SUBJECT: PROTECTED HEALTH INFORMATION

POLICY: CP 6007

Department of Origin: **Compliance and Audit Department**
Responsible Position: **Compliance Director**

Date(s) of Review and Revision: 12/13; 05/14; 12/14; 01/16**;** 01/17; 05/17; 9/17; 4/18
Policy Replaces: N/A

Policy Approved: 7/6/2018 Committee Meeting
Link
Department Approval:

Approval has completed on CP 600

PURPOSE
To ensure the Health Plan implements appropriate processes to protect member's Protected Health Information (PHI). The Health Plan educates members, employees and First Tier, Downstream and Related Entities (FDRs) about the ways in which member's may obtain or otherwise manage access to their PHI in accordance with the Health Plan and Corporate's code of conduct and as required by the Health Insurance Portability and Accountability Act's (HIPAA).

APPLICABILITY
This policy applies to all Lines of Business.

POLICY
The Health Plan takes appropriate measures to secure and protect member PHI and communicates these measures to members. The Health Plan provides members with mechanisms to access and manage their PHI. The Health Plan will use and disclose PHI in accordance with the uses and disclosures stated within the Privacy Notice.

DEFINITIONS

Please refer to the link below for full definitions for the following terms:
http://sharepoint/sites/hppandp/new/Lists/Definitions/PP%20Definitions.aspx

PROCEDURE

1.0 The Health Plan has established protocols to maintain secured access to the Health Plans computer systems, electronic mail, internet and to remove access for terminated employees upon employee exit.

2.0 Mandatory HIPAA Education
As a condition of employment with the Health Plan, all Health Plan employees are required to receive mandatory education on HIPAA within 60 days of hire or association with the Health Plan and annually thereafter.

2.1 All Health Plan FDRs are required to sign a Business Associates Agreement (BAA) and to abide by the BAA's HIPAA requirements.

2.2 The Health Plan Compliance Department ensures annual training and education for Health Plan employees. Participation in these educational programs will be documented in the Banner Learning Center.

3.0 Health Plan Employee "Need to Know"

3.1 In accordance with Health Plan policy CP 6006 Health Plan Privacy and Security Safeguards, only Health Plan employees with legitimate "need to know" may access, use or disclose PHI. Employees may only access, use or disclose the minimum information necessary to perform his or her designated role regardless of the extent of access provided.

3.2 The Health Plan identifies those employees who need access to PHI in order to carry out their duties as well as the type of PHI access is needed.

3.2.1 Each Department is responsible for identifying any conditions that may have an impact on an employee's ability to access and/or disclose the PHI they are authorized to access.

4.0 Minimum Necessary

4.1 The Health Plan will make reasonable efforts to limit access of PHI to what is necessary to carry out Health Plan duties, functions and/or responsibilities.

4.2 Internal and external requests to access PHI must be in compliance with this policy and may be reviewed by the Compliance Department to determine whether it meets the minimum necessary requirements.

4.3 Health Plan employees will only use and disclose the amount of PHI minimally necessary except in the following circumstances:

4.3.1 When the PHI is for use by or a disclosure to a healthcare provider for purposes of providing treatment to the patient;

4.3.2 When the disclosure is to the member or the member's legally authorized representative;

4.3.3 When the disclosure is pursuant to a valid authorization, in which case, the disclosure will be limited to the PHI specified on the authorization;
4.3.4 When the disclosure is to the Secretary of Health and Human Services; or
4.3.5 When the disclosure is required by law**.**

5.0 Health Plan Disclosures of PHI
5.1 The Health Plan will not disclose PHI unless permitted by Banner Health Corporate or Health Plan policies or as required by law. Member Protected Health Information (PHI) may be shared with a Covered Entity for purposes of treatment, payment or operations or with the member or member's authorized representative when requested and properly authorized.
5.2 The Health Plan does not use or disclose PHI for the purpose of underwriting.
5.3 The Health Plan does not use or disclose PHI for the purpose of research.

6.0 Notice of Privacy Practice (NOPP)
6.1 The Health Plan has developed and maintains a HIPAA-compliant NOPP.
6.2 The NOPP is used to notify Health Plan members of their rights and responsibilities with respect to their PHI. The NOPP also advises members of the Health Plan's responsibilities with respect to the PHI the Health Plan creates, collects and maintains.
6.3 The NOPP contains all HIPAA-required elements and describes how the Health Plan may use and disclose a member's PHI. The NOPP states the Health Plan's duties to protect member privacy, provide a notice of privacy practices and abide by the terms of the current NOPP. The NOPP describes a member's rights.
6.4 The NOPP includes a point of contact for further information and for making complaints to the Health Plan.
6.5 The NOPP will be in plain language and consistent with applicable laws, rules and regulations.
6.6 The NOPP will be in English and Spanish and any other language when 1,000 or 5%, whichever is less, members that speak that language have a Limited English Proficiency (LEP).
6.7 The NOPP will be made available to members in paper and on the Health Plan websites. The NOPP will be posted in a clear and prominent place in Health Plan offices.
6.8 The NOPP is made available to prospective members through the Health Plan websites and is included with sales and marketing materials.
6.9 The NOPP will be issued to each new member upon member's enrollment and members will be reminded annually that a current NOPP can be viewed on Health Plan websites and is available upon request.
6.10 The member's right to privacy and right to request a NOPP will be included in member materials which are disseminated to members at time of enrollment and all enrollment renewals or re-enrollment.

6.11 The Customer Care and Marketing Departments are responsible for maintaining the NOPP on the website and on materials. The Compliance Director is responsible for updating the NOPP. Material revisions to the NOPP will require redistribution of the NOPP to all Health Plan members within 60 days of revision.

7.0 Member Rights

7.1 Rights are granted to members related to their Health Plan Record:

7.1.1 The right to inspect their health information and to obtain a copy of their Health Plan Record. Members are given a choice of receiving a paper copy or an electronic email (encrypted or not) copy of their record. Members are provided with information that there is some level of risk that a third party could access their PHI without the member's consent when email is unencrypted and the Health Plan is not responsible for unauthorized access or for any risks such as a virus to the member's computer/device when receiving the PHI in an email. Under very limited situations, a member's request may be denied, such as a request for psychotherapy notes.

7.1.2 The right to request an Amendment to their Health Plan Record.

7.1.3 The right to an accounting of disclosures of the member's Health Plan Record made by the Health Plan.

7.1.4 The right to request restrictions on the uses and disclosures of the member's Health Plan Record made by the Health Plan.

7.1.5 The right to request that the Health Plan communicate confidentially with them about their health information in a certain way or at certain locations.

7.1.6 The right to receive a paper copy of the NOPP even if the member has requested or obtained it electronically.

7.1.7 The right to complain to Health Plan, the Department of Health and Human Services or the Office of Civil Rights if the member believes their privacy rights has been violated.

The right to be notified if the member is subject to a breach of unsecured protected health information

7.1.8 Some rights require action on the part of the member before the Health Plan can respond. This includes the member contacting the Health Plan's Customer Care Center and making any requests in writing and providing a reason that supports their request.

8.0 Member's Right to Inspect or Obtain Copies of Member's Health Plan Records

8.1 The Health Plan has implemented a process to fulfill member requests to access or release some or all of their health information.

8.2 Requests to release Health Plan Records must be accompanied by a member signed authorization. The Health Plan has created an "Authorization for Use, Inspection and Disclosure of Protected Health Information" form (Release Authorization). Either the Release Authorization or member-created alternative

may be used. Any member-created forms to release records that are not the Authorization Release may be accepted as long as these alternative forms contain the ten requirements listed in the Health Plan's Request for Medical Records Desktop.

8.2.1 The Release Authorization must include the following:

8.2.1.1 Information to be disclosed;

8.2.1.2 Name, address etc. of individual/organization to whom the Health Plan Records should be released;

8.2.1.3 The purpose for disclosing the information

8.2.1.4 A statement informing the member of his or her right to revoke the authorization in writing, how to revoke the authorization and any exceptions to the right to revoke

8.2.1.5 A statement that information disclosed pursuant to the authorization may be redisclosed by the recipient and is no longer protected by federal privacy regulations unless bound by other regulations such as Part 2 or Arizona Confidential Communications regarding communicable diseases - ARS 36-664.

8.2.1.6 A statement that the authorization will expire either on a specific date, after a specific amount of time or upon the occurrence of some event related to the member.

8.2.1.7 Agree/Disagree to release Health Plan Records on Drug/Alcohol Abuse, Psychiatric and HIV/AIDS Genetic Testing records.

8.2.1.8 If a member-created form to release record does not contain the ten requirements, The Health Plan will send the Health Plan's Authorization Form to the requestor for completion before proceeding.

8.2.1.9 Upon receipt of appropriately completed and signed Release Authorization, and a copy of identification (Driver's License or Picture ID) or confirmation of the member or authorized representative's identity from the Health Plan's ALTCS Case Manager, the Compliance Department will review the request and determine if Health Plan Records can be released. In the event the copy of identification is not received with the release form, the custodian of records or designee will contact the member with the information contained in the Health Plan Record to confirm the release was sent by the member, if applicable. The records will be provided in the form and format requested by the member if it is readily producible in such form or format; or if not, in a readable hard copy form or such other form or format as agreed upon by the Health Plan and the member.

8.3 If the Compliance Department determines the request can be fulfilled, the Compliance Department will collect the requested information and supply a copy to the member at no cost. The member will not be a charged if the member has only requested to inspect the member's Health Plan Record.

8.4 Under limited situations where the request may be denied, such as a request for psychotherapy notes, the Compliance Officer in consultation with the Chief Medical Officer will review and approve all denials and the member will be

notified of the reasons for the denial in writing. The Health Plan will make clear the member's rights to a review of the denial of access.

8.5 The Health Plan will fulfill member requests no later than thirty (30) days of receipt of appropriate written request and the completed Authorization Form. If the Health Plan is unable to take action within 30 days, the Health Plan may take an additional 30 days provided the Health Plan advises the member of the reason for the delay and provides the date the request will be completed. The Compliance Department is responsible for this communication to the member or authorized representative.

8.6 In the event an Authorization form is not returned to the Health Plan, the Service Request in the Customer Relationship Management System (CRM) for Health Plan Records will be closed after 30 days.

9.0 Member's Right to Amend Member's Health Plan Record

9.1 The Health Plan has implemented a process to fulfill a member's requests to Amend the member's Health Plan Records due to the Health Plan Record being incorrect or incomplete.

9.2 Upon receipt of a written request to Amend the member's Health Plan Record from a member or a member's authorized representative, the Compliance Department will review the request and consult with licensed clinical professionals or other subject-matter experts from the appropriate Health Plan Department to determine if the health information in the Health Plan Record is incorrect or incomplete.

9.3 After the Compliance Department and subject-matter experts evaluate the accuracy and completeness of the Health Plan Record, they will advise the Compliance Director of their findings. The Compliance Director will then review the findings and any associated documents to determine whether to grant or deny the Amendment request.

9.4 If the Compliance Director determines the Amendment request can be fulfilled, the Compliance Department will ensure the member's Health Plan Record is corrected and will provide the member or authorized representative with written confirmation of the Amendment. When the Correction is made, the Health Plan makes reasonable efforts to see that the corrected information is provided to Health Plan FDRs if applicable.

9.5 If the Compliance Director determines the Amendment request is denied, the Compliance Director will document the reason(s) for denial and notify the member or member's authorized representative of the denial. Notification of denial must include:

9.5.1 The basis /reason for denial;

9.5.2 A notification of the member's right to submit a written "statement of disagreement" with the denial. If the member submits a written "statement of disagreement", the Health Plan will include the member's "statement of disagreement" in the member's Health Plan Record. The Health Plan must

provide documentation of the dispute with any subsequent disclosure of the disputed PHI;

9.6 A description on how the member or member's authorized representative can file a complaint with the Health Plan, the Department of Health and Human Services or the Office of Civil Rights pursuant to HIPAA.

9.7 The Custodian of Records will ensure all Correction Amendments are maintained and stored in accordance with Federal and State laws in accordance with Health Plan Policy CP 6230 Custodian of Records.

9.7.1 The Health Plan will act on the Amendment request within sixty (60) days. If, under certain circumstances, the Health Plan cannot fulfill the request in 60 days, the Health Plan will notify the member in writing of reasons and their intent to extend an additional thirty (30) days.

10.0 Member's Right to Request to Receive an Accounting of Disclosures of Member's PHI

10.1 The Health Plan's has an implemented process to fulfill a member's request to receive an accounting of the Health Plan's disclosures of the member's PHI.

10.2 The NOPP supplies the member with instructions on how to request an accounting of disclosures. The member must contact the Health Plan's Customer Care Center to obtain and complete an "Accounting for Disclosure Authorization Form" (AD Form).

10.3 Once the member sends the completed AD Form to the Health Plan, the Compliance Department will research the request, collect the requested disclosure information, and send the information (up to six years) to the member.

10.4 The first request is free. Any additional request within a 12 month period may incur a fee.

10.5 The Health Plan will provide the member with an accounting of disclosures within sixty (60) days of request.

11.0 Member's Right to Request a Restriction on Use or Disclosure of Member's Health Information

11.1 The Health Plan has implemented a process to fulfill a member's request for restrictions on use or disclosure of member's Health Plan Record, in electronic or any other form.

11.2 The NOPP supplies the member with instructions on how to request a restriction. The member must submit the request for restriction in writing.

11.3 Once the request is received by the Health Plan, the Health Plan must agree to the restrictions unless the disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law. The PHI restriction will be posted as a flag or an alert on the member's account in all Health Plan systems.

11.4 If the Health Plan disagrees to the restrictions, the Compliance Director will document the reasons for disagreement, which are limited to carrying out

payment or health care operations or as otherwise required by law. A written notice of disagreement will be sent to the member.

11.5 The Health Plan may not use or disclose the member's restricted information, except that, if the member who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment. In the event the Health Plan provides the restricted PHI to a provider for emergency treatment, the disclosure will include the request to the providers not to further use or disclose restricted information which was disclosed for emergency purposes.

11.6 The termination of a restriction may occur as follows:

11.6.1 The member agrees to or requests a termination in writing;

11.6.2 The member orally agrees to the termination and the oral agreement is documented;

11.6.3 The Health Plan informs the member that it is terminating its agreement to a restriction, except that such termination is not effective for PHI restricted through HIPAA laws and regulations, and is only effective with respect to PHI created or received after the Health Plan has informed the member.

11.7 The Health Plan will fulfill the request within thirty (30) days of receipt of written request.

12.0 Member's Right to Request for Confidential Communication by Alternative Means or Alternative Locations

12.1 The Health Plan has implemented a process for member's requests for confidential communications by alternative means or at alternative locations.

12.2 The NOPP supplies the member with instructions on how to request confidential communications by alternative means or at alternative locations. The member must submit the request in writing.

12.3 Once the request is received by the Health Plan, if the member clearly states that the disclosure of all or part of the member's PHI could endanger the member, the Health Plan must accommodate the request to receive communications of PHI from the Health Plan by alternative means or alternative locations. The member's contact information will be updated in all Health Plan systems, and an alert will be posted in the Health Plan Customer Relationship Management System (CRM) on the members account.

If the member is an AHCCCS member, Customer Care Staff are required to change member contact information within the AHCCCS system. Telephone number and mailing address changes are made by Customer Care Staff logging into the AHCCCS System to make the change if the address remains within the same county. Address changes outside of the county must be made by the member contacting AHCCCS directly.

12.4 The Health Plan will supply the member with written confirmation of the Health Plan's agreement to the member's request.

12.5 If the Health Plan denies the member's request for any reason, the Health Plan's Compliance Director will notify the member in writing of the reason for the denial.

12.6 The Health Plan will fulfill the request within thirty (30) days of receipt of written request or immediately (within one business day) if the member clearly states that the disclosure of all or part of the member's PHI could endanger the member.

13.0 Discipline for Non-Compliance

13.1 The Health Plan will take disciplinary action against any employee or FDR who fail to comply with the Banner Health Corporate or Health Plan Code of Conduct, or policies, Federal and State laws and requirements.

13.1.1 Employees and FDRs are made aware that failure to report violations due to negligence or reckless conduct may result in disciplinary action.

13.1.2 Disciplinary actions for FDRs range from contract sanctions to immediate contract termination, as appropriate.

PERFORMANCE AND OUTCOME MEASURES

1.0 The Health Plan is fully compliant to all HIPAA requirements related to member rights and responsibilities.

2.0 The NOPP complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

REFERENCES

1.0 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

2.0 The Health Information Technology for Economic and Clinical Health Act (HITECH)

3.0 Omnibus Rule

4.0 Medicare regulations governing Parts C and D found at 42 CFR§ § 422 and 423 respectively.

5.0 NCQA Members Rights and Responsibilities

6.0 Banner Health Insurance Division Companies Compliance Program and Fraud, Waste and Abuse Plan.

7.0 Title 45 of the CFR, Part 164.522

8.0 Title 45 of the CFR, Part 164.526

9.0 Title 45 of the CFR, Part 164.528

10.0 Title 45 of the CFR, Part 164.508

11.0 Title 42 of the CFR, Part 2 – Confidentiality of Substance Use Discorder Patient Records

12.0 ARS 36-664

13.0 AHCCCS Acute Contract, Section D, Paragraph 20, Medical Records

14.0 AHCCCS EPD ALTCS Contract, Section D, Paragraph 78, Medical Records

ASSOCIATED POLICIES AND PROCEDURES

1.0 Health Plan Policy - CP 6230 Custodian of Records
2.0 Health Plan Policy - CP 6022 Maintenance and Retention of Health Plan Documents
3.0 Health Plan Policy - CP 6006 Health Plan Privacy and Security Safeguards
4.0 Banner Health Policy – 1323 Patient Notice of Privacy Practices
5.0 Banner Health Policy 381 Contracting with Business Associates
6.0 Banner Health Policy 382 Authority to Request Protected Health Information (PHI)
7.0 Banner Health Policy 390 Disclosures of Protected Health Information (PHI) to Law Enforcement/Government Officials
8.0 Banner Health Policy 1336 Use and Disclosure of Protected Health Information (PHI) Requiring Patient Authorization
9.0 Banner Health Policy 405 Use and Disclosure of Mental Health Information
10.0 Banner Health Policy 404 Use and Disclosure of Alcohol and Drug/Abuse Records
11.0 Banner Health Policy 408 Using, Disclosing and Requesting Minimum Amount of Protected Health Information (PHI)
12.0 Banner Health Policy 406 Use and Disclosure of PHI for Treatment, Payment and Health Care Operations
13.0 Banner Health Policy 396 Patient Requests for Records
14.0 Banner Health Policy 409 Patient Request to Amend or Supplement Records
15.0 Banner Health Policy 395 Patient Request for Accounting of Disclosures
16.0 Banner Health Policy 389 Disclosures of PHI Required by Law
17.0 Banner Heatlh Policy 1466 Disclosures of PHI in Judicial and Administrative Proceedings
18.0 Banner Health Policy 1335 Use and Disclosure of PHI Concerning Decedents
19.0 Banner Health Policy 401 Privacy and Security Mandatory Training
20.0 Banner Health Policy 2284 HIPAA Sanctions Policy
21.0 Banner Health Policy 1333 Disclosures of PHI to Family Members and Persons Involved in an Individual's Care
22.0 Banner Health Policy 399 PHI Breach Notification
23.0 Banner Health Policy 410 Workforce Confidentiality

ATTACHMENTS

N/A