

Protecting Patient Privacy

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When we last discussed¹ the Health Insurance Portability and Accountability Act of 1996² (HIPAA), Final Privacy Rule – Standards for Privacy of Individually Identifiable Health Information,³ the Department of Health and Human Services (DHHS) had reopened the public comment period and was accepting comments through March 30, 2001⁴. Despite much speculation to the contrary, DHHS decided not to make changes to the final rule, but instead, on July 6, 2001, DHHS issued, in the form of a detailed set of frequently asked questions and responses, the first of what it promised would be a series of “guidances” on the specific requirements of the Privacy Rule. The effective date of the Rule remained April 14, 2001, with a mandatory compliance date of April 14, 2003⁵. With required compliance only a year away, now is a good time to examine how the Privacy Rule, as informed by the DHHS guidance, specifically affects the delivery of rehab services.

The Privacy Rule and Referrals

Because the Privacy Rule prohibits the disclosure of “protected health information” (PHI) prior to obtaining the patient’s consent for “treatment, payment, or health care operations” (TPO), rehab service providers, and outpatient rehab providers in particular, are faced with a serious problem. How can a rehab service provider to whom a patient is referred for the first time, set up an appointment or schedule therapy without first obtaining the patient’s written consent to the use of the patient’s PHI?

DHHS states that “the Privacy Rule, as written, does not permit uses of PHI prior to obtaining the patient’s written consent for TPO. This unintended problem potentially exists in any circumstance when a patient’s first contact with a direct treatment provider is not in person.” Since virtually all of an outpatient rehab services provider’s business is generated by referrals from other providers, the Privacy Rule,

¹ Cherilyn G. Murer, J.D., C.R.A., *Trends and Issues: Privacy Packs a Punch*, April, 2001.

² Public Law 104-191.

³ 65 Fed.Reg. 82461.

⁴ 66 Fed. Reg. 12738.

⁵ 66 Fed.Reg. 12433.

as written, poses serious difficulties in generating new business. How, for example, can a physical therapist receive a referral from an orthopedist if the therapist cannot receive the patient's diagnosis before setting up the appointment?

The good news is that DHHS also states that "the Secretary is aware of the problem and will propose modifications to fix it." The bad news is that, to date, no such proposed modifications have been forthcoming. If DHHS does not modify the rule before the compliance date, outpatient rehab service providers should, as a stop-gap measure, supply the health care providers from whom they regularly receive patient referrals with PHI authorization forms that their patients can sign prior to the referral. Because the rehab services provider is itself a covered entity under the Privacy Rule, and because it will be seeking the authorization for its own purposes, the authorization will be subject to the "minimum necessary standard." The minimum necessary standard requires that most PHI disclosures be limited to "the minimum necessary to accomplish the intended purpose." In the case of rehab patient referrals, "minimum necessary" could mean that patient's name, address, phone number, age, diagnosis, and little else.

The Privacy Rule and the Rehab Treatment Environment

For rehab services providers, concerns about the minimum necessary standard go well beyond its effect on referrals. The very nature of some rehabilitation services like group therapy contemplates that patients will share PHI with each other. Other rehab services require delivery in an open environment, such as the PT gym or the OT ADL kitchen. Therefore, the minimum necessary standard, if strictly applied, could seriously disrupt the way rehab therapy is traditionally carried out. Fortunately, the guidance suggests that DHHS intends to apply a rule of reasonableness to the minimum necessary standard, and, therefore, the standard's impact on the rehab treatment setting, while not insubstantial, will not be too severe. As long as the rehab service provider's consent forms make it clear to the patient that the treatment will involve the sharing of PHI group therapy or will take place in an open setting where the patient's conversations with the therapist may be overheard by other patients and staff, the rehab provider should be able to continue to deliver services in the traditional manner without having to expend vast sums in structural changes to its facilities.

For example, in response to questions whether the Privacy Rule prohibits maintaining patient medical charts at bedside, X-ray light boards that can be seen by other patients and staff, and use of sign-in sheets in waiting rooms, DHHS responded that no specific measures are required by the minimum necessary standard. Thus, "while the Privacy Rule does not require that X-ray boards be totally isolated from all other functions, it does require covered entities to take reasonable precautions to protect X-rays from being accessible to the public. . . . We did not intend to prohibit the use of sign-in-sheets, but we understand that the Privacy Rule is ambiguous about this common practice. We, therefore, intend to

propose modifications to the rule to clarify that this and similar practices are permissible.”

Even though, once again, the proposed modifications are forthcoming, DHHS’ responses to these questions indicate that DHHS intends that the Privacy Rule will disrupt traditional practice as little as possible. In terms of the rule’s particular application to rehab services, it is probably safe to say that while the statement in the previous article that, “The use of a therapy board noting a patient’s name, room number and condition, that can be seen by any one in the clinic or on the unit, will be a mechanism of the past,” remains accurate, there is no need to throw the board away. Instead, positioning the board so that it is generally visible to the staff and not every patient in the facility probably will be sufficient.

The guidance’s discussion of the Privacy Rule’s applicability to oral communications lends even more force to the view that, while rehab services providers (like all other health care providers) must implement substantial privacy precautions, no radical change in the manner in which rehab providers dispense their services will be required. This conclusion is bolstered by DHHS’ statement in the preamble to its discussion of oral communications: “We also understand that oral communications must occur freely and quickly in treatment settings, and thus understand the heightened concern that covered entities have about how the rule applies,” and it is reinforced by the specific responses in the Q & A.

For example, in response to a question whether engaging in confidential conversations with other providers or with patients violates the rule if there is a possibility that the conversation could be overheard, DHHS replied emphatically:

“The Privacy Rule is not intended to prohibit providers from talking to each other and to their patients. . . . We also understand that overheard communications are unavoidable. . . . The Privacy Rule is not intended to prevent this appropriate behavior.”

Furthermore, DHHS included among the examples of appropriate oral communications: “A health care professional may discuss lab test results with a patient or other provider in a joint treatment area. . . . We will propose regulatory language to reinforce and clarify that these and similar oral communications (such as calling out patient names in a waiting room) are permissible.”

Even without the promised language proposals, it is clear from the guidance that rehab service providers will be able to continue to treat patients in the open settings, such as the gym and kitchen, that are most beneficial for their particular needs, and that therapists will be able to continue giving appropriate guidance to their patients in these settings.

DHHS also explicitly reassured providers that the Privacy Rule does not require the retrofitting of facilities to provide private rooms and soundproof walls in order to avoid any possibility that a conversation is overheard.

According to DHHS, “[t]he Privacy Rule does not require these types of structural changes be made to facilities. . . . ‘Reasonable safeguards’ mean that covered entities must make reasonable efforts to prevent uses and disclosures not permitted by the rule. The Department does not consider facility restructuring to be a requirement under this standard.” DHHS went on to specifically state that private rooms and soundproofing of rooms are not required.

DHHS then provided the following examples of reasonable safeguards:

- Curtains or screens in areas where oral communications often occur between doctors and patients or among professionals treating the patients; and
- Cubicles, dividers, shields, or similar barriers in areas where multiple patient-staff communications routinely occur. “For example a large clinic intake area may reasonably use cubicles or shield-type dividers, rather than separate rooms.”

Thus, rather than making prohibitively expensive and impractical alterations to existing facilities, rehab service providers may comply with the Privacy Rule by making relatively inexpensive adjustments to open treatment areas and waiting rooms. For example, setting off one corner of the PT gym with dividers for private conversations between the therapist and patient where the particulars of the patient’s condition and program can be discussed should be sufficient to comply with the Privacy Rule. This kind of affordable, practical measure coupled with consent forms that in plain language explain to the patient that some or all of the treatment may take place in group settings or open environments where other patients and staff may be party to or overhear conversations regarding the patients’ PHI should ensure a rehab therapy setting that is in full compliance with the HIPAA Privacy Rule.

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