

The Health Insurance Portability & Accountability Act (HIPAA): An Introduction

By

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The following article reviews and summarizes a federal law that most, if not all, neuropsychologists will be legally required to comply with by April 14, 2002. The interpretation of this law is evolving and the reader should understand that some of the information presented may be superseded before the ink dries on this article.

HIPAA is the result of a federal bill that was sponsored by Senators Kassebaum (R) and Kennedy (D), signed in 1996. The bill had two purposes: 1) preventing loss of insurance coverage when changing jobs, due to preexisting medical conditions; and 2) streamlining and improving the electronic transmission of health care claims. Streamlining and standardizing the transmission of health care insurance billing has been projected to save millions of dollars each year.

HIPAA has significant implications for how health care providers conduct their practices. As the health care industry became more computerized, nationwide practices of electronic transmission of confidential patient information grew quickly to mammoth proportions and without uniform regulations. This created a clear need to adopt standards to secure that information and to guarantee consumers' privacy. As a result of this perceived need, HIPAA spawned three rules: 1) the Privacy rule; 2) the Transactions rule; and 3) the Security rule.

Congress imposed a deadline to enact the Privacy rule legislation by 8/21/99 when a plan to implement HIPAA would be in place. Unfortunately, Congress could not agree on how to interpret the law and the deadline was not met. Thus, the task of interpretation and implementation was relegated to the Department of Health and Human Services (HHS). HHS rendered the final Privacy rule on 4/14/2001 with an expected compliance date for all health care entities by 4/14/2003.

Some psychologists have argued that they are not affected by HIPAA because they do not engage in electronic submission. However, the following scenarios are illustrative of how neuropsychologists may be involved in "electronic submission" perhaps without even knowing it: 1) a practitioner receives faxes from insurers that have patient data or information and the practitioner does not know whether that information was previously received or transmitted electronically. If so, then that information falls under HIPAA regulation and the practitioner as a recipient of that information must be HIPAA compliant; or, 2) depositing patient checks into a business checking account where the bank stores and transmits that information electronically. The upshot is short and clear: for all practical purposes, virtually all practicing neuropsychologists will fall within the ambit of HIPAA. In addition, even if only one patient falls within the electronic transfer criterion for HIPAA, at any time, then the entire practice must be HIPAA compliant.

For solo and small clinical practices, HIPAA requirements may seem onerous and, in some instances, ludicrous. It is likely that some regulations will be modified to be more applicable to small private practices. However, until that happens, it will be important for the practitioner to learn and adhere to the new regulations.

The Privacy rule promises to have a significant impact on all psychology practices. In many respects, the strictures of this rule will not be unfamiliar to licensed psychologists in New Jersey where the licensing law and regulations impose tight rules on the management of confidential patient information. HIPAA will preempt or trump state privacy laws/rules where HIPAA is more stringent in protecting the privacy of patient information. Conversely, state law/regulations will prevail when they are more stringent than HIPAA. Since New Jersey law/regulations are stricter than HIPAA in most instances, the reader should review the New Jersey laws/regulations while reviewing HIPAA.

The privacy rule requires informing patients about their privacy rights and the possible uses of their health care information. It requires creating clear privacy procedures, training our employees regarding privacy, designating a privacy officer, and securing patient records.

HIPAA designates a “privacy officer” as the central figure in implementing and monitoring the privacy provisions. In solo practices, the practitioner and privacy officer are the same person. As in other circumstances, it will be a good idea to consult with a colleague for a check on HIPAA compliance. In group practices, one person will be designated as the privacy officer. That person will document the training of staff and employees, keep the practice privacy guidelines on files for at least six years, develop a patient complaint process, and be sure that the practice is compliance with all the applicable HIPAA regulations. One such regulation will be an actual notice to patients of their rights under HIPAA and details about how the practice is protecting their rights. Practices will also need to apply sanctions for those in their practices who fail to comply with HIPAA. In addition, there is a duty to mitigate for any errors committed. For example, if by accident your secretary mails a report to the wrong insurance company, you will need to take and document action such as notifying the recipient of the error and retrieving the report. With regard to the patient complaint process noted above, NJ psychologists should already be in compliance by the posting of the notification regarding complaints that has been set forth by the NJ State Board of Psychological Examiners. If you are not sure about this, now is the time to thoroughly read the regulations. It is important to note that the foregoing must be committed to writing and kept in an accessible file.

The kinds of information that must be protected under HIPAA are: 1) **Health Information**: any information, oral or documented record, that health care professionals or entities use; 2) **Individually Identifiable Health Information**: health information in which a patient can be identified; 3) **Protected Health Information (PHI)**: any individually identifiable health information that is transmitted or maintained in any form.

For neuropsychologists, psychologists, and all other mental health practitioners, identifiable information is further categorized into *progress notes* or *psychotherapy notes*. This delineation is very important and evolving. HIPAA designates that these two types of information must be kept separately. The release of this type of information to third parties is regulated in different manners. Under HIPAA, insurers may have access to progress notes with patient consent. However, insurers may not make payment or coverage dependent on release of psychotherapy notes. In fact, psychotherapy notes are to be withheld from third party payors as well as patients. HIPAA specifies that patients do not have the right to inspect or obtain a copy of their psychotherapy notes. However, HIPAA also specifies that any state law that is more stringent or more protective of the patient supercedes HIPAA. An interesting consideration will be how our NJ Peer Review Law interfaces with HIPAA.

It is important to understand the definitions of these types of information. Under HIPAA, a progress note is defined as session start and stop times, medication information, types of treatment, results of tests, diagnoses or summaries of status, treatment plan, symptoms, prognosis or progress to date. Progress notes DO NOT include content of sessions or conversations. Psychotherapy notes are then defined as notes that are 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 and that are separated from the rest of the individual's record. These are records that capture the therapist's impressions about the patient and contain details of psychotherapy conversation.

APA has referred to psychotherapy notes as what psychologists typically call *process notes*. However, there is a middle ground of information that is not necessarily a process note but may include conversation content, and thus is not considered a progress note. For example, to indicate that a patient stated that she was upset because her husband mentioned the possibility of divorce, is not "process" in nature and, under HIPAA, would be considered a psychotherapy note, not a progress note.

The implication of the progress note vs. psychotherapy note for neuropsychological reports is even less clear. In a comprehensive neuropsychological report, there is often much personal/conversational information in the history and background gathering. Does that mean that neuropsychologists will need to write separate reports for insurers that only report test data, diagnosis, and general, unpersonalized recommendations? Furthermore, will neuropsychologists be required to keep the more personalized patient information, that is typically in reports, in a physically separate area or file? What currently remains unanswered is whether what is called a progress note vs. a psychotherapy note can be kept separate within the same file folder, or whether any mental health practitioner will need to keep separate files or even separate file cabinets for the two types of information.

The release of health care information under HIPAA is provided for by either *Consent* or *Authorization*. Consent is needed for treatment, payment, and health care operations,

whereas an authorization is required for release of psychotherapy notes. These distinctions are truly more relevant for nonpsychologist health care providers. In the state of NJ, our Board of Psychological Examiners requires what HIPAA describes as an authorization for the release of any and all types of patient information, except in unusual circumstances such as involving judge/court order and State Board investigation.

The Transaction rule requires that any and all electronic transactions of health care information be executed in standard formatting. Specifically, this concerns claims submission or inquiries about health plan eligibility or coverage. The compliance date for the Transaction rule was 10/16/02. However, health care entities were allowed to submit extension forms to permit deadline extensions until 10/16/2003. The American Psychological Association advised all practicing psychologists to submit this form, even if they believed that they did not fall under HIPAA. Interestingly, prior to the 10/16/2002 extension deadline, the Medical Society of NJ advised its physician members that an automatic extension would be given to all practices in which there were under 10 employees, and information from HHS that was available on the Internet documented this. In effect, it was advised that small practices did not need to submit an extension form.

However, the first author of the present article faxed the Medical Society of NJ and the HHS documents to the APA legal department for an opinion. APA through verbal communication advised that all psychologists, whether solo or in small or large practices should still submit the extension form. This is just one example of the difficulty in the interpretation and implementation of HIPAA, of which practitioners can plan to experience much more. Ultimately, what neuropsychologists need to realize is that there are many unanswered questions and yet unmet dilemmas that will challenge all health care providers for interpretation.

The Transactions rule requires that health care providers engage in formal contractual agreements with any entities, with which they interact, that may have access to patient information. These agreements will specify that these entities are HIPAA compliant. Such entities may include: accountants, billing services, transcription services, computer repair technicians, schools that receive reports, and so on.

The Security rule has not yet been completed by HHS. This rule focuses on providers' physical offices, files, computer, etc. and the assurance of private and confidential communication and maintenance of information.

To aid psychologists in their compliance, APA will be releasing a CD-ROM early next year, 2003, that should provide all the forms that a practice will need. These forms will be tailored to each state, so that they will be in compliance with HIPAA as well as with any state regulations that may supercede HIPAA. If you do not belong to APA, now is a very good time to join. On line resources that currently offer more information regarding HIPAA include www.apapractice.org. and www.apait.org/hipaa.

Authors:

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