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HIPAA FAQs

Issues and Responses from the Board-Provider Advisory Group

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ISSUE 1. KEYWORD(S): Time Limits For Authorizations for Billing and Payment Purposes

ISSUE SUMMARY: The sample MACSIS authorization forms presented at the May 15, 2003 training do not include the 180 day time limit required for authorizations for disclosure of information about mental health clients. Does the 180 day time limit apply to authorizations for billing and payment purposes?

ISSUE RESPONSE: The sample MACSIS authorization forms presented at the training on May 15, 2003 were intended to comply with all state and federal requirements related to authorizations needed for the exchange of health information related to the provision of publicly funded mental health and chemical dependency treatment services in Ohio. Those state and federal laws include: the HIPAA Privacy Rule, 42 C.F.R. Part 2, and Ohio mental health laws and rules, including OAC §5122-27-09 and ORC 5122.31. The sample forms were offered as training materials, not legal advice. Each provider and/or ADAMH Board is encouraged to carefully review the materials and to obtain the advice it feels is necessary to be in compliance with these complex regulations.

The sample forms authorizing community mental health agencies to disclose information through MACSIS for payment purposes do not include a provision for expiration after 90 or 180 days because neither HIPAA nor Ohio law require client authorization for disclosure of information for payment purposes. Under HIPAA, authorization is not necessary because this type of disclosure falls within TPO. In contrast, Ohio law requires that mental health clients be asked for permission to share information for payment purposes. However, Ohio law ultimately allows patient information to be disclosed by a community mental health agency for payment purposes even if the client does not authorize it. This has the effect of making other mental health authorization requirements unnecessary.

In Ohio, if client authorization is required for a community mental health agency to make a disclosure, all requirements governing authorization apply, including the requirement that authorizations to disclose information about mental health clients will expire no later than 90 or 180 days from the time of the authorization. Ohio Administrative Code §5122-27-09, which is the ODMH rule governing a community mental health agency's disclosure of mental health client information, provides that "all requests for information require a signed authorization for release of information according to this rule, except under the conditions specified in Section 5122.31 of the Revised Code." The rule goes on to specify the requirements for authorizations when they are required, including a requirement that an authorization shall expire no later than 90 or 180 days from the date of the authorization.¹ If a community mental health agency

¹ With respect to an authorization's expiration, OAC §5122-27-09(C) provides:

Authorization for release of information will automatically expire 90 days after the date of the authorization unless an earlier date, event, or condition is specified, except that a person served may specify a longer period of time under the following conditions:

- (1) If the person is part of an approved research study and has given authorization for a longer period of time, or

is required to obtain an authorization to disclose information, the 90 or 180 day time limit will apply to limit the duration of the authorization.

To determine whether client authorization is necessary, the community mental health agency must determine whether the disclosure falls within one of the conditions specified in ORC §5122.31. With respect to disclosures for payment purposes, ORC §5122.31(C) provides that “hospitals, boards of alcohol drug addition and mental health services, and community mental health agencies may release necessary medical information to insurers and other third-party payers, including government entities responsible for processing and authorizing payment, to obtain payment for goods and services furnished to the patient.”

Even though community mental health agencies may disclose information without authorization for payment purposes, they must first try to obtain consent for the disclosure. ORC §5122.31(O) requires that “before records are disclosed [for payment purposes], the custodian of the records shall attempt to obtain the patient’s consent for disclosure.” Since, ultimately, ORC §5122.31(C) permits a community mental health agency to disclose information for payment purposes without client authorization, the authorization requirements contained in OAC §5122-27-09, such as a 90 or 180 time limit do not apply.

This interpretation is consistent with ODMH’s approach to addressing agency disclosures to MACSIS. As part of its MACSIS guidelines, ODMH requires community mental health agencies to meet the requirement to try to obtain client consent for disclosures for payment purposes by having each mental health client sign a “MACSIS authorization” form. The form does not contain any reference to the 90/180 day time limit. Clients who do not sign the form may still obtain mental health services paid with public funds. Even if clients do not sign the MACSIS authorization, community mental health agencies may disclose client information to MACSIS for payment purposes.

(2) If the person served is expected to continue receiving services beyond 90 days and has given authorization for a longer period of time which may be up to 180 days.

ISSUE 2. KEYWORD(S): Compound Authorizations

ISSUE SUMMARY: The sample MACSIS Authorization forms presented at the May 15, 2003, training may be compound authorizations which are prohibited under HIPAA.

ISSUE RESPONSE: The sample MACSIS Authorization forms presented at the training on May 15, 2003, were intended to comply with all state and federal requirements relating to authorizations needed for the exchange of health information related to the provision of publicly funded mental health and chemical dependency treatment services in Ohio. Those state and federal laws include: the HIPAA Privacy Rule, 42 CFR Part 2, and Ohio mental health laws and rules. The sample forms were offered as training materials, not as legal advice. Each Provider and/or Board is encouraged to carefully review the materials and to obtain the advice it feels is necessary to be in compliance with these complex regulations.

The HIPAA Privacy Rule prohibits compound authorizations.¹ However, the sample MACSIS Authorization forms do not violate HIPAA because we believe that the requirements regarding authorization imposed by 42 CFR Part 2, which have been adopted as Ohio law, supersede HIPAA's prohibition on compound authorizations.

Per HIPAA, the following are the required core elements of a valid authorization:²

1. a description of the information to be used or disclosed;
2. the identification of the persons or class of persons authorized to make the use or disclosure of the protected health information;
3. the identification of the persons or class of persons to whom the covered entity is authorized to make the use or disclosure;
4. a description of each purpose of the use or disclosure;
5. an expiration date or event;
6. the individual's signature and date; and,
7. if signed by a personal representative, a description of his or her authority to act for the individual.

In addition, HIPAA requires a valid authorization to include several specific notification statements:³

1. a statement that the individual may revoke the authorization in writing, and either a statement regarding the right to revoke, and instructions on how to exercise such right or, to the extent this information is included in the covered entity's notice, a reference to the notice;

¹ What constitutes a compound authorization is not defined in HIPAA. The prohibition and other helpful information can be found at 45 CFR § 164.508(b)(3) and (4)

² 45 CFR § 164.508(b)(1)

³ 45 CFR § 164.508(c)(2)

2. a statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule or, if conditioning is permitted, a statement about the consequences of refusing to sign the authorization; and,
3. a statement about the potential for the protected health information to be redisclosed by the recipient.

Finally, HIPAA requires that covered entities who seek an authorization are required to provide the individual with a copy of the signed authorization form.⁴

The regulations governing the disclosure of substance abuse assessment and treatment records (42 CFR Part 2) have slightly different authorization requirements. These rules are required to be followed by certified providers of substance abuse assessment and treatment services in Ohio. To the extent that these requirements give more information or control to individuals, these rules will prevail over the HIPAA requirements noted above. For example, HIPAA does not permit treatment to be conditioned upon an authorization to disclose payment information. HIPAA also allows a covered entity to disclose payment information to another covered entity without individual authorization (as part of TPO). 42 CFR Part 2 requires authorization from the individual so that a treatment provider may disclose information to be paid for providing treatment services. In this instance, 42 CFR gives the individual more control over the use of her information and therefore preempts HIPAA. Our sample form incorporates this conclusion by telling individuals that their substance abuse treatment may not occur unless they permit their treatment provider to disclose information so that the provider can be paid for giving treatment services.

The statutes and rules governing the disclosure of information maintained by Ohio certified or licensed mental health services providers also have somewhat different authorization requirements. Again, to the extent that these requirements give more information or control to individuals, these rules will prevail over the HIPAA requirements noted above. For example, Ohio mental health rules require that the staff person attempting to obtain the authorization sign the authorization form. This requirement gives the individual more information, therefore this was included on the sample authorization form.

⁴ 45 CFR § 164.508(c)(4)

ISSUE 3. KEYWORD(S): Exchange of information regarding patients hospitalized pursuant to Ohio Revised Code Chapter 5122

ISSUE SUMMARY: (1) May ADAMH Boards communicate with each other without patient authorization in order to resolve residency disputes? (2) May an ADAMH Board, a hospital and a community mental health agency hold “case review” meetings to discuss a patient’s treatment without the patient’s authorization?

ISSUE RESPONSE:

(1) Exchange of Information Between ADAMH Boards Regarding Residency Disputes: Most ADAMH Boards in Ohio consider themselves to be covered by HIPAA as health plans. Even if an ADAMH Board does not consider itself a covered entity, it is still subject to Ohio laws pertaining to the confidentiality of mental health records. Pursuant to Ohio Revised Code Chapter 5122, an ADAMH Board has certain responsibilities to arrange and pay for hospital services provided to individuals residing in the ADAMH Board’s service district. In order to ensure that the ADAMH Board which is responsible for a hospitalized individual pays for hospital services rendered, ADAMH Boards may need to share information which is protected by HIPAA and Ohio law in order to determine an individual’s county of residence. Thus it is necessary to analyze both Ohio law and HIPAA to determine how an ADAMH Board can lawfully obtain and/or disclose patient information for payment purposes.

Under HIPAA, covered entities may disclose protected health information for payment purposes without an individual’s authorization. If the purpose of the disclosure between ADAMH Boards regarding an individual’s residency is for payment purposes, HIPAA would permit disclosures of the minimum amount of information necessary to permit the appropriate ADAMH Board to pay for services rendered.

Ohio law governing information about an individual hospitalized under Ohio Revised Code Chapter 5122 provides that “hospitals, boards of alcohol, drug addiction and mental health services . . . may release necessary medical information to insurers and other third party payors, including government entities responsible for processing and authorizing payment, to obtain payment for goods and services furnished to the patient.” See, ORC §5122.31(C). However, before making such a disclosure, the disclosing entity must first attempt to obtain the patient’s consent for the disclosure. See, ORC § 5122.31(O). Accordingly, before sharing patient information with another ADAMH Board to make a residency determination for payment purposes, the ADAMH Board making the disclosure must attempt to obtain patient consent. Once the attempt to obtain consent has been made (and documented) the ADAMH Board may lawfully make disclosures for payment purposes, subject to HIPAA’s minimum necessary requirement.

ISSUE 4. KEYWORD(S): Progress Notes and Audits

ISSUE SUMMARY: Should the progress notes only be for the date and service being audited as opposed to allowing the auditor to see all progress notes? There is a difference of opinion among various agencies and we are wondering how to proceed. Any light you can shed on the subject would be appreciated.

ISSUE RESPONSE: HIPAA's minimum necessary concept applies. Auditors must request and providers may disclose only that amount of information which is reasonably necessary to achieve the purpose of the audit (such as, to verify appropriate payment made for services rendered.)"

Follow the recommended compliance strategy on page 45 of the document section dealing with audits, especially the 2nd bullet item:

“In response to all requests for audits, providers should obtain information about the purpose of the audit so that the provider can determine whether client authorization, underlying arrangements or accounting of disclosures are required under HIPAA. Government auditors should identify the law or rule upon which an audit is based. Providers and auditors should use processes and standards contained in law or rule to determine the minimum necessary disclosures required for the audit. Where there is no governing legal standard, the provider and auditor should establish and memorialize the minimum necessary standard used. Boards should keep in mind that these principles also apply when a board is being audited by another governmental agency. In those situations, the board's responsibilities are analogous to the provider responsibilities previously described in this paragraph.”

Basically, since auditing is an allowed HIPAA function for disclosing PHI, the minimum necessary rule applies, and in the absence of any clear HIPAA or Ohio law guidelines, the recommendation is to reach an agreement with the Board and the auditor about what constitutes minimum necessary, including whether it is only the date and service being audited as opposed to all the progress notes. Then document this agreement.

ISSUE 5. KEYWORD(S): Accounting For Disclosures

ISSUE SUMMARY: The agency has requested additional clarification on the responsibility to account for disclosures, particularly disclosures related to reports of child abuse and neglect. Please pay particular attention to the footnotes contained in this response as they contain important details regarding the application of these complicated laws.

ISSUE RESPONSE: HIPAA contains a variety of circumstances where a covered entity may, if specifically required or permitted by state law, disclose PHI for reasons other than TPO, without the written authorization of an individual, or the opportunity of the individual to agree or to object.¹ There are many instances in Ohio where disclosures are required or permitted without authorization from an individual. An example of this for an Ohio mental health professional is the required reporting of suspected child abuse or neglect.² Even though the PHI can be disclosed without permission, HIPAA requires that certain disclosures be revealed to an individual upon request.³ This is called an accounting of disclosures.

The HIPAA Requirements for an Accounting of Disclosures

HIPAA permits individuals (or their personal representatives) to request that covered entities report disclosures of the individual's PHI for a period of up to six years from the date the accounting of disclosures is requested.⁴ This includes disclosures of PHI to or by business associates of the covered entity. The Department of Health and Human Services explains that the accounting requirement was created to allow the individual to find out the non-routine purposes for which his or her protected health information was disclosed by the covered entity. This knowledge increases the individual's awareness of persons or entities having possession of this information other than the individual's health care provider or health plan.

Upon request, an individual can receive an accounting of any disclosure of PHI **EXCEPT:**

1. Disclosures to carry out treatment, payment, and health care operations.⁵
2. Disclosures to individuals about themselves.⁶

¹ 45 CFR §§ 164.502; 164.506; 164.508; 164.510; and 164.512

² Ohio Revised Code §2151.421

³ 45 CFR § 164.528

⁴ Accountings must be acted upon by the covered entity within sixty days of the request. Though the first accounting in any twelve month period must be without charge, a covered entity may charge a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the twelve month period as long as the covered entity notifies the individual of its fees. In general, an accounting must contain: the date of the disclosure, the entity/person who received the disclosure (along with an address, if known), a brief description of the PHI disclosed, and a brief statement about the purpose of the disclosure. In lieu of these requirements, the covered entity may disclose a copy of the written request for the disclosure. Slightly different disclosure requirements exist for multiple disclosures to the same entity/person for the same purpose and for disclosures for research purposes. 45 CFR § 164.528(b)(3) and (4)

⁵ 45 CFR §164.528(a)(1)(I)

3. Disclosures pursuant to an authorization.⁷
4. Disclosures to correctional institutions or law enforcement officials having lawful custody of an inmate or individual for the treatment of that individual, or for law enforcement or health and safety purposes related to the institution in which the individual is being held.⁸
5. Disclosures for national security and intelligence activities authorized under the National Security Act.⁹
6. Disclosures as part of a limited data set.¹⁰
7. Disclosures for the facility's directory or to persons involved in the individual's care or for other notification purposes.¹¹
8. Disclosures that occurred prior to the compliance date (April 14, 2003) for the covered entity.¹²
9. Disclosures regarding known or suspected child abuse or neglect pursuant to Ohio Revised Code § 2151.421.¹³
10. Certain disclosures for law enforcement or health oversight activities may be suspended from inclusion into an accounting for disclosures for a limited period of time.¹⁴
11. Under very limited circumstances, HIPAA allows a covered entity to determine that it will not include a disclosure regarding victims of abuse, neglect or domestic violence in an accounting for disclosures.¹⁵

⁶ 45 CFR §164.528(a)(1)(ii)

⁷ 45 CFR §164.528(a)(1)(iv)

⁸ 45 CFR §164.528(a)(1)(vii)

⁹ 45 CFR §164.528(a)(1)(vi)

¹⁰ 45 CFR §164.528(a)(1)(viii)

¹¹ 45 CFR §164.528(a)(1)(v)

¹² 45 CFR §164.528(a)(1)(ix)

¹³ HIPAA specifically states that state laws mandating the reporting of suspected child abuse or neglect always preempt HIPAA. Ohio law currently requires that certain professionals immediately report suspected child abuse or neglect. Furthermore, the report as well as the identity of the reporter are required to be kept confidential. This means that the fact that a report of suspected child abuse or neglect has been made should not be included in an accounting for disclosures. Nor should any documentation of that report be shared with an individual (or personal representative) who is exercising his or her lawful record access rights. As a technical matter, neither Ohio law nor HIPAA mandate the inclusion of documentation of reporting suspected abuse or neglect as part of either the integrated clinical record or designated record set. For basic risk management reasons, documentation of the fact that a report was made should be maintained in a consistent manner, though not necessarily in the client's individual records.

¹⁴ A covered entity must comply with a law enforcement or health oversight agency's written request for a temporary suspension of the disclosure of protected health information to the individual who is requesting an accounting for disclosure. The law enforcement or health oversight agency must put its' request in writing and must assert that an accounting to the individual would be reasonably likely to impede the law enforcement or health oversight agency's activities. The written statement must also specify the time for which such a suspension of the accounting for disclosure is required (the suspension cannot be indefinite). If the law enforcement or health oversight agency won't submit the suspension request in writing, the covered entity must document the oral request, including the identity of the agency or official making the statement; temporarily suspend the individual's right to an accounting of disclosures subject to the statement; and limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless a written statement from the law enforcement or health oversight agency is submitted during that time. 45 CFR §164.528(a) (2).

¹⁵ This occurs in two ways. First, in relation to adult victims of abuse or domestic violence, HIPAA requires that the victim be told that a report regarding domestic violence has been made. Ohio law does not

The following disclosures of PHI **must be included** in an accounting if one is requested by the individual:

1. Disclosures required by law (Note that special rules exist in HIPAA for disclosures of PHI about victims of abuse, neglect and domestic violence; for judicial and administrative proceedings, and for various law enforcement purposes. See 45 CFR §§ 164.512(c) (e) and (f).).
2. Disclosures required by law for public health activities, such as birth and death reporting.¹⁶
3. Disclosures about suspected adult victims of abuse, neglect or domestic violence to any governmental authority authorized by law to receive reports of such abuse, neglect, or domestic violence.¹⁷

currently require that suspicions of domestic violence be reported to any external agency. However, if an Ohio mental health professional chooses to report a suspicion of domestic violence to an outside entity, HIPAA requires that this fact be affirmatively disclosed to the individual (or his/her personal representative) unless:

1. The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or
2. The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment. 45 CFR §164.512(c) (2).

A similar standard applies to personal representatives who request an accounting for disclosures. If a request for an accounting for disclosures is made by a personal representative of an individual, the covered entity may elect not to treat a person as the personal representative of an individual if:

1. The covered entity has a reasonable belief that:
 - i. The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
 - ii. Treating such person as the personal representative could endanger the individual; and
2. The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

¹⁶ 45 CFR §164.512(b)(1)(I)

¹⁷ See the discussion at footnote 15 for ways that this accounting responsibility may be altered based upon the circumstances and the professional judgment of the covered entity.

4. Disclosures to health oversight authorities for oversight activities authorized by law.¹⁸
5. Disclosures for judicial and administrative proceedings.¹⁹
6. Disclosures for law enforcement purposes.²⁰
7. Disclosures to funeral homes and coroners as authorized by state law.²¹
8. Disclosures for cadaveric organ, eye or tissue donation purposes.²²
9. Disclosures for research purposes.²³
10. Disclosures required by law to avert a serious threat to health or safety.²⁴
11. Disclosures for specialized government functions.²⁵
12. Disclosures as authorized and to the extent necessary to comply with laws relating to workers' compensation.²⁶
13. Disclosures made for the covered entity's fundraising purposes.²⁷
14. Disclosures for underwriting and related purposes.²⁸

¹⁸ 45 CFR §164.512(d). See footnote 14 for a discussion of a limited suspension of accountings of disclosures for health oversight purposes.

¹⁹ 45 CFR §164.512(e)

²⁰ 45 CFR §164.512(f)

²¹ 45 CFR §164.512(g)

²² 45 CFR §164.512(h)

²³ 45 CFR §164.512(i).

²⁴ 45 CFR §164.512(j)

²⁵ 45 CFR §164.512(k)

²⁶ 45 CFR §164.512(l)

²⁷ 45 CFR §164.514(f)

²⁸ 45 CFR §164.514(g)

ISSUE 6. KEYWORD(S): Emergency Room PHI for High ER Users

ISSUE SUMMARY: In an effort to manage costs, a Board has asked a Provider to become a repository of PHI and to share PHI with emergency rooms about persons who are considered by the Board to be frequent users of emergency rooms. Releases may not always be in place for these persons. Some of the persons may not be patients of the Provider. In some circumstances, the person's presentation at the emergency room may not meet the definition of an emergency. Can the Provider receive, maintain, and disclose the PHI without a release?

ISSUE ANSWER: Yes. It appears that the Board is requesting this assistance in order to perform a utilization review process with the emergency room in order to manage the Board's costs. Thus, the purpose of the disclosure can probably be characterized as 'payment'. As a health plan, the Board is a covered entity under HIPAA. Both the Provider and the Emergency Room are covered entities as well, but this exchange of information is being done at the request of the Board in order to fulfill an obligation of the Board's, so the Board's requirements are of primary importance in this analysis. Typically, as a Provider, the Agency would not be permitted to disclose information about patients or non-patients in non-emergencies to the Emergency Room without authorization from the Individual. What this Provider is being asked to do goes beyond what it customarily does as a Provider. It is being asked to do something *on behalf of* the Board.

It is possible for this to take place through a formalized business associate relationship. If the Board enters into a *business associate agreement* with the Provider documenting that the Provider is receiving, maintaining and disclosing PHI on behalf of the Board, the information can be released by the Provider when solicited by the Emergency Room. The PHI received, maintained and disclosed in accordance with the business associate agreement between the Board and the Provider should be kept separately from the Provider's regular client records.

As a covered entity, the Board should carefully define the circumstances under which both Emergency Rooms and the Provider, on behalf of the Board, can solicit and disclose health information about the Individual. Under no circumstances would it be possible for the Emergency Room to routinely call the Provider for possible health information about the Individual as a general screening step. Only if the Individual is known to the Emergency Room as having received publicly funded mental health services in the past or if the Individual's presenting behavior meets certain well-defined (by the Board) criteria should the Emergency Room be permitted to seek and the Provider disclose health information, on behalf of the Board.

ISSUE 7. KEYWORD(S): Authorizations for Disclosure for Dually Funded Providers

ISSUE SUMMARY: In reviewing the sample “Authorization for Disclosure of Confidential Information About Persons Receiving Services” form, it appears that a client is not given any option about disclosing some forms of information and not others. Since (1) providers will not be able to bill for services unless authorization to allow submission of claims via MACSIS is approved and (2) all the other forms of information are listed on the same form without the option of deselecting any items, it appears that this will necessarily mean that clients will either authorize all disclosures or the provider will not be able to provide service (unless willing to provide service without reimbursement).

We found the following wording on the joint ODMH-ODADAS certified agency authorization to be problematic.

“I understand that the (provider organization) may disclose information necessary to be paid for mental health services even if I do not authorize disclosure. I must, however, authorize disclosure of information necessary for payment purposes in order to receive alcohol and drug addiction services. My treatment or payment for my services cannot be conditioned upon my giving authorization to disclose information for any purpose other than for payment of alcohol and drug addiction services.”

We would like to change this language to the following. Would there be a problem with this change?

“I understand that if I receive treatment for substance abuse problems, the information disclosed is protected by applicable law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that the (dually certified agency) cannot control the use of this information once it has been disclosed.”

ISSUE RESPONSE: The assumption is incorrect regarding the redisclosure of mental health treatment information. **Both** 42 CFR Part 2 (for AOD clients) and OAC 5122-27-09 (for mental health clients) purport to continue to protect client identifying information after it is disclosed pursuant to client authorization. Both of these laws prohibit the redisclosure of the information. If a provider wants to have a more specific statement on the authorization form about which law controls what information, the provider could revise the sentence to read:

“I understand that the information disclosed is protected by 42 CFR Part 2 (governing substance abuse services information) and/or OAC 5122-27-09 (governing mental health services information) and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that the (Name of Your Dually-Certified) Agency cannot control the use of this information once it has been disclosed.”

ISSUE 8. KEYWORD(S): Minimum Necessary Related to Authorizations

ISSUE SUMMARY: I disagree that minimum necessary rule does not apply if an authorization exists - example: request (with ROI) for entire medical record for the purpose of, for example, housing info, current medications, etc

ISSUE RESPONSE: Minimum necessary is an overarching principle for HIPAA Privacy rules. It was not the intent of the training to imply that with authorizations the minimum necessary principle is no longer a concern. The guiding principle should be that the minimum necessary PHI be released to meet the function or use for which it is being legally requested. HIPAA Privacy Rule reference: 164.502 (b)

ISSUE 9. KEYWORD(S): MUI, Authorization for Release and “Knowing Consent”

ISSUE SUMMARY: How can authorization for the release of health information contained within MUI reporting for a mental health provider be integrated into the proposed authorization on page 64 of the May 15th and still be considered knowing consent and authorization to the release of information when, at the time the authorization is executed, there is no way for the person to know what, if any, information will be released in the event of an MUI?

ISSUE RESPONSE: We agree that whether an MUI will be reported and what it will contain are not predictable at the time an authorization is filled out. However, we believe that what we created is sufficient for the following reasons:

1. Ohio law, 42 CFR Part 2 and HIPAA require authorization forms to identify the type of information to be disclosed, to whom it will be disclosed, and for what purpose. Based upon our research of the issue, we believe all of these laws permit providers to use forms which include general descriptions or identify categories or types of information. Recently, in fact, the Office for Civil Rights has stated that a valid authorization does not have to specifically describe the exact information that is to be disclosed. It is sufficient that it describe the type of information that is authorized to be disclosed.
2. The authorization form references certain requirements with which the provider must comply as a recipient of public funds---including major unusual incident reporting requirements. This puts the individual on sufficient notice to inquire of the provider the types of information that may have to be disclosed. Providers should be prepared to sufficiently answer these types of questions.
3. Neither HIPAA, 42 CFR Part 2, nor Ohio law require a “knowing” authorization. If such authorization was required---the forms would be much longer and more complicated than they are now. The governing laws merely require that individuals be given sufficient information so that they can make choices regarding their health information and understand that circumstances under which their health information may be disclosed, if authorized.

ISSUE 10. KEYWORD(S) Definition of Covered Entities and Sharing PHI with Auditors

ISSUE SUMMARY: Our organization is a regional council of governments funded primarily by the Ohio Department of Mental Health. Our Director of Crisis Services authorizes hospitalizations of children with mental health problems who do not qualify for insurance or Medicaid. The Consortium pays the invoice. When the state auditors review our books they have access to these invoices detailing the services provided to these children. By asking the auditors to sign a confidential statement, are we covering ourselves under the HIPAA confidentiality rules? Do we fall under the TPO classification indicating we are not required to follow HIPAA guidelines? Do we need to notify the agency through which the child came into the system that information on their client has been shared with an auditor?

ISSUE RESPONSE: Covered Entity: Your organization receives protected health information on children, maintains this information and then pays claims for them. Under HIPAA, this qualifies your organization as a covered entity, as a health plan, and therefore subject to the HIPAA rules.

Notify referring agency that PHI is being shared with the auditor: There are different requirements, depending on the type of audit you are referencing. A financial/claims audit comes under the TPO (treatment/payment/operations) provisions of HIPAA and a Business Associate Agreement is needed to ensure that the PHI is handled properly. A program audit comes under the Oversight provision of HIPAA and no BA is required. Notifying the agency through which the child came into the system that their client's PHI has been shared with the auditor, is not required under HIPAA. However, accounting for disclosures is required if requested by the client, in which case you are required to account for any disclosures for purposes which are not TPO or for which the client did not sign an authorization.

ISSUE 11. KEYWORD(S) Custom Designed Compound Authorization Form

ISSUE SUMMARY: Provider designed “Sharing of Information Form”. Is this form HIPAA compliant?

ISSUE RESPONSE: We cannot advise through this forum whether the form you designed is HIPAA compliant. We do recommend two sources of information that should help you determine whether your form is compliant:

1. *HIPAA Privacy Regulation: Consents & Authorizations* (from a 6/20/01 Audio Conference by the Phoenix Health Systems). This document is available from the Ohio Council of Behavioral Healthcare Providers, mspurg5119@aol.com.
2. *Privacy Notice: Consent; Authorization – Sample Documents Relating to Use and Disclosure of Protected Health Information (PHI)*. A draft document released by ODMH in May, 2002. This document is available from the Ohio Council of Behavioral Healthcare Providers, mspurg5119@aol.com.

If further advice is required as to whether your authorization form is HIPAA compliant, we recommend you seek legal counsel.

ISSUE 12. KEYWORD(S) Required Authorization Elements

ISSUE SUMMARY: What elements must be included on a release of information/authorization form in order to comply with state and federal law?

ISSUE RESPONSE: The following elements must be included on a release of information/authorization form in order to be compliant with HIPAA, state law, and federal alcohol and drug confidentiality laws:

- ~~///~~ Full name of client
- ~~///~~ Date of birth of client
- ~~///~~ Purpose of disclosure
- ~~///~~ Specific information to be disclosed
- ~~///~~ Name or title of person or entity disclosing the information
- ~~///~~ Name or title of person or entity receiving the information
- ~~///~~ Date, event, or condition upon which the authorization shall expire, not to exceed six months from the date of its completion unless documentation reflects that the client agrees to a longer authorization period
- ~~///~~ Statement notifying the client of his/her right to shorten or lengthen the authorization period
- ~~///~~ Statement that the client has the right to revoke the authorization at any time except to the extent the program or person to which the disclosure was made has already acted in reliance on it
- ~~///~~ Dated signature of the client or, as appropriate, a legally authorized agent and the agent's relationship to the client

In addition, the following statement must accompany all released records that include information about any diagnosis or treatment of drug or alcohol abuse:

“This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.”

ISSUE 13. KEYWORD(S) Health Oversight Agencies

ISSUE SUMMARY: Are Boards considered to be “Health Oversight Agencies” pursuant to HIPAA?

ISSUE RESPONSE:

The HIPAA regulations define a “Health Oversight Agency” as:

... a political subdivision of a State ... that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant. 45 CFR 164.501

The Department of Health and Human Services commentary on this section explains that:

"Overseeing the health care system," which is a concept included in the definition of health oversight, encompasses activities such as: oversight of health care plans; oversight of health benefit plans; oversight of health care providers; oversight of health care and health care delivery; oversight activities that involve resolution of consumer complaints ... and a health oversight agency's analysis of trends in health care costs, quality, health care delivery, access to care, and health insurance coverage for health oversight purposes ... agencies may sometimes perform audits and investigations and at other times conduct general oversight of health benefit plans. Such entities are considered health oversight agencies under the rule for any and all of the health oversight functions that they perform. 65 Fed. Reg. 82492 (December 28, 2000)

ADAMH/CMH/ADAS Boards are considered to be “political subdivisions” under Ohio law and are statutorily mandated to serve as the community mental health and drug and alcohol planning agencies which includes evaluating the need for facilities and services, setting priorities, and developing plans for the operation of facilities and services. Boards are also mandated to review and evaluate the quality, effectiveness, and efficiency of services provided through its community plan. Therefore, Boards meet the definition of Health Oversight Agencies pursuant to the HIPAA regulations.

The regulations state that a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; activities necessary for appropriate oversight of government benefit programs for which health information is relevant to beneficiary eligibility; or other activities necessary for appropriate oversight of the health care system.

ISSUE 14. KEYWORD(S) Child Fatality Review Boards

ISSUE SUMMARY: The Executive Director of an ADAMH Board is required to be a member of the Child Fatality Review Board established in their district. Are they allowed to share information about recipients of mental health and/or drug and alcohol services at the review board's request?

ISSUE RESPONSE: Sections 307.621 to 307.629 of the Ohio Revised Code govern the structure and functions of Child Fatality Review Boards (CFRB). Section 307.622 requires the "executive director of a board of alcohol, drug addiction, and mental health services or designee" to be a member of the review board. One of the purposes of a CFRB is to develop an understanding of the causes and incidence of child deaths. In order to determine potential causes and contributing factors in child deaths, Executive Directors that serve on the boards are often asked to disclose whether the parent of the child was a recipient of mental health or drug and alcohol services as well as any related information.

In regards to information pertaining to recipients of mental health services, both state and federal law permit such disclosures. HIPAA allows disclosures made for the purpose of 'public health investigations'¹ as well as disclosures about victims of abuse, neglect, or domestic violence². Ohio law specifically allows disclosures of confidential information to the CFRB. Section 307.627 of the Revised Code states that "Notwithstanding 3701.243 and any other section of the Revised Code pertaining to confidentiality, any individual; public children services agency, private child placing agency, or agency that provides services specifically to individuals or families; law enforcement agency; or other public or private entity that provided services to a child whose death is being reviewed by a child fatality review board, on the request of the review board, shall submit to the review board a summary sheet of information." Therefore, both state and federal law permit an Executive Director (or their designee) to make disclosures to the CFRB about individuals receiving mental health services.

In regards to information pertaining to recipients of alcohol and drug addiction services, both HIPAA and state law permit the disclosure of PHI to the CFRB. *However*, 42 CFR Part 2, the Federal Drug and Alcohol Confidentiality law, prohibits such disclosures. 42 CFR Part 2 permits information to be disclosed without the patient's consent in very few instances and disclosures to CFRBs do not fit into any of the exceptions. Although a court order would allow the information to be disclosed, that option is not a very practical or efficient way of obtaining information in the context of a CFRB. Therefore, since the Federal Drug and Alcohol Confidentiality law is more protective of the individual's PHI than state and other federal law, Directors would not be allowed to share any information with the CFRB regarding recipients of alcohol and drug addiction services without a court order permitting them to do so.

¹ 45 CFR §164.512 (b)(1)

² 45 CFR §164.512 (c)(1)