ORGANIZATION POLICY

POLICY TITLE: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

POLICY NUMBER: 186

PURPOSE: OMH will use and disclose protected health information without patient authorization for treatment, payment, or healthcare operations as permitted by law. All use and disclosures shall follow the "minimum necessary" standard.

DEFINITIONS:

Healthcare Operations means any of the following activities:

(i) Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guideline, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(ii) Reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities;

(iii) Most underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance of health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for healthcare (including stop-loss insurance and excess of loss insurance);

(iv) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(v) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and);

(vi) Business management and general administrative activities, including, but not limited to:

- Management activities relating to implementation of and compliance with HIPAA;
- Customer service;
- Resolution of internal grievances;
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if potential successor in interest is a covered entity;
- The sale, transfer, merger, or consolidation of all or part of one covered entity with another, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- Creating de-identified health information or a limited data set, fundraising for benefit of the covered entity.

Individually identifiable health information means information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and

2. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

   a. That identifies the individual; or

   b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Payment means the activities undertaken by a healthcare provider or health plan to obtain or provide reimbursement for the provision of healthcare including, but not limited to:

- Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, claims management, collection activities, obtaining payment under contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related healthcare data processing;
- Review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
- Disclosure to consumer reporting agencies of any of the following protected health information relating to collections or premiums or reimbursement: Name and address, date of birth, social security number, payment history, account number and name and address of the healthcare provider and/or health plan

Protected health information (PHI) means individually identifiable health information that is:

1. Transmitted by electronic media (e.g., internet, intranet, extranet, facsimile dial up lines);
2. Maintained in any medium of electronic media (e.g., computer hard drives, removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card); or
3. Transmitted or maintained in any other form or medium.

Treatment means the provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another.

PROCEDURE:

1. Protected Health Information will only be used or disclosed for the purposes of Treatment, Payment, or Health Care Operations, unless otherwise permitted or required by law.

2. OMH is not required to obtain an Authorization from a patient prior to the use or disclosure of PHI if such use or disclosure is for the purpose of carrying out treatment, payment, or healthcare operations as follows:

    - For use by OMH in its own treatment, payment or healthcare operations;
    - For treatment activities of another provider;
    - To another covered entity (e.g., healthcare provider, payer, or clearinghouse) for payment activities;
    - To another covered entity for its healthcare operations as long as the entity either has (or had) a relationship with the patient, the information pertains to such a relationship and the disclosure is either:
        - For the purposes of conducting quality assessment and improvement activities or reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers, training of non-healthcare professionals, accreditation, certification, licensing or credentialing activities; or
        - For the purpose of healthcare fraud and abuse detection or compliance.
        - To another covered entity that participates in any Organized Healthcare Arrangement of OMH for any healthcare operations activities of the Organized Healthcare Arrangement.

3. When disclosures for Payment or Healthcare Operations are made, OMH shall limit the PHI disclosed to the minimum amount reasonably necessary to achieve the purpose of the disclosure ("minimum necessary standard"). The "minimum necessary standard" includes limiting the type, amount, or scope of PHI used or disclosed, and also includes limiting the number of people who can access or view the PHI. Except for Treatment purposes, OMH will not disclose an entire medical record unless such disclosure is specifically justified as reasonably necessary to accomplish the purpose of the disclosure.

EFFECTIVE DATE: June 2005

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