HIPPA Privacy Rule Policies

Policies and Procedures **USES AND DISCLOSURES FOR PAYMENT**	Policy # 19	
APPROVED BY: SUPERCEDES POLICY: NEW	ADOPTED:	
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Purpose

To describe the circumstances under which LifeMed ID workforce members may use and disclose Protected Health Information (PHI) for payment purposes in accordance with state and federal privacy laws, HIPAA Regulations and LifeMed ID's contracts with its customers.

Policy

It is the policy of LifeMed ID to protect PHI and to use and disclose PHI for payment in accordance with state and federal privacy laws, HIPAA Regulations and LifeMed ID's contracts with its customers.

All workforce members must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

Definitions

"Customer" is an entity from which LifeMed ID receives PHI subject to a Business Associate Agreement (or other written agreement with the entity) in compliance with the HIPAA Regulations and approved by LifeMed ID's legal counsel.

"Payment" - See the definition of "payment" in the *Regulatory Authority* section of this Policy.

For definitions of other capitalized terms or phrases, please refer to: *HIPAA-HITECH Privacy and Security Glossary*.

Procedures

An individual's PHI may be used or disclosed for payment purposes in accordance with this Policy.

1. Use or Disclosure for Payment. Subject to any requirement of federal or state law that requires patient consent, LifeMed ID may use or disclose PHI for payment purposes in accordance with this policy and consistent with state and federal privacy laws and HIPAA regulations. If not otherwise required by federal or state law, except as described below, it is not mandatory for LifeMed ID to obtain written consent to use or disclose an individual's PHI for payment purposes. PHI may not be used or disclosed for payment purposes, if it is contained in Psychotherapy Notes, except under very limited

circumstances. Refer to*: Privacy Policy #12: Authorization to Use or Disclose Protected Health Information*).

2. Restriction Request. An individual may request a restriction on the uses or disclosures of PHI for payment purposes. A Covered Entity is not required to agree to a requested restriction, unless the request is to restrict disclosure of PHI about the individual to a health plan and:
    a. The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and
    b. The PHI pertains solely to a health care item or service for which the individual (or a person other than the Health Plan on behalf of the individual, has paid the Covered Entity for the item or service in full.

Under the terms of LifeMed ID's contract with its customer, LifeMed ID will assist the customer in responding to an individual's request to restrict the uses or disclosures of the individual's PHI for payment purposes. Refer to: *Privacy Policy #7: Requests for Restrictions on Uses and Disclosures.*

3. Disclosure to Others. LifeMed ID may disclose PHI to a Covered Entity or subcontractor for the payment activities of the entity that receives the information.
4. Prohibition on Conditioning of Authorizations. LifeMed ID may not condition payment on behalf of an individual on the provision by the individual of an authorization.
5. Confidential Communications. LifeMed ID may require the individual to make a request for a confidential communication in writing and may condition the provision of a reasonable accommodation on when appropriate, information as to how payment, if any, will be handled and specification of an alternative address or other method of contact. Refer to: *Privacy Policy #8: Requests for Confidential Communications.*
6. Waiver of Rights. LifeMed ID may not require individuals to waive their rights as a condition of the provision of Treatment, payment, enrollment in a Health Plan, or eligibility for benefits. Refer to: *Privacy Policy #6: No Retaliation or Waiver.*
7. Minimum Necessary. Information that is used and shared for payment purposes is subject to the minimum necessary rules. Only LifeMed ID workforce members who have been granted appropriate authority are allowed to use or review PHI for payment purposes, and may access only the information needed to carry out their duties. PHI may be shared only with those workforce members who have a need for it based on specific operations. Refer to: Privacy Policy #5: Minimum Necessary: Uses, Disclosure, and Requests.

Accounting of Disclosures. Disclosures for payment activities are not required to be included in the Accounting of Disclosures. Refer to: *Privacy Policy #11: Accounting of Disclosures.*

Documentation

This version of the policy, together with any forms and other documentation created or obtained in accordance with the policy, will be retained by LifeMed ID for a period of at least 6 years plus the current year from the date of creation or the date when last in effect, whichever is later.

Regulatory Authority

45 C.F.R. §164.501 Definitions.

Payment *means:*

(1) The activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

(ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) 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;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;

(B) Date of birth;

(C) Social security number;

(D) Payment history;

(E) Account number; and

(F) Name and address of the health care provider and/or health plan.

45 C.F.R. §164.502 Uses and disclosures of protected health information: general rules.

(a) Standard. *A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.*

> *(1) Covered Entities: Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows:*
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> > *(i) To the individual;*
> >
> > *(ii) For treatment, payment, or health care operations, as permitted by and in compliance with §164.506;*
>
> *(3) Business associates: Permitted uses and disclosures. A business associate may use or disclose protected health information only as permitted or required by its business associate contract or other arrangement pursuant to § 164.504(e) or as required by law. The business associate may not use or disclose protected health information in a manner that would violate the requirements of this subpart, if done by the covered entity, except for the purposes specified under § 164.504(e)(2)(i)(A) or (B) if such uses or disclosures are permitted by its contract or other arrangement.*

45 C.F.R. §164.506 Uses and disclosures to carry out treatment, payment, or health care operations.

(a) Standard: *Permitted uses and disclosures. Except with respect to uses or disclosures that require an authorization under §164.508(a)(2) through (4) or that are prohibited under §164.502(a)(5)(i), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.*

(b) Standard: *Consent for uses and disclosures permitted.*

> *(1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.*
>
> *(2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under §164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart.*

(c) Implementation specifications: *Treatment, payment, or health care operations.*

> *(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.*
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> *(2) A covered entity may disclose protected health information for treatment activities of a health care provider.*
>
> *(3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.*
>
> *(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had*

a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:

(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

(ii) For the purpose of health care fraud and abuse detection or compliance.

(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to other participants in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

45 C.F.R. §164.508 Uses and disclosures for which an authorization is required.

(a) Standard: *Authorizations for uses and disclosures—(1) Authorization required: General rule. Except as otherwise permitted or required by this subchapter, a covered entity may not use or disclose protected health information without an authorization that is valid under this section. When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with such authorization.*

(2) Authorization required: Psychotherapy notes. Notwithstanding any provision of this subpart, other than the transition provisions in §164.532, a covered entity must obtain an authorization for any use or disclosure of psychotherapy notes, except:

(i) To carry out the following treatment, payment, or health care operations:

(A) Use by the originator of the psychotherapy notes for treatment;

(B) Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

(C) Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual; and

(ii) A use or disclosure that is required by §164.502(a)(2)(ii) or permitted by §164.512(a); §164.512(d) with respect to the oversight of the originator of the psychotherapy notes; §164.512(g)(1); or §164.512(j)(1)(i).

(b) Implementation specifications: *General requirements*

(4) Prohibition on conditioning of authorizations. A covered entity may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except:

(i) A covered health care provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research under this section;

(ii) A health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if:

(A) The authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and

(B) The authorization is not for a use or disclosure of psychotherapy notes under paragraph (a)(2) of this section; and

(iii) A covered entity may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

45 C.F.R. §164.510

(b) Standard: *uses and disclosures for involvement in the individual's care and notification purposes*

(1) Permitted uses and disclosures.

(i) A covered entity may, in accordance with paragraphs (b)(2), (b)(3), or (b)(5) of this section, disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information directly relevant to such person's involvement with the individual's health care or payment related to the individual's health care.

45 C.F.R. §164.522 Rights to request privacy protection for protected health information.

(a) **(1) Standard:** *Right of an individual to request restriction of uses and disclosures.*

(i) A covered entity must permit an individual to request that the covered entity restrict:

(A) Uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations; and

(B) Disclosures permitted under §164.510(b).

(ii) Except as provided in paragraph (a)(1)(vi) of this section, a covered entity is not required to agree to a restriction.

(vi) A covered entity must agree to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if:

(A) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and

(B) The protected health information pertains solely to a health care item or service

for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

(b) **(1) Standard:** *Confidential communications requirements.*

(i) A covered health care provider must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the covered health care provider by alternative means or at alternative locations.

(ii) A health plan must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the health plan by alternative means or at alternative locations, if the individual clearly states that the disclosure of all or part of that information could endanger the individual.

(2) Implementation specifications: *Conditions on providing confidential communications.*

(i) A covered entity may require the individual to make a request for a confidential communication described in paragraph (b)(1) of this section in writing.

(ii) A covered entity may condition the provision of a reasonable accommodation on:

(A) When appropriate, information as to how payment, if any, will be handled; and

(B) Specification of an alternative address or other method of contact.

(iii) A covered health care provider may not require an explanation from the individual as to the basis for the request as a condition of providing communications on a confidential basis.

(iv) A health plan may require that a request contain a statement that disclosure of all or part of the information to which the request pertains could endanger the individual.

45 C.F.R. §164.530 Administrative requirements.

(h) Standard: *Waiver of rights. A covered entity may not require individuals to waive their rights under §160.306 of this subchapter, this subpart, or subpart D of this part, as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.*

References

Internal

1. Privacy Policy #5, Minimum Necessary: Uses, Disclosures and Requests
2. Privacy Policy #6, No Retaliation or Waiver
3. Privacy Policy #7, Requests for Restrictions on Uses and Disclosures
4. Privacy Policy #8, Requests for Confidential Communications
5. Privacy Policy #11, Accounting of Disclosures
6. Privacy Policy #12, Authorization to Use or Disclose Protected Health Information

External

1. Omnibus Final Rule: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=a1031c979126e6440b522063b7bba578&rgn=div5&view=text&node=45:1.0.1.3.78&idno=45%20