HIPAA PRIVACY RULE: USE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I. Policy

A. General Rule.

University of Southern California (USC) [1] is permitted to use and disclose an individual's Protected Health Information [2] for treatment, payment and health care operations, provided:

1. USC gives patients a Notice of Privacy Practices (Notice), which describes the ways in which USC may use patients' PHI;

2. USC makes a good faith effort to obtain written acknowledgement of receipt of the Notice; and

3. USC only uses and releases the minimum amount of health information necessary when doing so for payment or healthcare operations purposes.

Regardless of the general rule above, disclosures of HIV test results, certain mental health records, psychotherapy notes and alcohol and drug treatment records may require a separate patient authorization or notice. Please refer to USC HIPAA Policy CLIN-203 for information as to the disclosure of such information.

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[1] For purposes of the HIPAA Privacy Rule, USC includes those entities that comprise Keck Medicine of USC, including but not limited to, USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the Keck School of Medicine, School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy as well as USC Care Medical Group, affiliated medical foundations of Keck and their physicians, nurses and clinical personnel, USC Verdugo Hills Hospital, its nurses and other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahluwalia, M.D., Inc. and those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance.

[2] Protected Health Information is identifiable information that relates to an individual's past, present or future physical or mental condition or to payment for health care.

B. Minimum Necessary Standard.

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity or Business Associate covered by the HIPAA privacy regulations, USC makes reasonable efforts to limit Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request, except as set forth below. The minimum necessary standard applies to uses and disclosures for payment and health care operations.

1. Exceptions to Minimum Necessary Standard. USC is not required to apply the minimum necessary standard under the following circumstances:

   a. For Treatment. Disclosures to or requests by a health care provider for purposes of diagnosing or treating a patient.

   b. To Patient. Uses or disclosures made to the patient.

   c. Pursuant to Patient's Authorization. Uses or disclosures pursuant to a valid patient authorization. USC's use or disclosure of information must be consistent with any limitations imposed by the authorization.

   d. To HHS. Disclosures to the Director, Office for Civil Rights of the U.S. Department of Health and Human Services ("HHS") for HIPAA compliance purposes.

   e. Required by Law. Uses or disclosures that are required by law (i.e., a mandate that is contained in law that compels USC to use or disclose Protected Health Information and that is enforceable in a court of law, e.g., court orders, court-ordered subpoenas, civil or authorized investigative demands, Medicare conditions of participation).

   f. Required for Compliance with HIPAA

Administrative Simplification Provisions. Uses or disclosures that are required for compliance with the regulations implementing the HIPAA transactions and code sets standard, security and electronic signature standards, etc.

C. Discussions with or in the Presence of Family Members/Caregivers.

USC is permitted to disclose certain patient information to family members or caregivers if the patient is given an opportunity to object or if the patient's consent to the disclosure can be clearly inferred from the circumstances.

D. Disclosures over the telephone:

In general, USC employees should not give patient status information to a person over the telephone. Employees may release Protected Health Information over the telephone only in very limited circumstances as described below.

II. Procedures

A. Use or Disclosure of Protected Health Information for Treatment

1. As a general rule, USC may use or disclose Protected Health Information in connection with "treatment of a patient.

2. *Definition.*

"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.

B. Use or Disclosure of PHI for Payment

1. *General Rule.*

USC may use or disclose Protected Health Information for USC's own payment activities.

2. *Definition of Payment Activities.*

Payment activities shall mean activities to obtain or provide reimbursement for the provision of health care. Examples of payment activities include:

a. Determinations of eligibility or coverage

b. Billing, claims management, collection activities,

c. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

d. Utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and

e. Disclosure to consumer reporting agencies of any of the following protected health information 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 Health Care Provider and/or Health Plan.

f. Only the minimum amount of information

necessary should be used or disclosed when obtaining payment information. For example, diagnosis of patient should not be disclosed when accepting payment information from the insurance holder.

3. *Disclosure for Payment Activities of Another Covered Entity or Health Care Provider.*

USC may disclose Protected Health Information to another Covered Entity or a Health Care Provider for the Payment activities of the entity that receives the Protected Health Information.

C. Use or Disclosure of PHI for Health Care Operations

1. *General Rule.*

USC may use and disclose Protected Health Information for the purpose of USC's own health care operations.

2. *Definition of Health Care Operations.*

Health Care Operations means any of the following activities:

a. 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;

b. 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;

c. 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;

d. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

e. 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

f. 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 promulgated pursuant to HIPAA;

   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. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a Covered Entity or, following completion of the sale or transfer, will become a Covered Entity; and

v. Consistent with the applicable requirements of § 164.514 of the Privacy Rule, creating de-identified health information, fundraising for the benefit of the Covered Entity, and marketing for which an individual authorization is not required as described in § 164.514(e)(2).

3. *Disclosure for Health Care Operations of Another Covered Entity.*

USC may disclose Protected Health Information to another Covered Entity for Health Care Operations of the entity that receives the Protected Health Information, if all of the following conditions are met:

a. Both USC and the receiving entity either has or had a relationship with the patient who is the subject of the Protected Health Information being requested;

b. The Protected Health Information pertains to such relationship; and

c. The disclosure is either:

i. For either purpose of health care fraud and abuse detection or compliance; or

ii. For either of the following purposes:

(A) 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;

(B) 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.

D. General Procedures for Implementing Minimum Necessary Standard

This policy recognizes that each USC department must limit the access to Protected Health Information and Electronic Protected Health Information ("ePHI") by its Workforce Members to the minimum necessary to accomplish the intended purpose of the use. Determinations regarding the use of, and disclosures and requests for Protected Health Information should be consistent with this policy. As a general rule, USC should not use, disclose or request an entire medical record of a patient unless the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure or request. For example, access to the entire medical record is appropriate for treating practitioners as well as fellows, residents and students who are performing clinical functions as part of their training, whereas an individual who performs the function of a receptionist who registers patients most likely will not require access to that patient's entire medical record to perform that responsibility.

This policy also recognizes that each department at USC that uses or discloses Protected Health Information has a unique organizational structure and that an employee of the unit may perform various functions for the unit that require different levels of access to Protected Health Information. Further, the responsibilities designated to these functions vary across each department at USC and cannot be determined solely based on job title or description.

For these reasons, it is the responsibility of department at USC that uses and discloses Protected Health Information to determine the level of

access required to perform particular functions and responsibilities within that unit.

When access, use, or disclosure is required outside of one's routine job responsibilities, a department supervisor must approve such non-recurring instances based on the minimum necessary criteria.

1. Limitation of Access. Once persons within USC or Business Associates of USC who need access to Protected Health Information and categories of information are identified, USC must make reasonable efforts to limit access of such identified parties only to their respective identified categories of Protected Health Information.

2. Type of Disclosure or Request. The type of use, disclosure or request dictates what procedures are required:

a. Recurring. When a use, disclosure or request is of the type that occurs on a recurring basis, USC, through the relevant clinical departments, will implement a standard protocol that limits the Protected Health Information disclosed or requested to the amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each recurring disclosure is not required.

For example, for billing purposes, the protocol may be to disclose only records for service at issue. For outside billers, the protocol may be to disclose only that portion of the medical record that the biller needs to prepare the bill.

Each department should consider reasonable physical, administrative and technical security controls when using or disclosing Protected Health Information, including the following:

i. Sign-In Sheets. The Privacy Rule does not require USC to abandon the practice of using sign-in sheets. However, ideally,

patient intake should be handled to minimize patient contact with another patient's health information.

ii. Waiting Rooms. USC employees should be mindful that waiting rooms are public areas, not clinical treatment spaces. Staff should be mindful not to divulge clinical information in the waiting room, such as diagnoses or scheduled tests.

iii. Medical Records Use and Storage. The Privacy Rule requires clinical units to keep medical records secure. For example, hard copies records should be in locked cabinets and not left in treatment rooms overnight. When a patient is expected in the office, care should be taken to keep the medical record shielded and inaccessible to other patients. Staff should avoid placing patient information on the outside of the patient file. Staff required as part of their job to move records outside of the hospital or Health Sciences Campus must safeguard and protect the records.

For electronic medical records systems, departments shall shield computers from sight and staff must have access codes that limit access to identified persons and identified categories of Protected Health Information. Staff members should always log off computers when not attended.

iv. Treatment Rooms. Consistent with common sense and good clinical judgment, health care providers and their staff should seek to maintain privacy in patient treatment rooms.

v. Wallboards/Displays. If a practitioner

office uses a wallboard to track patient information, the practitioner and staff should consider whether the wallboard is viewable by patients or visitors and should make reasonable efforts to minimize the information kept on public wallboards. Where information is highly sensitive, it should not be placed on a wallboard.

b. Non-Recurring. Each clinical department at USC will evaluate uses, disclosures and requests relating to health care operations or billing that are outside the scope of the normal course of business, and will limit the Protected Health Information disclosed to the amount reasonably necessary to accomplish the purpose of the disclosure or request.

Non-recurring requests for use or disclosure of Protected Health Information shall be evaluated and approved by the department supervisor upon consultation with the Office of Compliance. Any questions regarding the Minimum Necessary Standard requirements should be directed to the Office of Compliance.

Appropriate criteria for evaluating requests outside the ordinary scope of business may include, without limitation, the following:

i. The purpose of the request, use or disclosure;
ii. The nature and extent of information requested, used or disclosed;
iii. The identity of the party that will request, use or disclose the Protected Health Information;
~~iv.~~ The extent to which the risk to the Protected Health Information has been mitigated;
v. The extent to which requested Protected Health Information can be extracted from the rest of the medical record without undue burden and without viewing unnecessary parts of the record;

vi. The location where Protected Health Information will be viewed or used and the limitation on removal of the Protected Health Information;

vii. The availability of physical, technical and other security measures at the place of viewing or use; and

viii. The immediacy or urgency of the need for the requested Protected Health Information

3. Responding to Requests for Disclosures. USC faculty, staff and other covered workforce may rely on a requested disclosure as the minimum necessary for the stated purpose (if reliance is reasonable under the circumstances) in the following situations:

   a. When making disclosures to public officials under USC HIPAA Policy GEN - 103 [concerning disclosures based on public policy considerations without a patient's authorization] if the requesting official represents that the information requested is the minimum necessary for the stated purpose.

   b. When the information is requested by another covered entity.

   c. When the information is requested by a health care professional (e.g., a physician or nurse) who is a member of USC's workforce or is a business associate of USC for the purpose of providing professional services to USC, if the professional represents that the information requested is the minimum necessary for the stated purpose(s).

   d. When the information is requested for research purposes and the person requesting the information has provided documentation or representations that

comply with USC HIPAA Policy RES - 301.

4. Business Associates. USC's contract with a business associate may not authorize the business associate to use or further disclose the information in a manner that would violate the HIPAA Privacy Rule if done by USC. Thus, a business associate contract must limit the business associate's uses and disclosures of, as well as requests for, Protected Health Information to be consistent with USC's minimum necessary policies and procedures. Given that a business associate contract must limit a business associate's requests for Protected Health Information on behalf of USC to that which is reasonably necessary to accomplish the intended purpose, USC is permitted to reasonably rely on such requests from a business associate or another covered entity as the minimum necessary.

5. Minimum Necessary Violations.

   a. USC Workforce Members should return or destroy any information beyond that which is permitted under the minimum necessary standard.

   b. The USC Office of Compliance will investigate any minimum necessary violation to determine the probability that the Protected Health Information has been compromised and whether any breach notification is required. Minimum necessary violations should be reported according to the Breach Notification Rule (See USC HIPAA Policy PAT-608).

E. Disclosures to Family/ Patient Caregivers

1. *General Rule.*

Subject to the limitations below, the HIPAA Privacy Rule permits:

a. Disclosure to family members, other relatives, close friends, or any other person designated by the patient of Protected Health Information directly relevant to that person's involvement with the patient's healthcare;

b. Disclosure of the patient's Protected Health Information to public or private entities authorized by law or its charter to assist in disaster relief efforts in order to coordinate the notification efforts described in this Section[3]. This includes notifying a family member, personal representative of the patient, or another person responsible for the care of the patient of the patient's location, general condition, or death.

2. *Limitations.*

a. USC employees may not disclose any portion of the Protected Health Information that is not relevant to the patient's current condition or the caregiver's role.

b. USC employees should not assume that a patient's agreement or lack of objection implies agreement to disclose Protected Health Information indefinitely in the future.

3. *Disclosure Permitted Where Patient Agrees to Disclosure.*

[3] Per OCR, "HIPAA allows health care professionals the flexibility to disclose limited health information to the public or media in appropriate circumstances. These disclosures, which are made when it is determined to be in the best interest of a patient, are permissible without a waiver to help identify incapacitated patients, or to locate family members of patients to share information about their condition. Disclosures are permissible to same sex, as well as opposite sex, partners."

Where a patient is present for and capable of agreeing to the disclosure, USC faculty and staff may disclose the patient's Protected Health Information only in the following situations:

a. Agreement. The patient agrees to the disclosure; or

b. No Objection. The patient does not express an objection to the disclosure when given the opportunity to do so; or

c. Reasonable Inference. The USC faculty or staff member reasonably infers from the circumstances, based on the exercise of professional judgment that the patient does not object to the disclosure.

i. Generally, when possible, a USC employee should ask the patient (outside the presence of the family member, close personal friend, etc.) whether the patient objects to such person's presence during a procedure or discussion.

ii. Reliance on inferences should be infrequent and based on sound clinical judgment.

iii. *Example of reasonable inference*: if a patient's family member is in the same room as patient during a procedure, staff typically can infer that disclosures to the family member are appropriate.

4. *Disclosure Permitted When Patient is Unable to Agree but Disclosure is in Patient's Best Interest.*

Where a patient is not available or cannot agree or object to a use or disclosure because of incapacity, incompetency or emergency, appropriate USC staff may disclose Protected Health Information as follows:

a. USC faculty or staff determine, in the exercise of professional judgment that the disclosure is in the best interest of the patient or that the patient would not object.

For example, pharmacy staff may infer that it is in the best interests of the patient to allow another person to pick up a prescription on behalf of the patient. Or in a potentially crisis situation where a patient is incapacitated a health care professional can disclose information to a family member, or other person searching for the patient.

b. The disclosure is limited only to the minimum Protected Health Information directly relevant to the person's involvement in the patient's health care.

F. Disclosures over the Telephone.

In general, USC employees should not give patient status information to a person over the telephone. Employees may release Protected Health Information over the telephone only in very limited circumstances once the caller's identity has been confirmed, such as the following:

1. When the staff member recognizes the voice of a person who had previously been identified by a patient.

2. Staff members obtain two identifiers of the caller and the caller has some familiarity of the patient's condition.

3. If a patient's Personal Representative (as defined in HIPAA Policy CLIN-202: Personal Representatives of Patients) is the caller, and USC has documentation/verification that the patient designated the individual as their Personal Representative.

4. In order to facilitate immediate treatment or to interpret the health care practitioner's instructions to a person who is assisting the patient, and only after the health care practitioner has determined that the patient is unavailable (and therefore cannot give consent) and has determined that it is in the best interest of the patient to disclose the Protected Health Information.

The Protected Health Information disclosed over the telephone should be limited to the information directly relevant to the person's involvement in the patient's care. If more detailed information is requested, the health care practitioner should

make an appointment with the patient and the person requesting the information.

Additional References

45 CFR §§ 164.506; 164.510(b); 164.520

Responsible Office: Office of Compliance
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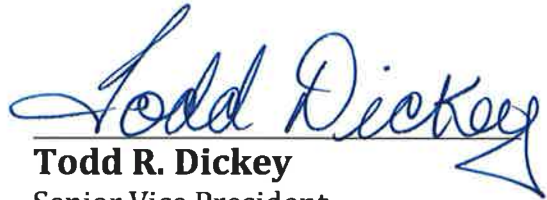

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Date issued: November 30, 2016