

Requests for Release of Patient Records

February 20, 2015

Dear APsaA Members,

CGRI has analyzed an alert that went out from the American Psychiatric Association's legal office concerning letters that some APA members are receiving from insurers requesting patient records. Prudy Gourguechon, APsaA's liaison to the APA, sent the alert along to CGRI, and we in turn asked Jim Pyles for his opinion.

The situation is complicated. The insurers who are writing these letters might say they are required to do so by the Affordable Care Act. It is in their interest to demonstrate that they include high risk patients in their list of insureds, but at the same time they want to minimize costs. Whether you are required to respond and how you need to respond depends on a number of factors, including whether you are subject to HIPAA rules or exempt and whether you are a provider for that insurer or out of network.

Jim Pyles informed us of the complexities of the situation—basically, every particular case is unique. Most importantly Jim offered the following crucial reminders that all of us need. There is a lot to digest, and this is information you will want to have on hand for ongoing reference. **My suggestion is for each member to print out the advice section of this email because it applies to every request for information and should be accessible to all our practicing members.** In sum, there are patient and practitioner rights that can and should be taken into account.

The alert from the American Psychiatric Association is pasted at the bottom of this message for those of you who want to see the APA's opinion in more detail. Meanwhile, here are the things we all need to remember:

Members with specific questions can email me at hgross@herbertgross.com, and CGRI will do our best to provide you with answers given the particulars of your situation.

Best regards,

Herb Gross
Chair, Committee on Government
Relations and Insurance

Advice re: Patient Records for APsaA Members

This document covers:

Who is exempt from HIPAA provisions?

Special HIPAA Protections for Psychotherapy Notes

Definition of Psychotherapy Notes

Importance of “minimum necessary”

Rights of patients and practitioners

Consent

Role of ethical standard re: confidentiality

- If a psychotherapist has not submitted a health insurance claim electronically since October 15, 2002, the effective date of the HIPAA Privacy Rule, he or she may not be covered by HIPAA requirements (faxing is not considered an electronic transmission). 45 CFR § 160.102(a)
- Therefore, what HIPAA “allows” is irrelevant for those practitioners who are HIPAA exempt. However, contract terms between the therapist and the insurer would still be important and perhaps determinative.
- If you are subject to the HIPAA Privacy Rule, you may still elect to adopt patient privacy policies and procedures (such as the right of patient consent for disclosures) that are more stringent than HIPAA requirements since HIPAA is only a “floor” of federal privacy protections but more stringent privacy protections must be reflected in your policies and procedures.
- Even if a practitioner is covered by the HIPAA Privacy Rule, a health insurer may not demand “psychotherapy notes” and may not refuse payment of a claim if those notes are not disclosed. 45 CFR §§ 164.508(a)(2) and 164.501. See also, § 164.508(b)(4)(ii)(B) prohibiting conditioning payment of health coverage on use or disclosure of psychotherapy notes.

- Psychotherapy notes are defined as notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversations during a counseling session that are separated from the rest of the individual's medical record.
- Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- HIPAA does not permit the use and disclosure of identifiable health information that is more than the "minimum necessary" amount for the intended purpose. 45 CFR § 164.502(b). The minimum necessary standard is intended to be applied in a manner that is "consistent with, and [does] not override, professional judgment and standards." APsaA's standards for the ethical practice of psychoanalysis provide:
 - **IV. Confidentiality.** Confidentiality of the patient's communications is a basic patient's right and an essential condition for effective psychoanalytic treatment and research. A psychoanalyst must take all measures necessary to not reveal present or former patient confidences without permission, nor discuss the particularities observed or inferred about patients outside consultative, educational or scientific contexts.
- So the ethical standards for a member of APsaA may be different than the ethical standards of other psychotherapists. But the therapist should apply his or her judgment with respect to whether an unconsented disclosure would harm the patient's treatment or health.
- Health plans are also required by HIPAA to have criteria to limit the use and disclosure of health information to that necessary to accomplish the intended purpose. 45 CFR § 164.514(d)(3)(ii). So

those receiving requests for information could ask the health plan for those criteria to ensure that they are so limiting.

- Federal case law established by the Supreme Court in Jaffee v. Redmond, 116 S. Ct. 1923 (1996) recognizes a “psychotherapist-patient privilege” under which communications between a psychotherapist and patient may not be disclosed without the patient’s consent. Section 13421(c) of the HITECH Act of 2009 provides that nothing in that act, which amends the HIPAA Privacy Rule extensively, “shall constitute a waiver of any privilege otherwise applicable.” The Supreme Court in Jaffee found that all 50 states and the District of Columbia had recognized a psychotherapist-patient privilege. So this “privilege” on psychotherapist-patient communications is both federal and state law, but is not included in HIPAA.
- Finally, section 13405 of the HITECH Act of 2009 amended the HIPAA Privacy Rule to state that if a patient pays out-of-pocket for an item or service, the patient has a right to request and receive an assurance from a practitioner that any information about such an item or service will not be disclosed to a health insurance plan for payment or health care operations purposes without the patient’s consent. Practitioners therefore must agree to such requests for restrictions by the patient if the patient pays out-of-pocket for services and must not disclose such information to a health plan without the patient’s permission.

Attachment: Alert from American Psychiatric Association regarding Health Plan Requests for Release of Patient Records

Many members have received letters from insurance plans or third parties saying they are requesting patient records on behalf of insurance plans so that insurers can comply with the requirements of the Patient Protection and Affordable Care Act (ACA). The APA's general counsel, Colleen Coyle, has provided the following recommendations for handling these requests. While this information will soon be provided to members through District Branch Execs, I am informing you in advance both so you can assure the information is provided to all members of your District Branch or constituency group and so you can be available to direct members to the right source for further information.

Reason for the Letters

These letters are being sent so that insurers can comply with the requirements of the Patient Protection and Affordable Care Act (ACA). Drafters of the ACA were concerned that insurers would cherry pick healthy individuals in an effort to avoid the cost of long term and serious illness. To offset that possibility, the ACA contains a "Risk Adjustment" formula that requires carriers who have fewer seriously ill members to make payments that will go to those carriers that have more seriously ill members so that, in the end, the risk of loss due to covering serious illness is equitably shared by the insurance industry and there will be no benefit to discriminating against more complex individuals.

Why Patient Records Are Requested

To determine which carriers get paid and which will pay, the law requires carriers to report claims data to the state or to the Department of Health and Human Services. The carriers are responsible for ensuring that the data reported is accurate and therefore are conducting audits of their own data, which was originally derived from claims submission forms. Insurers have a record of the numbers of patients they paid claims for with X disease and that will be compared to how many consumers with X disease other insurers report. To ensure that the reporting is accurate, some insurers have hired audit firms that will review patient files to make certain that coding was correct and that, in the case of multiple diseases, all have been reported so that their company will accurately be placed in the correct grouping of those who pay because they have fewer seriously ill members or those who receive payment because they have more. These letters seek patient files in order to audit the data the insurance company has for the patients and make sure that their reports to the government will be accurate.

Your Responsibility

The answer to the question of whether the treating physician has to provide the data is different depending on the physician's status with the insurer and the patient's agreement with the insurer.

1. Participating physicians. *Physicians who participate in the insurance network that is asking for the information need to check their contract to determine what documentation they are required to provide. It is likely that the agreement requires the physician to provide documentation when requested, but this could vary from contract to contract. In this situation, HIPAA allows a physician to provide the information to the insurance plan or to its "business associate."*

2. Non-participating physicians. *Physicians who do not participate in the insurer's network and have no contractual relationship with the insurer probably have no legal duty to the insurer and no obligation to respond to the insurer's request for information. Your patient, on the other hand, may have a duty to provide the information to the insurer under the terms of his/her plan and this may vary from plan to plan. Several options are reasonable in this circumstance.*

a) Inform the patient *of the request and reason therefore, and if the patient consents to providing the information, cooperate with the request.*

b) Inform the entity *making the request that they need to first secure the patient's permission for you to provide the records.*

c) Wait for further communication from the requesting entity *and then let them know that they need to contact the patient first for consent.*

d) Wait for further communication from the requesting entity *and ask them to provide in writing the statute, regulation, or contract that they believe requires you to provide the records.*

Produce Records Only to a HIPAA Covered Entity

If the letter you received is not from the insurer, but instead comes from a company claiming to be a business associate of the insurer, you should check with the insurer before providing records to confirm that the requesting company is actually the insurer's business associate. If the letter you received comes directly from the insurer with whom you contract and it represents that a third party is a business associate under HIPAA, it should be fine to provide the records to that third party.