TITLE: **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

PURPOSE: To provide guidance on the use and disclosure of protected health information for treatment, payment or healthcare operations purposes.

POLICY STATEMENT:

Harris Health System (Harris Health) will use and disclose protected health information in accordance with state and federal laws and regulations for treatment, payment or healthcare operations.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **COVERED ENTITY**: A health plan, a healthcare clearinghouse, or a healthcare provider (Harris Health) that electronically transmits health information covered by the HIPAA regulations. Harris Health is a Covered Entity.

B. **DISCLOSURE:** The release, transfer, provision of, access to, or divulging in any manner PHI outside of Harris Health.

C. **HEALTHCARE OPERATIONS:** 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 study resulting from such activities; patient safety activities (as defined in 42 C.F.R. §3.20); population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting Healthcare Providers and patients with information about treatment alternatives; and related functions that do not include treatment.
2. Reviewing the competence of 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.

3. Except as prohibited under 45 C.F.R. §164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related 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 healthcare (including stop-loss insurance and excess of loss insurance), provided that the requirements of 45 C.F.R. §164.514(g) are met, if applicable;
4. Conducting or arranging for medical review, legal services, and auditing functions, 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:

    a. Management activities relating to implementation of and compliance with the requirements of 45 C.F.R. §164.500;
    b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer;
    c. The sale, transfer, merger, or consolidation of all of 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
    d. Consistent with the applicable requirements of 45 C.F.R. §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity.

D. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION:** 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 condition of an individual; the provision of healthcare to an individual; and
    a. 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.

E. **HEALTHCARE PROVIDER**: A provider (e.g., hospital, physician, advance practice nurse) of care, services, or supplies related to the health of an individual who furnishes, bills, or is paid for healthcare in the normal course of business.

F. **MINIMUM NECESSARY**: The Minimum Necessary PHI required to accomplish the intended purpose of the request, use, or Disclosure of PHI when:

1. A Harris Health Workforce member uses PHI for a job specific function;
2. Harris Health discloses PHI to an outside person or entity; or
3. Harris Health requests PHI from an outside person or entity.

G. **ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)**: An Organized Health Care Arrangement is:

1. A clinically integrated care setting in which individuals receive healthcare from more than one Healthcare Provider;
2. An organized system of healthcare in which more than one covered entity participates and in which the participating covered entities:

   a. Hold themselves out to the public as participating in a joint arrangement; and
   b. Participating in joint activities that include at least one (1) of the following: Utilization review, in which healthcare decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf:

      i. Quality assessment and improvement activities in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or
      ii. Payment activities, if the financial risk for delivering healthcare is shared, in part or in whole, by participating covered entities through the joint arrangement, and if PHI created or received by a Covered Entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

3. A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to PHI created or received by such health insurance issuer or HMO, that relates to individuals who are or who have been participants or beneficiaries in such group health plan;
4. A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or
5. The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs, that relate to individuals who are or have been participants or beneficiaries in any of such group health plans.

H. **PAYMENT**: The activities undertaken by:

1. A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and the provision of benefits under a health plan, except as prohibited under 45 C.F.R. §164.402(a)(5)(i); or
2. A Healthcare Provider or health plan to obtain or provide reimbursement for the provision of healthcare; and
3. The activities set forth above, include but are not limited to:

    a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication of subrogation of a health benefit claim;
    b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
    c. Billing, claims management, collection activities, obtaining Payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related healthcare data processing;
    d. Review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
    e. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
    f. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

        i. Name and address;
        ii. Date of birth;
        iii. Social Security number;

iv. Payment History;
v. Account Number; and
vi. Name and address of the Healthcare Provider and/or health plan.

I. **PROTECTED HEALTH INFORMATION (PHI):** Individually Identifiable Information that is created, received, transmitted, or maintained by Harris Health in any form or medium that relates to the patient's healthcare condition, provision of healthcare, or Payment for the provision of healthcare. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

    a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
    b. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of health; and all ages over 89 and all elements of date (including year) indicative of such age, except that ages and elements may be aggregated into a single category of age 90 or older;

4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;

16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

J. **TREATMENT**: 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.

K. **USE:** Regarding PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

II. PERMITTED USES AND DISCLOSURES:

A. Harris Health may Use and disclose a patient's PHI without the patient's authorization for Treatment, Payment, or Healthcare Operations.

B. Uses and Disclosures Related to Treatment:

1. Harris Health may disclose a patient's PHI without the patient's authorization for Harris Health's own Treatment, Payment, or Healthcare Operations.
2. Harris Health may disclose a patient's PHI without an authorization to carry out the Treatment activities of a Healthcare Provider, which may include a Healthcare Provider external to Harris Health.

C. Uses and Disclosures Related to Payment:

1. Harris Health may Use and disclose a patient's PHI without an authorization for its own Payment activities.
2. Harris Health may Use and disclose a patient's PHI without an authorization to another Covered Entity for the Payment activities of that Covered Entity.
3. Harris Health may Use and disclose a patient's PHI without an authorization to another Healthcare Provider for the Payment activities of that Healthcare Provider, which may include a Healthcare Provider external to Harris Health.

D. Uses and Disclosures Related to Healthcare Operations:

1. Harris Health may Use or disclose a patient's PHI without an authorization for its own Healthcare Operations.
2. Harris Health may disclose a patient's PHI to another Covered Entity without an authorization for the Healthcare Operations of the other Covered Entity if:

    a. Harris Health has or had a relationship with the patient whose PHI is being disclosed;
    b. The Covered Entity that receives the patient's PHI has or had a relationship with the patient;
    c. The PHI being disclosed pertains to the relationship; and
    d. The Disclosure of the patient's PHI is for:

        i. 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 study resulting from such activities; patient safety activities (as defined in 42 C.F.R. §3.20); population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting Healthcare Providers and patients with information about Treatment alternatives; and related functions that do not include Treatment; or
        ii. Reviewing the competence of 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; or
        iii. For the purpose of healthcare fraud and abuse detection or compliance.

3. Harris Health participates in an Organized Health Care Arrangement (OHCA), and may disclose a patient's PHI to other participants in the OHCA for Healthcare Operations of the OHCA.

E. Harris Health will reasonably safeguard its patients' PHI to limit incidental Uses or Disclosures made pursuant to an otherwise permitted or required Use or Disclosure.

III. MINIMUM NECESSARY:

A. When using or disclosing a patient's PHI for the purposes of Payment or Healthcare Operations, Harris Health must make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the Use or Disclosure.

B. The Minimum Necessary standard does not apply when a patient's PHI is Used or disclosed for Treatment purposes.

REFERENCES/BIBLIOGRAPHY:

45 C.F.R. §164.502(b) (1996).

45 C.F.R. §164.506 *et seq.* (1996).

45 C.F.R. §164.514(d) (1996).

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Office of Corporate Compliance

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
04/14/2003	1.0	Approved 04/14/2003	Harris Health System President/CEO
	2.0	Approved 10/06/2009	Harris Health System Policy Review Committee
	2.0	Approved 10/09/2009	Harris Health System President/CEO
	3.0	Revised/Approved 03/8/2016	Operations Policy Committee