

HIPAA Definitions: Treatment, Payment and Health Care Operations

Federal Rule Allows Broad Use and Disclosure of Private Medical Record Data Without Patient Consent

The federal *Standards for Privacy of Individually Identifiable Health Information* (45 CFR Parts 160/164) — authorized by the 1996 Health Insurance Portability and Accountability Act (HIPAA), and often referred to as the “HIPAA Privacy Rule” or just “HIPAA”— allows broad sharing of individually identifiable “protected health information” without patient consent for activities including treatment, payment and health care operations, sometimes called business operations.

To understand the array of activities covered by the terms “treatment, payment and health care operations,” we include the following quotes and paraphrased definitions out of the HIPAA Rule, October 2002.

AUTHORITY TO SHARE: “A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations...[and] for treatment activities of a health care provider.” It may also disclose protected health information to other providers for payment activities and for health care operation activities of another covered entity if that entity has a relationship with the individual who is the subject of the data.

PROTECTED HEALTH INFORMATION: “individually identifiable information...that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media...; or (iii) Transmitted or maintained in any other form or medium.”

TREATMENT: “Treatment means 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.”

PAYMENT: “Payment means”: activities to obtain premiums, determine coverage, obtain or provide reimbursement, determine eligibility and cost-sharing, determine medical necessity, appropriateness of care, utilization review, preauthorization, retrospective review of services, risk adjustment, billing, claim management, collection activities, disclosure to consumer reporting agencies of name, address, birth date, Social Security number, payment history, account number, name and address of health care provider and health plan.

HEALTH CARE OPERATIONS (~400 words long): “Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, 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 health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

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

3) Underwriting, premium rating, 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 claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

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

(5) 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

(6) Business management and general administrative activities of the entity, including, but not limited to:

- (i) Management activities relating to implementation of and compliance with the requirements of this subchapter;
- (ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer;
- (iii) Resolution of internal grievances;
- (iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- (v) Consistent with the applicable requirements of §164.514, creating de-identified health information, or a limited data set, and fundraising for the benefit of the covered entity.”

NOTE: Congress allows States to impose stricter, more privacy-protecting medical record and health data laws. Such laws supercede HIPAA, and must be followed. For example, current Minnesota law often requires patient consent for use and disclosure of health data. Conforming Minnesota law to HIPAA would eliminate the patient’s current right to refuse such use and disclosure.

HIPAA Source: OCR/HIPAA Privacy Regulation Text, October 2002.