Disclosing PHI for Treatment, Payment, or Health Care Operations (TPO): Overview for NC Local Health Departments

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Introduction

The HIPAA Privacy Rule allows covered entities to disclose individuals' protected health information (PHI) for purposes of treatment, payment, and health care operations (TPO). HIPAA does not require a written authorization, consent, or any other form of release for most TPO disclosures. There are three exceptions to this general rule. A HIPAA-compliant written authorization is required:

- If the disclosure includes psychotherapy notes, as that term is defined by HIPAA;
- If the disclosure is for marketing purposes; or
- For the sale of PHI.

Even when HIPAA doesn't require a release, a NC local health department may still require a release, if:

- The particular service, program, or information is subject to another confidentiality law in addition to HIPAA, and the other law requires a release; or
- The health department has chosen to require releases for TPO disclosures.

The remainder of this document is organized into the following sections:

- **Definitions and Disclosure Rules**. This section defines the terms treatment, payment, and health care operations, and gives the basic disclosure rules for each.
- **TPO Disclosures Requiring a HIPAA-Compliant Authorization**. This section focuses on disclosures of psychotherapy notes. Because local health departments do not usually sell PHI or disclose PHI for marketing, those are not discussed further.
- **TPO Disclosures Requiring Written Consent Under Laws Other than HIPAA**. This section addresses two programs that local health departments may offer that generally require written consent for TPO disclosures: family planning, and behavioral health.
- **Option to Obtain Written Consent for TPO Disclosures When Not Required**. This section discusses a local health department's option to choose to obtain written consent for TPO disclosures, even when it is not required.
- **Restriction on Disclosures to Health Plans when Individual Pays in Full**. This section describes a portion of HIPAA that prohibits disclosures to health plans (insurers) when an individual pays in full for a health care service or item and requests a restriction on disclosures.

Definitions and Disclosure Rules

It is customary to refer to treatment, payment, and health care operations collectively as TPO, but it is important to recognize that these are three different activities. Each activity has its own definition and its own disclosure rules under HIPAA. The disclosure rules for the three activities are similar, but they are not exactly the same. This section provides the definitions and disclosure rules for each.

Treatment

HIPAA defines "treatment" as the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. 45 C.F.R. 164.501.

The definition of treatment refers to "health care," which HIPAA defines as care, services, or supplies related to the health of an individual. The term health care includes, but is not limited to: preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and sale or dispensing of a drug, device, equipment, or other prescription item. 45 C.F.R. 160.103.

HIPAA sets out the following general rules for disclosures for treatment purposes:

- A local health department may use or disclose PHI for its own treatment activities. 45 C.F.R. 164.506(c)(1).
- A local health department may disclose PHI for the treatment activities of another health care provider. 45 C.F.R. 164.506(c)(2).
- Written authorization is not required for these disclosures, unless the disclosure includes psychotherapy notes. 45 C.F.R. 164.506(a).
- Although written authorization is not required, a covered entity may choose to require written consent for disclosures for treatment purposes. 45 C.F.R. 164.506(b). (Note: Although HIPAA makes this a choice, other federal or state confidentiality laws that apply to a particular program or service may *require* a written consent or release.)

Several North Carolina laws have adopted HIPAA's definition of treatment and its rules for disclosures for treatment purposes, including the law that protects local health department patient records (G.S. 130A-12), and the law that protects the confidentiality of information about reportable communicable diseases (G.S. 130A-143). That means that information protected by those laws may be disclosed for treatment purposes in accordance with HIPAA's rules and without written authorization or consent, unless the information is maintained by a program that is subject to another law that requires consent, or the local health department has chosen to require consent.

Payment

HIPAA defines "payment" as two kinds of activities:

- 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
- Activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

The types of activities that are covered in the definition include billing, claims management, collection activities, medical necessity reviews, preauthorization, and precertification. This is not a complete list. See 45 C.F.R. 164.501 for the full definition.

HIPAA sets out the following general rules for disclosures for payment purposes:

- A local health department may use or disclose PHI for its own payment activities. 45 C.F.R. 164.506(c)(1).
- A local health department may disclose PHI for the payment activities of another health care provider or another covered entity (such as an insurer). 45 C.F.R. 164.506(c)(3).
- Written authorization is not required for these disclosures, unless the disclosure includes psychotherapy notes. 45 C.F.R. 164.506(a).
- Although written authorization is not required, a covered entity may choose to require written consent for disclosures for payment purposes. 45 C.F.R. 164.506(b). (Note: Although HIPAA makes this a choice, other federal or state confidentiality laws that apply to a particular program or service may *require* a written consent or release.)
- There is an exception to these general rules: If an individual pays for a health care service or item in full, and requests that PHI about the item or service not be disclosed to the individual's health plan (insurer), the health department may not disclose PHI about the item or service to the health plan. 45 C.F.R. 164.522(a)(1)(vi).[1]

Several North Carolina laws have adopted HIPAA's definition of payment and its rules for disclosures for payment purposes, including the law that protects local health department patient records (G.S. 130A-12), and the law that protects the confidentiality of information about reportable communicable diseases (G.S. 130A-143). That means that information protected by those laws may be disclosed for payment purposes in accordance with HIPAA's rules and without written authorization or consent, unless the information is maintained by a program that is subject to another law that requires consent, or the local health department has chosen to require consent.

[1] This is addressed in more detail in the section titled "Restrictions on Disclosures to Health Plans when Individual Pays in Full."

Health Care Operations

"Health care operations" can be understood generally as the business and administrative activities that covered entities undertake to support their treatment and payment activities. Some of the activities that local health departments engage in that are covered by HIPAA's definition of health care operations are:

- Population-based activities to improve health or reduce health care costs, case management and care coordination, and contacting health care providers and patients with information about treatment alternatives;
- Quality assessment and improvement and patient safety activities;
- Reviewing the competence or qualifications of health care professionals;
- Conducting or arranging for medical review, legal services, and auditing functions;
- Conducting training programs that permit students, trainees, or health care practitioners to practice or improve their skills;
- Business planning and development;
- Business management and general administrative activities, including activities related to implementing and complying with HIPAA; customer service; and resolution of internal grievances.

This is not the complete list of activities covered by the term health care operations. See 45 C.F.R. 164.501 for the full definition.

HIPAA sets out the following general rules for disclosures for purposes of health care operations:

- A local health department may disclose PHI for its own health care operations. 45 C.F.R. 164.506(c)(1).
- A local health department may disclose PHI to another covered entity for the health care operations of the entity that receives the information *if* three conditions are met: (1) both the local health department and the entity receiving the PHI has or had a relationship with the individual who is the subject of the PHI; (2) the PHI pertains to that relationship; and (3) the disclosure is for one of the following purposes: conducting quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or health care fraud or abuse detection or compliance. 45 C.F.R. 164.506(c)(4).
- Written authorization is not required for these disclosures, unless the disclosure includes psychotherapy notes. 45 C.F.R. 164.506(a).
- Although written authorization is not required, a covered entity may choose to require written consent for disclosures for health care operations purposes. 45 C.F.R. 164.506(b). (Note: Although HIPAA makes this a choice, other federal or state confidentiality laws that apply to a particular program may *require* a written consent or release.)
- There is an exception to these general rules: If an individual pays for a health care service or item in full, and requests that PHI about the item or service not be disclosed to the individual's health plan (insurer), the health department may not disclose PHI about the item or service to the health plan. 45 C.F.R. 164.522(a)(1)(vi).[2]

[2] This is addressed in more detail in the section titled "Restrictions on Disclosures to Health Plans when Individual Pays in Full."

- Finally, a local health department may disclose a "limited data set" for health care operations purposes. This does not require that both entities have a relationship with the individual. However, there are special requirements for this type of disclosure that include removing specified identifiers from the data, and entering a data use agreement with the recipient. The HIPAA requirements for limited data sets are in 45 C.F.R. 164.514(e).

Several North Carolina laws have adopted HIPAA's definition of health care operations and HIPAA's rules for disclosures for health care operations purposes, including the law that protects local health department patient records (G.S. 130A-12), and the law that protects the confidentiality of information about reportable communicable diseases (G.S. 130A-143). That means that information protected by those laws may be disclosed for health care operations purposes in accordance with HIPAA's rules and without written authorization or consent, unless the information is maintained by a program subject to another law that requires consent, or the local health department has chosen to require consent.

TPO Disclosures Requiring a HIPAA-Compliant Authorization

There are three circumstances in which a TPO disclosure requires a HIPAA-compliant written authorization:

- If the disclosure includes psychotherapy notes, as that term is defined by HIPAA;
- If the disclosure is for marketing purposes; or
- For the sale of PHI.

This section focuses on psychotherapy notes. Because local health departments do not usually sell PHI or disclose PHI for marketing, those activities are not discussed further.

The term "psychotherapy notes" has a specific and narrow definition. It means "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of an individual's record." The definition specifically excludes "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 the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." 45 C.F.R. 164.501. In other words, this term does not refer to all mental health records or information – it refers very narrowly to a specific type of notes a mental health professional takes during a therapy session and keeps separate from the medical record.

HIPAA requires written authorization for all uses and disclosures of psychotherapy notes except for a few that are specifically identified in the authorization rule. Three of the uses and disclosures of psychotherapy notes that are allowed without authorization address TPO purposes:

- Use by the mental health professional who made the notes for treatment purposes;
- Use or disclosure by the covered entity for its own training programs that are specifically for students, trainees, or practitioners to learn under supervision in practice or to improve their skills in group, joint, or individual counseling; or
- Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.

45 C.F.R. 164.508(a)(2). Authorization is required for all other TPO uses and disclosures.

An authorization for use or disclosure of psychotherapy notes must be in writing on a form that complies with HIPAA's authorization rule. See 45 C.F.R. 164.508(c) for more information about the requirements for a HIPAA-compliant form.

TPO Disclosures Requiring Written Consent Under Laws Other than HIPAA

HIPAA is only one of many health information confidentiality laws. Sometimes a program, service, or type of information is subject to another law that requires written consent or release for the information to be disclosed for a TPO purpose.

This document addresses two types of services that fall in this category: family planning and behavioral health. A local health department may have other services or programs that are in this category as well. Each local health department should determine whether it is subject to additional confidentiality laws and ensure that its HIPAA policies and procedures address when a release is required, and what type of form must be used.

Family Planning

Title X-funded family planning programs are subject to a federal regulation that prohibits disclosure of "all information as to personal facts and circumstances" without documented consent, unless the disclosure is necessary to provide services or is required by law. 42 C.F.R. 59.11.

In North Carolina, the general consent form for family planning services (DHHS Form 4112) specifies that health department staff will not share or send medical information from the family planning clinic to anyone unless the patient consents in writing or the disclosure of information is required by law. This means that local health departments must obtain written consent before disclosing PHI pertaining to family planning services for TPO purposes.

Behavioral Health

A local health department that provides behavioral health services should determine whether it is subject to North Carolina's mental health confidentiality laws (G.S. Chapter 122C) and/or the federal substance abuse confidentiality laws (42 C.F.R. Part 2). A full review of those laws is beyond the scope of this document, but I will address two points in general terms: when the laws apply, and what they mean for disclosures for treatment purposes.

The confidentiality requirements of G.S. Chapter 122C apply to information created or maintained in connection with particular types of services—specifically, those that have the *primary* purpose of providing treatment or other care related to mental health, developmental disabilities, or substance abuse. The requirements do not apply to mental health information that may be acquired as part of a service that has a different primary purpose, such as primary care. Similarly, the confidentiality requirements of 42 C.F.R. Part 2 apply to particular types of programs—specifically, federally-assisted substance abuse programs. The requirements do not apply to substance abuse information that may be acquired as part of a service that is not a federally-assisted substance abuse program.

When the requirements apply, they restrict disclosures for TPO purposes. Some TPO purposes are allowed under G.S. Chapter 122C, but the scope is narrower than HIPAA would allow. As a result, when information is subject to G.S. Chapter 122C, a local health department may need to obtain the

individual's written consent before disclosing the information for TPO purposes. The law for federally-assisted substance abuse programs, 42 C.F.R. Part 2, is even stricter, requiring written consent for most disclosures of information for TPO purposes.

This document does not provide a comprehensive treatment of behavioral health confidentiality law and should not be relied on for decision-making in a particular situation. For purposes of this general review of the TPO rules, the takeaway message is this: local health departments that provide behavioral health services will likely need to get their clients' written consent to disclose PHI related to those services. If a health department offers behavioral health services, its HIPAA policies & procedures should be clear about when consent is required to disclose PHI related to those services for TPO purposes.

Health department workforce members who work with PHI associated with these programs should know and abide by their agency's policies and procedures for TPO disclosures.

Option to Obtain Written Consent for TPO Disclosures When Not Required

A covered entity may choose to obtain written consent before disclosing PHI for TPO purposes, even when no law requires it. 45 C.F.R. 164.506(b). If a health department makes this choice, the department's HIPAA policies and procedures should address when a release is required, and what type of form must be used.

Local health department staff members are sometimes surprised to learn that some TPO disclosures are allowed without a written release. This surprise probably reflects the fact that North Carolina law has changed over time. When the HIPAA Privacy Rule went into effect in 2003, NC local health departments were advised to continue obtaining written consent for all TPO disclosures because of state laws that seemed to require consent. In the years since, several North Carolina laws have been amended to align state law more closely to HIPAA. For local health departments, the major changes were:

- In 2004, G.S. 130A-12 (the main confidentiality law for local health department patient records) was amended to allow TPO disclosures in accordance with HIPAA's rule.
- In 2011, G.S. 130A-143 (the communicable disease confidentiality law) was amended to allow TPO disclosures of reportable communicable disease information in accordance with HIPAA's rules.

Each of these state laws adopted HIPAA's definitions of the terms treatment, payment, and health care operations, and also adopted HIPAA's TPO disclosure rules. This means that written consent is no longer required by the laws described above when the disclosure is for a TPO purpose and is made in accordance with the HIPAA rules. However, a local health department may still *choose* to obtain written consent for any or all of these disclosures. If a health department has made this choice, it should be reflected in the department's HIPAA policies and procedures.

Health department workforce members should know and abide by their own agency's policies and procedures for TPO disclosures.

Restriction on Disclosures to Health Plans when Individual Pays in Full

If an individual pays for a health care service or item in full *and* requests that the information not be disclosed to the individual's health plan (insurer), information about the particular health care service or item the individual paid for must not be disclosed to the health plan, unless disclosure to the health plan is required by law. This means that PHI related to the health care service or item the client paid for may not be disclosed to the insurer for either payment purposes or health care operations purposes.

This rule comes from the section of the HIPAA Privacy Rule that gives individuals the right to request restrictions on the disclosure of their PHI, 45 C.F.R. 164.522. This is the only request for a restriction on disclosure that health care providers are required to agree to.

Note that this provision is quite limited:

- It applies only if all the conditions are met: the individual pays for a health care service or item in full, the individual requests that PHI about the particular service or item not be disclosed to the health plan, and there is no law requiring disclosure to the health plan
- It prohibits disclosures to health plans (insurers). It does not prohibit disclosures to other entities.
- It prohibits disclosures for payment or health care operations purposes. It does not prohibit or restrict other types of disclosures, such as disclosures for public health purposes.
- The only PHI that is restricted is PHI related to the health care item or service that the individual paid for in full.

Because it is limited, local health departments may not face this issue very often in practice. However, a health department needs to have procedures that ensure PHI is not improperly disclosed if and when an individual invokes their right to this restriction on disclosures to a health plan.