

**MEDICAL ASSOCIATES HEALTH PLANS  
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL  
POLICY NUMBER: PP 57**

**POLICY TITLE:** CONFIDENTIALITY OF PATIENT INFORMATION

**POLICY STATEMENT:** It is the intent of this policy to ensure that protected health information (PHI) obtained during the course of activities of the Health Care Service Department will be kept confidential in accordance to standards set forth by HIPAA and Federal and State laws. This policy applies to all forms of PHI handled by all Health Care Services staff i.e. in person, telephone, mail, electronic transmission, and faxes. All Health Care Services staff are required to abide by the above policy and procedure. Failure to do so may result in disciplinary action including termination.

**Protected health information (PHI):**

- Is created, received, or maintained by provider, health plan, or clearinghouse
  - Relates to past, present or future healthcare
  - Identifies individual by name, or specific identifying elements which could cause individual to be identified
  - Is transmitted or maintained electronically or in any form or medium such as internet, extranet, leased line, dial-up line, private network transmission, information stored on paper, information read from computer screens and discussed orally, telephone calls, voice mail, video conferencing, and faxes.
1. This information will be used solely for the purposes of utilization review, quality assurance, discharge planning and case management. Protected health information is to be released only for treatment, payment, or operation (TPO) or as required/allowed by law and then only to those who have a “need to know” and only the “minimum necessary” to be released. Any other information requires a release of information form. The authorization for release of information must be documented and will be kept on file in a chronological file.
  2. Patient information will only be shared with such staff as the MAHP Chief Medical Officer, Health Care Services staff, Quality Improvement Committee, appropriate claims processing staff who have authority to receive such information, stop loss carriers, transplant networks, Marketing Department, and Finance Department, and external review organizations. This information will be shared on a “need to know” basis for MAHP to perform treatment, operations, or payment.

In addition to the above departments, PHI for self-funded clients may be released to the Benefits Consultant for the purposes of coordinating management of the self-funded health plan with the sponsor of the health plan, stop loss carriers and internal departments. Identifiable PHI will not be released to Marketing Account Representatives.

Internal routine disclosures for the purposes of Treatment, Payment or Operations are those disclosures, which occur on recurring basis in the normal administration of the MAHP. Examples include information exchanged between:

- Claims and Health Care Services Department for the purpose of claims processing or health care management activities;

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- Patient Services Department, Claims, Member Services and Health Care Services for the purpose of member eligibility, claims processing or health care management;
- Finance, Contracts/Compliance, and Health Care Services for the purpose of management of stop-loss coverage, underwriting activities, health plan management, or health care management activities;
- Marketing and Health Care Services for the purpose of management of group renewals. Research supplied on large claims data for group renewal will include the diagnosis and prognosis of the member. No member names will be supplied.

All disclosures, which do not qualify as allowable under “treatment, payment, or operations”, will be considered non-routine and must be considered on an individual basis. Some requests may be allowable under other sections of the code or may require a signed authorization. It is the decision of the Privacy Officer as to when disclosures are appropriate.

3. Summary data will not be considered confidential if it does not provide sufficient information to allow identification of individual patients.
4. All protected health information (PHI) will be stored in a locked drawer or cabinet at the end of each workday.
5. All recycling bins are to be emptied at the end of each workday into central recycling bin for shredding. Any PHI to be discarded will be shredded on site for added protection.
6. All pcs are to be “locked” when not in attendance.
7. The copy machine will not be left unattended during the process of copying any material that contains PHI. When copiers jam, every attempt should be made to retrieve any jammed material that contains PHI.
8. All faxes being sent from Health Care Services will have a cover sheet and subsequent pages stamped confidential if they contain PHI.
9. When printing material that contains PHI, every attempt will be made to retrieve printed material as soon as possible after printing.
10. Each employee will have their own password to access pc programs. Passwords are not to be shared. Program access (security level) will be assigned by the respective supervisor at the time of employment. Program access is reviewed as needed such as when new program or application becomes available.
11. Ongoing educational sessions are performed by the Director and/or Manager of Health Care Services/Quality to update staff on any changes, new rules or interpretations. These sessions will occur at regularly scheduled staff meetings and documented in the minutes. Sign in

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sheets are kept on file to document educational sessions. If employee is not present at staff meeting, the employee will review the documentation and sign as having read and reviewed it. In addition, documentation on training sessions on HIPAA is kept in the HIPPA Manual. A copy of the educational session is also incorporated into the HCS Orientation Manual. Documentation will be kept on file for six years.

12. Past Chronological files containing denials, appeals, PHI, etc. will be stored in the designated locked storage center in a properly marked box noting contents of the box, and date to be destroyed. The box will be placed in storage only after the file sheet has been logged in the electronic file for storage materials.
13. Any material that has been forwarded to Health Care Services for review in the referral, concurrent review, retrospective review processes will be kept in a locked location as noted above. Should the material contain such items as photos, they will be returned to the provider office, facility etc., and will be sent in a sealed in an envelope stamped confidential. Any PHI that is sent to provider offices via interoffice mail, will be stamped confidential and placed in a secured envelope. If verification is obtained from the provider office or facility to destroy the documents, a note will be entered into the system of what was destroyed, how it was destroyed, date and time.
14. Any emails sent by this department, which contain PHI will adhere to company email policies and procedures.
15. Should a member request that PHI be released to a relative or other representative, the member may give verbal consent over the telephone if situation is temporary. The HCS staff will send a release of information form to the member for signature in order for HCS to speak to a representative about PHI information. if the length of the situation is undetermined. Both verbal and written releases are document in the information system. If PHI is to be sent to the representative, the following information will be obtained prior to release of information:
  - Enrollee's name
  - Enrollee's member number
  - Statement that appoints an individual, as their representative-an example of that statement would be: "I (enrollee's name) appoint (name of person acting as the representative) to act as my representative"
  - length of time release is authorized ( may be a one time release or a designated time frame)
  - Enrollee's signature and written date of the statement
  - Signature of the representative and the date.

This procedure applies to all MAHP members. The signed statement will be kept on file with the respective documentation.

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Should PHI be released without authorization, or as otherwise permitted/required by law, follow MAHP Administrative Policy #4. Breach Notification

16. An audit to ensure compliance with the HIPAA Privacy/Security Act is performed on a quarterly basis. Additional audits may be conducted on an as needed basis. All such audits will be documented and kept for a period of six years. Any non-compliance discovered during an audit will be discussed with the Health Care Services staff, either on an individual or group basis, for the purpose of refining procedures to prevent non-compliance in the future. Ongoing non-compliance may result in disciplinary actions up to and including termination. Any audit which results in discovery of non-compliance shall be reported to the Privacy Officer and the Director of Human Resources, if appropriate.

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Judy Riniker, R.N.  
Manager of Health Care Services/Quality Improvement

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Date

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Mary Leary, R.N.  
Director of Health Care Services/Quality Improvement

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Date

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