USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

[*45 CFR 164.506*]

Background

The HIPAA Privacy Rule establishes a foundation of Federal protection for personal health information, carefully balanced to avoid creating unnecessary barriers to the delivery of quality health care. As such, the Rule generally prohibits a covered entity from using or disclosing protected health information unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities.

Ready access to treatment and efficient payment for health care, both of which require use and disclosure of protected health information, are essential to the effective operation of the health care system. In addition, certain health care operations—such as administrative, financial, legal, and quality improvement activities—conducted by or for health care providers and health plans, are essential to support treatment and payment. Many individuals expect that their health information will be used and disclosed as necessary to treat them, bill for treatment, and, to some extent, operate the covered entity's health care business. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities.

How the Rule Works

What are Treatment, Payment, and Health Care Operations? The core health care activities of "Treatment," "Payment," and "Health Care Operations" are defined in the Privacy Rule at 45 CFR 164.501.

- "Treatment" generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

- "Payment" encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

In addition to the general definition, the Privacy Rule provides examples of common payment activities which include, but are not limited to:

- Determining eligibility or coverage under a plan and adjudicating claims;
- Risk adjustments;
- Billing and collection activities;
- Reviewing health care services for medical necessity, coverage, justification of charges, and the like;
- Utilization review activities; and
- Disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).

- "Health care operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, which are limited to the activities listed in the definition of "health care operations" at 45 CFR 164.501, include:

  - Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, and case management and care coordination;
  - Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing, or credentialing activities;
  - Underwriting and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims;
  - Conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs;
  - Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity; and
  - Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

General Provisions at 45 CFR 164.506. A covered entity may, without the individual's authorization:

- Use or disclose protected health information for its own treatment, payment, and health care operations activities.

  For example:

  - A hospital may use protected health information about an individual to provide health care to the individual and may consult with other health care providers about the individual's treatment.
  - A health care provider may disclose protected health information about an individual as part of a claim for payment to a health plan.
  - A health plan may use protected health information to provide customer service to its enrollees.

- A covered entity may disclose protected health information for the treatment activities of any health care provider (including providers not covered by the Privacy Rule).

  For example:

  - A primary care provider may send a copy of an individual's medical record to a specialist who needs the information to treat the individual.
  - A hospital may send a patient's health care instructions to a nursing home to which the patient is transferred.

- A covered entity may disclose protected health information to another covered entity or a health care provider (including providers not covered by the Privacy Rule) for the payment activities of the entity that receives the information.

  For example:

  - A physician may send an individual's health plan coverage information to a laboratory who needs the information to bill for services it provided to the physician with respect to the individual.
  - A hospital emergency department may give a patient's payment information to an ambulance service provider that transported the patient to the hospital in order for the ambulance provider to bill for its treatment

services.

- A covered entity may disclose protected health information to another covered entity for certain health care operation activities of the entity that receives the information if:

  - Each entity either has or had a relationship with the individual who is the subject of the information, and the protected health information pertains to the relationship; and
  - The disclosure is for a quality-related health care operations activity (i.e., the activities listed in paragraphs (1) and (2) of the definition of "health care operations" at 45 CFR 164.501) or for the purpose of health care fraud and abuse detection or compliance.

  For example:

  - A health care provider may disclose protected health information to a health plan for the plan's Health Plan Employer Data and Information Set (HEDIS) purposes, provided that the health plan has or had a relationship with the individual who is the subject of the information.

- A covered entity that participates in an organized health care arrangement (OHCA) may disclose protected health information about an individual to another covered entity that participates in the OHCA for any joint health care operations of the OHCA.

  For example:

  - The physicians with staff privileges at a hospital may participate in the hospital's training of medical students.

Uses and Disclosures of Psychotherapy Notes. Except when psychotherapy notes are used by the originator to carry out treatment, or by the covered entity for certain other limited health care operations, uses and disclosures of psychotherapy notes for treatment, payment, and health care operations require the individual's authorization. See 45 CFR 164.508(a)(2).

Minimum Necessary. A covered entity must develop policies and procedures that reasonably limit its disclosures of, and requests for, protected health information for payment and health care operations to the minimum necessary. A covered entity also is required to develop role-based access policies and procedures that limit which members of its workforce may have

access to protected health information for treatment, payment, and health care operations, based on those who need access to the information to do their jobs. However, covered entities are not required to apply the minimum necessary standard to disclosures to or requests by a health care provider for treatment purposes. See the fact sheet and frequently asked questions on this web site about the minimum necessary standard for more information.

Consent. A covered entity may voluntarily choose, but is not required, to obtain the individual's consent for it to use and disclose information about him or her for treatment, payment, and health care operations. A covered entity that chooses to have a consent process has complete discretion under the Privacy Rule to design a process that works best for its business and consumers.

A "consent" document is not a valid permission to use or disclose protected health information for a purpose that requires an "authorization" under the Privacy Rule (see 45 CFR 164.508), or where other requirements or conditions exist under the Rule for the use or disclosure of protected health information.

Right to Request Privacy Protection. Individuals have the right to request restrictions on how a covered entity will use and disclose protected health information about them for treatment, payment, and health care operations. A covered entity is not required to agree to an individual's request for a restriction, but is bound by any restrictions to which it agrees. See 45 CFR 164.522(a).

Individuals also may request to receive confidential communications from the covered entity, either at alternative locations or by alternative means. For example, an individual may request that her health care provider call her at her office, rather than her home. A *health care provider* must accommodate an individual's reasonable request for such confidential communications. A *health plan* must accommodate an individual's reasonable request for confidential communications, if the individual clearly states that not doing so could endanger him or her. See 45 CFR 164.522(b).

Notice. Any use or disclosure of protected health information for treatment, payment, or health care operations must be consistent with the covered entity's notice of privacy practices. A covered entity is required to provide the individual with adequate notice of its privacy practices, including the uses or disclosures the covered entity may make of the individual's information and the individual's rights with respect to that information. See the fact sheet and frequently asked questions on this web site about the notice standard for more information.

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Treatment/Payment/Health Care Operations

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)