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Rights to Access Medical Records Under the HIPAA Privacy Regulation

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Access to medical records is often essential to consumer health assistance programs that are advocating for consumers' rights and quality health care. This issue brief describes how consumers and their advocates may access medical records. It includes a discussion of consumer and advocate rights to access records in many contexts: I) the recent HIPAA privacy regulation, which went into effect on April 14, 2003; II) the HIPAA privacy regulation's interaction with existing state law; and III) the HIPAA's privacy regulation's interaction with federal law such as A) the Medicaid managed care regulation; B) the ERISA claims procedure regulation for members of group health plans; C) the special rights of nursing home residents and their advocates; and D) the rights of consumers denied coverage by Medicare + Plus Choice plans.

I. Does the Consumer Have a Right to Access Medical Records Under the HIPAA Privacy Regulation?

In the summer of 2002, the U.S. Department of Health and Human Services (HHS) issued the final modifications to the Health Insurance Portability and Accountability Act Standards for Privacy of Individually Identifiable Health Information Regulation (HIPAA privacy regulation).¹ The HIPAA privacy regulation guarantees consumers the right to inspect, obtain a copy of, and amend their own medical records and restricts when and how “covered entities” that maintain medical records may use and disclose protected health information.² Under the HIPAA privacy regulation, “covered entities” have deadlines for responding to requests for medical records, and the regulation establishes a procedure for reviewing denials of these requests. However, the regulation applies only to medical records that meet the definition of “protected health information” and to requests of “covered entities.”

The following discussion explains A) the definition of “protected health information”; B) the definition of “covered entity”; C) consumers’ rights to access their medical records; D) the rights of advocates, family members, and other consumer representatives to access medical records; E) consumers’ rights to amend their medical records; and F) actions a consumer can take if a covered entity violates the HIPAA privacy regulation.

A. Are the Needed Medical Records Considered Protected Health Information (PHI) Under the HIPAA Privacy Regulation?

The consumer’s right to access medical records applies only if the information in the medical record falls within the definition of protected health information (PHI) under the HIPAA privacy regulation. PHI must be both 1) health information and 2) individually identifiable. Health information is broadly defined and means any oral or recorded information relating to the past, present, or future physical or mental health of an individual; the provision of health care to the individual; or the payment for health care. Individually identifiable means health information that identifies or reasonably can be used to identify the individual (and does not include information that has been de-identified).³

B. Is the Consumer Requesting Information from a “Covered Entity” Under the HIPAA Privacy Regulation?

Covered entities under the regulation include health plans, health care clearinghouses, and health care providers that transmit health information in electronic form in connection with specified financial and administrative transactions.⁴

Covered Entities

Taken from *Summary of HIPAA Privacy Rule*, Health Privacy Project, Institute for Health Care Research and Privacy at Georgetown University⁵

Health Plan

The definition of “health plan” generally includes any individual or group plan that provides or pays for medical care. The term encompasses both private and governmental plans. HMOs and high-risk pools are specifically covered. Most employee health benefit plans are covered. However, *employers* who sponsor these group health plans are not covered entities under the regulation (Generally, the regulation permits group health plans to a plan sponsor for plan administration purposes, but prohibits disclosure for employment-related actions.)⁶

Additionally, the rule specifically excludes certain entities that provide or pay for health care. For example, small employee health benefit plans (fewer than 50 participants) that are self-administered are exempt from the rule. Likewise, workers’ compensation carriers are excluded from the definition of health plan. Government-funded programs that only incidentally provide or pay for the cost of health care are not health plans. Government-funded programs that have as their principal purpose the provision of health care are not health plans, but they may meet the definition of health care provider.⁷

Health Care Clearinghouse

“Health care clearinghouse” is a term of art under the regulation, and differs somewhat from the manner in which the term is generally used. Under the regulation, a health care clearinghouse is an entity that translates health information received from other entities either to or from the standard format that will be required for electronic transactions. For instance, a health provider may submit claims information to a health care clearinghouse to process that information into a standard format for submission to a health plan.

Health Care provider who electronically transmits health information in standard format

The regulation covers health care providers who transmit health information electronically in a “standard format” in connection with HIPAA standard transactions. Determining whether a person or organization comes within this category entails applying a three-prong test: 1) Is the person or organization a “health care provider” as defined in the regulation? 2) Do they transmit health information electronically in connection with one of the financial or administrative transactions specified in HIPAA *and* 3) Is that health information transmitted in a standard electronic format?

1. Health care provider

For purposes of the regulation, “health care provider” includes any person or entity that furnishes bills or is paid for health care in the normal course of business. “Health care,” in turn, is broadly defined as “care, services, or supplies related to the health of an individual.” Thus, the term health care provider includes both persons (such as dentists and podiatrists) and entities (such as hospitals and clinics). It includes mainstream practitioners (such as physicians, nurses, and psychotherapists), as well as providers of alternative care (such as homeopaths, acupuncturists, and naturopaths). The regulation also covers both the providers of care and services (such as practitioners) and the providers of health supplies (such as pharmacists and hearing aid dispensers). However, the regulation is not intended to encompass blood banks, sperm banks, organ banks, and similar organizations.

2. Transmitting health information electronically in connection with standard transactions

To transmit health information electronically, a provider must transfer personally identifiable health information via computer-based technology. Using the Internet, and Intranet, or private network system will bring a provider within the reach of the regulation. Similarly, transferring information from one location to another using magnetic tape or disk is the type of electronic transmissions included in the regulation. In contrast, sending information via telefax is not considered to be transmitting information electronically.

To come within the scope of the regulation, the health information must be transmitted in connection with one of the financial and administrative transactions listed in Section 1173 of HIPAA. These transactions include, but are not limited to, health claims, determining enrollment and eligibility in a health plan, and referral authorization. Providers who directly submit health claims electronically clearly come within the regulation. Even providers who rely on third-party billing services to conduct such electronic transactions on their behalf are covered under the regulation.

In contrast, providers who operate solely on a paper basis and do not submit insurance claims electronically will not be subject to the legislation. For instance, an Internet pharmacy that only accepts credit card payments will not be covered by the privacy regulation. If this Internet pharmacy submits insurance claims electronically, however, then it would be covered by the regulation.

3. Transmitting information in the required “standard format”

A provider that transmits health information electronically in relation to any of the standard transactions, such as verifying insurance coverage or filing a health claim, must use a standard electronic format (i.e., the provider must include certain information and use specified codes for diagnosis and treatment) required by HIPAA. HHS has taken the position that only providers who actually use the standard format are covered by the privacy regulation.

C. What are Consumers’ Rights to See and Obtain a Copy of Their Medical Records Under the HIPAA Privacy Regulation?

In general, a consumer must be allowed to inspect or obtain a copy of her PHI from a covered entity within 30 days from the date the request is received. If the covered entity provides a written statement of the reasons for delay, the deadline can be extended up to 30 days.⁸ The covered entity can charge “reasonable” cost-based fees for providing the information.⁹ State law that is not preempted by HIPAA (see discussion below) may establish a fee standard. If the covered entity does not maintain the individual’s PHI, the covered entity must let the consumer know where to direct her request. If the consumer agrees to the arrangement and to the fees, the covered entity can

provide the consumer with an explanation or a summary of the requested information, rather than a copy of the PHI.¹⁰ Under conditions described below, a covered entity can deny access to certain information and only need provide an opportunity for the consumer to review the denial. Any time a covered entity denies a consumer access to all or part of his or her PHI, it must give the consumer a written denial within 30 days.¹¹ The denial notification must contain a basis for the denial and, if applicable, information about the consumer's review rights and procedures for filing a complaint with the covered entity or the Secretary of HHS.¹²

A covered entity *does not* have to give a consumer access to the following *and does not* have to give the consumer an opportunity for review:¹³

- ◆ psychotherapy notes (the HIPAA privacy regulation's definition of psychotherapy notes is narrow: "Psychotherapy notes 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 the individual's medical record*" (emphasis added));¹⁴
- ◆ information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding;
- ◆ PHI maintained by a covered entity controlled under the Clinical Laboratory Improvements Amendments of 1988;
- ◆ under certain circumstances, information requested by an inmate;
- ◆ information created or obtained by a covered health care provider in the course of research that includes treatment, which may be temporarily suspended while the research is in progress, if the consumer has agreed to the denial of access when consenting to participate in the research . . .

and the covered health care provider has informed the individual that the right of access will be reinstated when the research is complete;

- ◆ information contained in records subject to the Privacy Act;¹⁵ and
- ◆ information obtained by the covered entity from someone other than a health care provider under a promise of confidentiality and access to which would be “reasonably likely to reveal the source of that information.”

A covered entity *may* deny a consumer access to her PHI, *but* it *must* provide the consumer an opportunity for review of the denial if a licensed health care professional, in the exercise of professional judgment, determines that¹⁶

- ◆ it is reasonably likely that access to the requested information would endanger the life or physical safety of the consumer or another person;
- ◆ because the information makes reference to another person, it is reasonably likely to cause substantial harm to the other person; or
- ◆ because the consumer’s personal representative requested the information, it is reasonably likely to cause substantial harm to the consumer or another person.

D. What are the Rights of Advocates, Family Members, and Other Consumer Representatives to Access the Consumer’s Medical Records under the HIPAA Privacy Regulation?

Advocates, family members, and other consumer representatives may access the medical records 1) if the advocate is the consumer’s “personal representative”; 2) if the advocate has a written authorization from the consumer; or 3) if the advocate is part of a health oversight agency.

1. If the Advocate is the Consumer's "Personal Representative"

Personal representatives have special rights to access a consumer's medical records. Under the HIPAA privacy regulation, "personal representative" generally means the parents of minor children¹⁷ and persons who "under applicable law (have) the authority to act on behalf of (the) individual . . . in making decisions related to health care" for adults and emancipated minors."¹⁸ The preamble explains that the rights of the personal representative are limited to the rights of a person to make decisions about an individual under other law.¹⁹ For example, if a husband has the authority only to make health care decisions about his wife in an emergency, he would have the right to access PHI related to that emergency, but he may not have the right to access information about treatment that she had received ten years ago. The preamble to the rule also notes that personal representatives include "anyone who has authority to act on behalf of a deceased individual or such an individual's estate, not just legally appointed executors."²⁰ Specific exceptions allow covered entities not to release PHI to individuals who may have subjected the consumer to domestic violence, abuse, or neglect.²¹

2. If the Advocate Has Written Authorization from a Consumer

A consumer may authorize a specific covered entity to disclose medical information to anyone she wants, including an advocate, a family member, or someone else.²² The consumer must submit a written authorization form to the covered entity containing *all* of the following information:

1. a description of the information to be disclosed that identifies it in a "specific and meaningful" fashion AND
2. the covered entity, person, or person(s) authorized to make the disclosure AND
3. the name of the person or persons authorized to request the disclosure AND
4. an expiration date that relates to the purpose or use of the disclosure or the person(s) authorized to request the disclosure AND
5. a statement of the individual's right to revoke the authorization in writing AND

6. a statement that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information²³ AND
7. the signature of the consumer and date AND
8. if the authorization is signed by a “personal representative,” a description of the personal representative’s authority to act for the individual, AND
9. the authorization form must be in “plain language.”

It is important to note that an authorization for use and disclosure of psychotherapy notes must be separated from authorizations to get other records.²⁴

3. If the Advocate is Part of a Health Oversight Agency or is a Business Associate of a Covered Entity

Under the HIPAA privacy regulation, a “health oversight agency” is given special access to medical records. A covered entity must disclose PHI to a “health oversight agency” for oversight activities authorized by law, such as audits, investigations, inspections, licensure, proceedings, and other activities necessary for oversight.²⁵ A “health oversight agency” must be 1) a public agency and 2) authorized by law to oversee the health care system 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.²⁶

For example, the Administration on Aging has determined (and HHS Office for Civil Rights has (OCR) concurred) that representatives of the federal and state Long-Term Care Ombudsman Program (LTCOP) are health oversight agencies because they have oversight responsibilities authorized by law for a component of the health care system.²⁷ Therefore, the HIPAA privacy regulation does not preclude release of residents’ clinical records to the LTCOP, with or without authorization of the resident or the resident’s legal representative.²⁸

The “health oversight agency” rule may also apply to mental health ombudsmen who investigate wrongful deaths or serious injuries.

In addition, a consumer health assistance program that contracts with the Medicaid agency to assist consumers may be a “business associate” of the Medicaid agency because under contract, the program is assisting the Medicaid agency in a function or activity involving the use or disclosure of individually identifiable health information.²⁹ If this is the case, the Medicaid agency may disclose PHI to the program if the program assures the Medicaid agency that the program will appropriately safeguard the information.³⁰

E. What are the Consumer’s Rights to Amend Medical Records under the HIPAA Privacy Regulation?

The HIPAA privacy regulation gives consumers the right to amend or supplement their own PHI. The consumer has this right for as long as the covered entity maintains the information. The covered entity must act on a consumer’s request for amendment within 60 days of receiving the request. This deadline may be extended up to 30 days if the covered entity provides the consumer with a written statement of the reasons for delay in complying with the request and the date by which the covered entity will fulfill his or her request.³¹

1. Acceptance of Request to Amend

If an entity accepts the request, it must do three things: 1) make the amendment; 2) inform the consumer within either 60 or 90 days that the amendment has been made; and 3) provide the amendment to entities identified by the consumer and any other entities known to have received the erroneous or incomplete information.³²

2. Denial of Request to Amend

A covered entity may deny a consumer’s request for amendment if the entity determines that the information is accurate and complete or if the record³³

- ◆ was not created by the covered entity, unless the originator of the PHI is no longer available to make the amendment;
- ◆ was not a part of the designated record set; or
- ◆ is available for inspection.

If the covered entity denies a consumer’s request, it must give the consumer timely written denial that includes³⁴

- ◆ the basis for the denial,
- ◆ notice of the consumer’s right to submit a written statement to the covered entity disagreeing with the denial and information about how to exercise that right and a description of how to file a complaint with the covered entity or the Secretary of HHS, and
- ◆ a statement that the consumer can request the covered entity to include the consumer’s request and the denial with any future disclosures of the information.

3. Statement of Disagreement

If the covered entity denies a consumer’s request to amend, the consumer may file a statement of disagreement with the covered entity. The covered entity can prepare a rebuttal to the consumer’s statement, which it must provide to the consumer.³⁵ All of the documents mentioned above—the request for amendment, the denial, the statement of disagreement, and the rebuttal or a summary of such information—must be provided with any subsequent disclosures of the PHI.³⁶

F. What Actions Can the Consumer Take if the Covered Entity Violates the HIPAA Privacy Regulation?

No private cause of action is available under the HIPAA privacy regulation itself; however, a consumer may file a complaint with the Secretary of HHS. The Secretary is authorized to conduct an investigation to review policies, procedures, and practices of the covered entity and the circumstances of the complaint. After an investigation, the Secretary will notify the covered entity and the complainant of the outcome of the investigation. The Secretary will, whenever possible, attempt to resolve the matter informally by working with the entity. The HIPAA statute establishes a \$100-\$25,000 civil penalty per year for each standard violated.³⁷ It also establishes criminal penalties for certain wrongful disclosures of PHI.³⁸

A complaint³⁹

1. must be filed in writing, either on paper or electronically,
2. must name the entity and describe how the entity violated the regulation (by acts or omissions), and

3. must be filed within 180 days of when the complainant knew (or should have known) that the regulation was violated. The Secretary can waive this time limit if the consumer can show good cause.

HIPAA PRIVACY REGULATION RESEARCH TIPS

- A very helpful version of the Complete HIPAA Privacy Rule Text, as modified (05/31/02, 08/14/02), is at <http://www.hhs.gov/ocr/combinedregtext.pdf>.
- HHS has a HIPAA Privacy Web site, which is a central place to get updates about the HIPAA privacy regulation, at <http://www.hhs.gov/ocr/hipaa/finalreg.html>.
- HHS has a decision tool that helps you determine whether the entity from which records are desired is a covered entity, available at <http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp>.
- The Health Privacy Project at the Institute for Health Care Research and Privacy at Georgetown University compiled an excellent summary of the HIPAA Privacy regulation, available at http://www.healthprivacy.org/usr_doc/RegSummary2002.pdf.
- The Health Privacy Project has an easy-to-use complaint form, complete with instructions for filing, available on its Web site at <http://www.healthprivacy.org/>.

II. Does Your State Law Provide Access To Medical Records?

States vary in the rights they give to consumers to access and amend their own medical records.⁴⁰ Some states have no such right of access, and some only allow patients to access certain types of records. On the other end of the spectrum, some states allow consumers to access many types of records from many

sources, such as different types of providers, insurers, government agencies and entities, and schools. In addition, some states allow patients to amend or correct their medical information and provide a detailed procedure for doing so.

The following discussion explains whether a state law might be preempted by the HIPAA privacy regulation and summarizes some of the helpful elements of state law.

A. Is a State Law Preempted By the HIPAA Privacy Regulation?

To the extent your state has other helpful laws that are not preempted by the HIPAA privacy regulation, they are valid.⁴¹ The HIPAA privacy regulation establishes a floor for protecting privacy, and state laws related to privacy that are “more stringent” than the federal rule will remain in effect.⁴² With respect to patient access, a state law is “more stringent” when it provides individuals greater access to information.⁴³ However, state laws that are “contrary” to the HIPAA privacy regulation are preempted by HIPAA. “Contrary” means that a covered entity would find it impossible to comply with both state and federal requirements or that a provision of state law is an obstacle to accomplishing a provision of the federal rule.⁴⁴ States may request an exception to preemption from HHS or amend their state law to make it as stringent as the HIPAA privacy regulation.⁴⁵

B. Fees

Under many state statutes, entities can charge consumers fees for copies of their medical records. Some states specify a cost or require that fees be waived if the consumer is contesting an adverse decision.⁴⁶ For example, Montana limits fees to the “actual cost” of copying the records; Alabama and Louisiana set costs at \$1 a page. Indiana and Louisiana have additional handling/retrieval fees.⁴⁷ It is important to note that under the HIPAA privacy regulation, a covered entity can charge “reasonable” cost-based fees for providing the information.⁴⁸ Fees that are not cost-based may be contrary to the HIPAA privacy regulation and therefore preempted by the regulation.

C. Authorization

Generally, state statutes prohibit a person or entity from disclosing information without consumer authorization.⁴⁹ Some states specify the format and content of the authorization form in statute, and some states allow patients to revoke authorizations.

D. Other Restrictions

Most state statutes include restrictions on access to medical records, usually based on the belief/assessment of the entity holding the medical records or based on the kind of information being held. The restriction is that a consumer can be refused access if the recordholder believes that the information could endanger the life or safety of the consumer or another person.

STATE PRIVACY LAW RESEARCH TIPS

A good place to start to find out about your state's law is The Health Privacy Project's *The State of Health Privacy: An Uneven Terrain*, available at <http://www.georgetown.edu/research/ihrp/privacy/statereport.pdf>. The back of the guide has a summary of each state's privacy statutes. However, this guide is current through 1999, so you must verify that your state law has not changed.⁵⁰ If you have questions about your state law or preemption issues, please contact the Health Assistance Partnership.

III. Is There Another Federal Law or Regulation that Provides Access to Medical Records?

Consumers have the right under other federal law and regulations (distinct from the HIPAA privacy regulation) to access their medical records. The preamble to the HIPAA privacy regulation explains that covered entities subject to the HIPAA privacy regulation are also subject to other federal statutes and regulations.⁵¹ The preamble states that there should be few instances in which conflicts exist between a statute or regulation and the HIPAA privacy rule.⁵² In cases where a potential conflict appears, HHS OCR would attempt to resolve it so that both laws apply and many apparent conflicts will not be true conflicts.⁵³ This section examines four federal laws/regulations that also address consumers' rights to their medical records: A) the Medicaid

managed care regulation; B) the ERISA claims procedure regulation for members of group health plans; C) the special rights of nursing home residents and their advocates; and D) the rights of consumers denied coverage by Medicare + Plus Choice plans.

A. Is the Consumer Enrolled in Medicaid Managed Care?

Under the Medicaid managed care regulation, Medicaid beneficiaries enrolled in managed care have a right to request and receive a copy of their medical records and to request that their medical records be amended or corrected as specified by policy rules.⁵⁴

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- The Medicaid Managed Care Regulation (67 Fed. Reg. 40989 (June 14, 2002)) is available at <http://www.cms.gov/medicaid/managedcare/cms2104f.asp>.
- The Health Assistance Partnership analysis of the Medicaid Managed Care Regulation is available on the Medicaid page of <http://www.healthassistancepartnership.org/>.

B. Is the Consumer Enrolled in A Group Health Plan?

As of January 1, 2003, privately insured consumers who are enrolled in ERISA-governed group health plans (both fully funded and self-funded) have a right to receive very helpful information in the notification of adverse benefit determination (NABD).⁵⁵

i. What is the NABD, and When Does a Consumer Have a Right to Get It?

The NABD is a written or electronic notice that a health care claim has been denied (in whole or in part), which an administrator must provide a claimant. In the case of an NABD concerning a claim involving urgent care, notification may be provided *orally* as long as written or electronic notification is furnished no later than three days after the oral notification.⁵⁶

ii. What Must be Included in the NABD?

Consumers have a right to receive a lot of very valuable information in the NABD, including the reason why the claim was denied and the criteria used in making the decision.

The NABD must include

- ◆ the specific reason for the adverse determination,
- ◆ a reference to the specific plan provision on which the determination is based,
- ◆ a description of any additional information the consumer could provide to get the claim reconsidered and approved and an explanation of why this material or information is necessary,
- ◆ a description of the plan's review procedures and the time limits applicable to these procedures, and
- ◆ notice of the consumer's right to bring a civil action following an adverse benefit determination on review.

In addition, the NABD must advise consumers that the following will be provided *free of charge* upon request:

- ◆ the criteria (rule, guideline, protocol, etc.) used in making decisions about their right to health care services; and
- ◆ if the adverse benefit determination decision is based on a medical necessity or experimental treatment exclusion or limit, "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances";⁵⁷ and
- ◆ for an NABD involving urgent care, a description of the *expedited* review process is required.

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- ERISA Claims and Appeal Procedure Regulation - Resource Materials, Health Assistance Partnership <http://www.healthassistancepartnership.org/site/PageServer?pagename=privateerisatitle>.
- ERISA Claims Procedures Regulation, 39 CFR 2560.503-1(g) at <http://www.dol.gov/pwba/regs/fedreg/final/2000029766.pdf>.

C. Is the Consumer a Resident of a Nursing Home?

Any resident of a nursing home that participates in Medicare or Medicaid has a right to access her medical records upon her request or the request of her resident's legal representative.⁵⁶ Under the regulations, the resident or the resident's legal representative has the right⁵⁹

1. upon an oral or written request, to access all records pertaining to the resident, including current clinical records, within 24 hours (excluding weekends and holidays); and
2. after the records are received, to purchase at a cost not to exceed the community standard, photocopies of the records or any portions of them upon request, and the facility has two working days to provide the photocopies; and
3. to be fully informed, in language that she can understand, of her total health status, including but not limited to her medical condition.

Further, as discussed above, representatives of the LTCOP have special rights to access nursing home residents' records.⁶⁰ These representatives have the following rights:⁶¹

1. "appropriate" access to review the medical and social records of a resident if either of the following are met: a) the representative has the permission of the resident or the resident's legal representative OR b) the resident is unable to consent to the review and has no legal representative; and
2. access to the records is necessary to investigate a complaint if all three of the following are met: a) a legal guardian of the resident refuses to give the permission and b) a representative of the LTCOP has reasonable cause to believe that the guardian is not acting in the best interests of the resident and c) the representative obtains the approval of the LTCOP;
3. access to the administrative records, policies, and documents that the residents have or the general public has of long-term care facilities; and
4. access to and, on request, copies of all licensing and certification records maintained by the state with respect to long-term care facilities.

D. Is the Consumer Being Denied Coverage By a Medicare+Choice Plan?

Consumers have a right to access medical records when they have received a denial of coverage from a Medicare+Choice Plan (such as a Medicare HMO). Under the Medicare+Choice (M+C) Grievance and Appeal Regulation, the M+C plan must provide the enrollee with a copy of, or access to, any documentation sent to an independent review organization by the M+C plan as a part of the reconsideration stage of a M+C appeal. This documentation includes records of any information provided by telephone. The M+C plan may charge the enrollee a reasonable amount to cover the costs of duplicating the information for the enrollee and/or delivering the documentation to the enrollee. The M+C plan must accommodate such a request by no later than close of business of the first day after the day the material is requested.

Endnotes

- ¹ The HIPAA Privacy Regulation was initially issued on December 28, 2000 and was modified on May 31, 2002 and on August 14, 2002. For the Complete Privacy Rule Text, as modified (known as the unofficial version), see <http://www.hhs.gov/ocr/combinedregtext.pdf>. The Office of Civil Rights at the U.S. Department of Health and Human Services (HHS) provides oversight of this regulation.
- ² The Use and Disclosure rules under HIPAA are beyond the scope of this issue brief. For a good outline of them, see *Summary of HIPAA Privacy Rule*, Health Privacy Project, Institute for Health Care Research and Privacy, Georgetown University, Washington, DC. (September 13, 2002), See, in particular, Section IV, "General Rules for Use and Disclosure." http://www.healthprivacy.org/usr_doc/RegSummary2002.pdf.
- ³ HHS made clear that employment records held by a covered entity in its capacity as employer are excluded from the definition of PHI. For more information on the definition of PHI, see 45 CFR 164.103 and 164.501.
- ⁴ For more information on what is a covered entity, see 45 CFR 164.102, 164.103, and 164.500.
- ⁵ 45 CFR 160.103. *Summary of HIPAA Privacy Rule*, Health Privacy Project, Institute for Health Care Research and Privacy, Georgetown University (September 13, 2002). See, in particular, Section II, Scope of Coverage. http://www.healthprivacy.org/usr_doc/RegSummary2002.pdf.
- ⁶ For a specific discussion of "group health plan," see 45 CFR 164.504(f).
- ⁷ See the Health Assistance Partnership's *HIPAA Privacy Questions and Answers for Health Assistance Programs*, May 2003, at www.healthassistancepartnership.org.
- ⁸ 45 CFR 164.524(b)(2).
- ⁹ 45 CFR 164.524(c)(3).
- ¹⁰ 45 CFR 164.524(c)(2).
- ¹¹ *Ibid.*
- ¹² 45 CFR 164.524(d).
- ¹³ 45 CFR 164.524(a)(1-3).
- ¹⁴ 45 CFR 164.501. Definition of psychotherapy notes.
- ¹⁵ The Privacy Act of 1974 regulates the collection, maintenance, use, and dissemination of personal information by federal executive branch agencies. The Privacy Act restricts disclosure of medical records and provides access and amendment procedures for medical records maintained by federal agencies, which is relevant for Medicaid and Medicare appeals work. 5 U.S.C. § 552a (2000). For an overview of the Privacy Act of 1974 (May 2002), see the U.S. Department of Justice Web site at http://www.usdoj.gov/04foia/04_7_1.html.
- ¹⁶ 45 CFR 164.524(a)(2).
- ¹⁷ 45 CFR 164.502(g).
- ¹⁸ 45 CFR 164.502(g)(2).
- ¹⁹ 65 Fed. Reg. 82634 (December 28, 2000).
- ²⁰ 65 Fed. Reg. 82633 (December 28, 2000).
- ²¹ 45 CFR 164.502(g)(5).
- ²² 45 CFR 164.508(c).
- ²³ The Office for Civil Rights included this provision because under the HIPAA privacy regulation, the recipient of the medical record might not be another "covered entity" and therefore not subject to the privacy requirements in the HIPAA privacy regulation. However, other state or federal law may prevent the recipient from redisclosing the information, or the consumer and the recipient of the medical record may make a separate agreement that the information is not to be redisclosed.
- ²⁴ The HIPAA privacy regulation states: "An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes." 45 CFR 164.508(b)(3).
- ²⁵ 45 CFR 164.512 (d).
- ²⁶ 45 CFR 164.501.
- ²⁷ Administration on Aging, Information Memorandum, AOA IM-03-01, Ombudsman Access to Residents' Records and Other Information; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and its Effect on Access to Residents' Records by the Long-Term Care Ombudsman Program, Residents and Residents' Representatives (February 4, 2003). On file with the author.
- ²⁸ *Ibid.*
- ²⁹ 45 CFR 160.103.
- ³⁰ For more information, see the Health Assistance Partnership's *HIPAA Privacy Questions and Answers for Health Assistance Programs*. May 2003, at www.healthassistancepartnership.org.

³¹ 45CFR 164.526.

³² 45CFR 164.526(c).

³³ 45CFR 164.526(d).

³⁴ Ibid.

³⁵ 45CFR 164.526(d)(5).

³⁶ Ibid.

³⁷ P.L. 104-191§ 1176(a) and P.L. 104-191§1177(b).

³⁸ Ibid.

³⁹ 45CFR 160.306.

⁴⁰ For an excellent comprehensive survey of each state's statutes, see *The State of Health Privacy: An Uneven Terrain*, Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University (August 1999) <http://www.georgetown.edu/research/ihrp/privacy/statereport.pdf>.

⁴¹ 45 CFR 160.201-205. Preemption is "the principle (derived from the Supremacy Clause) that a federal law can supersede or supplant any inconsistent state law or regulation." The Supremacy Clause is "the clause in Article VI of the U.S. Constitution declaring that all laws made in furtherance of the Constitution and all treaties made under the authority of the United States are the 'supreme law of the land' and enjoy the legal superiority over any conflicting provision of a state constitution or law." See *Black's Law Dictionary*, 7th ed. 1999.

⁴² 45CFR 160.202.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ The governor or the governor's designee can request this exception. For more information, see 45 CFR 160.201-205.

⁴⁶ For a review of state law regarding access to and cost of reproduction of medical records, see Paul V. Stearns, "Access To and Cost of Reproduction of Patient Medical Records: A Comparison of State Laws," *Journal of Legal Medicine* (March 2000). See also *The State of Health Privacy: An Uneven Terrain*, Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University (August 1999) <http://www.georgetown.edu/research/ihrp/privacy/statereport.pdf>.

⁴⁷ Paul V. Stearns, "Access To and Cost of Reproduction of Patient Medical Records: A Comparison of State Laws," *Journal of Legal Medicine* (March 2000).

⁴⁸ 45 CFR 164.524(c)(3).

⁴⁹ State statutes often allow disclosures for treatment, securing payment, and auditing and quality assurance activities and research without patient authorization. *The State of Health Privacy: An Uneven Terrain*, Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University (August 1999) <http://www.georgetown.edu/research/ihrp/privacy/statereport.pdf>.

⁵⁰ *The State of Health Privacy: An Uneven Terrain*, Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University (August 1999) <http://www.georgetown.edu/research/ihrp/privacy/statereport.pdf>.

⁵¹ 65 Fed. Reg. 82480 (December 28, 2000).

⁵² Ibid.

⁵³ Ibid. For more information, see the preamble, which contains several examples.

⁵⁴ Medicaid Managed Care, New Provisions, 67 Fed. Reg. 40989 (June 14, 2002) to be codified at 42 CFR 438.100.

⁵⁵ 39 CFR 2560.503-1(g).

⁵⁶ An urgent care case is any case in which abiding by the time frames for non-urgent claims could either 1) seriously jeopardize the life or health of the consumer or his or her ability to regain maximum function OR 2) in the opinion of a physician familiar with the consumer's condition cause the consumer severe pain that could not be treated adequately without the care or treatment that is the subject of the claim. The "prudent layperson" standard applies to these determinations. A treating physician's determination that a claim involves urgent care shall be treated as an urgent care claim. 39 CFR 2560.503-1(m)(1)(i).

⁵⁷ 39 CFR 2560.503-1(g).

⁵⁸ 42 USC 1395(i)(3)(c)(1)(A)(iv)-(v) (Medicare). 42 USC 1396(r)(c)(1)(a)(iv) (Medicaid).

⁵⁹ 42 CFR 483.10(a)(2).

⁶⁰ Representatives of the State Long-Term Ombudsman must meet the following requirements: 1) have demonstrated capability to carry out the responsibilities of the Office; and 2) be free of conflicts of interest and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves; and 3) in the case of the entities, be public or nonprofit private entities; and 4) meet such additional requirements as the Ombudsman may specify. 42 USC 3058g(a)(5)(C).

⁶¹ 42 USC 3058g(b).

The **Health Assistance Partnership** provides support to the approximately 1,300 consumer health programs across the country. The Health Assistance Partnership's mission is to help these programs to serve and educate health care consumers and to advocate for consumers' health care rights. These programs provide services to individuals and families whether they are privately insured, publicly insured, or uninsured. A project of Families USA, the Health Assistance Partnership is funded by the Robert Wood Johnson Foundation and has as its partners the Alliance of Community Health Plans, the American Hospital Association, and the American Nurses Association.

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