." Providers cite requests utilizing language such as, "any and all," "past, present, and future," or even

"records for the lifetime of the patient" as examples that pose this conflict.

Conversely, health plans cite the HIPAA Privacy Rule and the ability to request these records for payment purposes but rarely acknowledge the Privacy Rule's "minimum necessary" standard.

In addition, health care providers' response to health plan requests may be impacted by other federal and state regulations, which may preempt HIPAA.

In April 2003, covered entities (health care providers and plans) implemented the HIPAA Privacy Rule and the following standard: A covered health care provider may, without consent, use or disclose protected health information to carry out treatment, payment, or health care operations.

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The Rule provided the following definition for "payment":

Payment means 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

■ a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care.

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 health care data processing;

■ review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and

■ utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services.

With regard to payment and payment activities, both health plans and health care providers, as covered entities, 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.”

The “Department of Health & Human Services Health Information Privacy and Civil Rights Questions and Answers” Web site 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.

Since covered entities are charged with the responsibility of safeguarding the privacy of patient health information as well as compliance with HIPAA and other federal and state regulations that impact the disclosure of patient health record copies, they should develop and maintain policies and procedures for requesting and

disclosing protected health information for payment purposes that:

1. enforce the minimum necessary standard, including when to seek further justification when the request seems excessive (e.g., any and all medical records, to establish pre-existing conditions);

2. clearly identify relevant federal and state regulations that impact the request and disclosure of protected health information by the organization (e.g. diagnoses of behavioral health, HIV, or alcohol and substance abuse);

3. clearly identify patient authorization requirements for requests for health information with special protection (e.g. diagnoses of behavioral health, HIV, or alcohol and substance abuse);

4. require health information management professional’s participation in contract negotiations between health plans and the health care provider that address access to and disclosure of patient PHI for payment purposes (e.g. ensure contract language review pertaining to release of information).

5. defines parameters for what may be considered reasonably relevant or minimum necessary information with regard to the payment activity. For example:

a. The 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 the last XX months/years).

b. The request for additional information must be made within an appropriate time period surrounding the patient encounter and must be reasonably related to the payment activity (e.g., within XX months/years of the encounter).

c. The request for additional information may be justified through an investigation of potential claim fraud (e.g. disclosure of health plan and health care provider information).

6. Identify resources available to assist, such as:

a. Privacy Officer of health plan or health care provider,

b. State Insurance Commissioner and/or appropriate State agencies, and

c. The Office for Civil Rights (OCR).

CONCLUSION. The information presented in this article reinforces the need to maintain open communication and dialogue between health plans and health care providers concerning health information management.

Such communication would ensure that health care providers and health plans are exchanging the necessary protected health information for payment activities and still protect the patient’s privacy rights under HIPAA and specific state and federal regulations.

It is clear that under HIPAA, protected health information may be disclosed for payment purposes and moving forward both plans and providers must be cognizant of the need to include reasonable verbiage in their contracts to ensure that the authorization, reimbursement, and appeal process can be achieved in a timely, efficient and effective manner to meet the needs of the patient, the plan, and provider.