

HIPAA

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The Health Insurance Portability and Accountability Act (HIPAA)¹ is a massive piece of legislation that is having a profound impact on many aspects of health care and health insurance in the United States. The intent behind this legislation was to protect electronically stored individually identifiable health information and electronic data interchange (EDI). With EDI becoming the common method of transferring data for health care and billing purposes, Congress feared that that the easy interchange might lead to a risk to privacy and security of individual health care information.

Law enforcement officers will encounter HIPAA restrictions in a variety of ways. For example, officers often expect to receive information as to a victim's medical condition from EMS crews at the scene, or from the hospital emergency room, and it is expected that those interactions will be strictly limited under the new regulations. If the patient is able to consent to the release of the information, the officers should have no problem, but if the patient refuses or is unable to consent, the officer will need to take further actions to get access to information that is needed immediately, when that information is held by a "Covered Entity."

"Covered Entities," or CE, are those entities which are subject to HIPAA regulation. CEs include health insurance plans, healthcare clearinghouses and healthcare providers who transmit health information electronically with specified transactions codes – in other words, virtually all hospitals, EMS services and other healthcare providers.² Health care information is defined very broadly and includes any information that relates to an individual's past, present or future medical information or care. The regulations specifically cover "protected health information" or PHI, which is any healthcare information that is "individually identifiable," that information that can be directly tied to a specific individual.

Individual CEs are expected to develop policies and procedures to limit the amount of information exchanged to that which is the minimum necessary to achieve the purpose. HIPAA requires that a patient's authorization be obtained for any disclosure of PHI that does not meet a specific exception, and it is expected the CE will develop forms for that purpose. (And unfortunately, this also means that every CE may have a different form for the purpose.)

There are exceptions to the requirement for this authorization, but they are very strict and very limited for law enforcement³. (They will be discussed later in this paper.) Disclosure that is required by state law continues to be allowed under

¹ Public Law 104-191 (Aug. 21, 1996)

² 45 C.F.R. §160.103

³ 45 C.F.R. §164.501 et seq.

HIPAA, if that disclosure is mandatory. If the state only permits disclosure, it may be argued that disclosure is not permitted under HIPAA.

In Kentucky, the type of disclosures that are mandatory include the following:

- a) Psychiatric hospitals are required to notify law enforcement if an involuntarily committed patient escapes or is released, if that patient has been charged with or convicted of a violent crime. (KRS 202A.410)
- b) Medical and other professionals who suspect insurance fraud (KRS 304.47-050)
- c) Medical professionals (and in fact, anyone) who has knowledge concerning child (KRS 620.030) or adult abuse (KRS 209.030, 194A.709). (see below)
- d) Reporting of a suspicious death to the coroner (KRS 72.020)
- e) Public health issues (see below)
- f) HIV-AIDS (see below)
- g) Animal bites (see below)
- h) Pharmaceuticals (see below)

Under KRS 202A.410, psychiatric hospitals are required to notify certain law enforcement agencies if a patient who has been involuntarily committed and who has been “charged with or convicted of a violent crime as defined in KRS 439.3401⁴” is released or escapes from the facility. If the patient is released, the notification is the “law enforcement agency in the county to which there person is to be released,” and if they escape, it is to the agency in the county where the facility is located. (Other notifications are to be made to the Kentucky Department of Corrections and local prosecutors.)

4 439.3401 Parole for violent offenders -- Applicability of section to victim of domestic violence or abuse -- Time of offense.

(1) As used in this section, "violent offender" means any person who has been convicted of or pled guilty to the commission of:

- (a) A capital offense;
- (b) A Class A felony;
- (c) A Class B felony involving the death of the victim or serious physical injury to a victim;
- (d) The commission or attempted commission of a felony sexual offense described in KRS Chapter 510;
- (e) Use of a minor in a sexual performance as described in KRS 531.310;
- (f) Promoting a sexual performance by a minor as described in KRS 531.320;
- (g) Unlawful transaction with a minor in the first degree as described in KRS 530.064(1)(a);
- (h) Human trafficking under KRS 529.100 involving commercial sexual activity where the victim is a minor;
- (i) Criminal abuse in the first degree as described in KRS 508.100;
- (j) Burglary in the first degree accompanied by the commission or attempted commission of an assault described in KRS 508.010, 508.020, 508.032, or 508.060;
- (k) Burglary in the first degree accompanied by commission or attempted commission of kidnapping as prohibited by KRS 509.040; or
- (l) Robbery in the first degree.

The court shall designate in its judgment if the victim suffered death or serious physical injury

The issue of reporting real or suspected child abuse, at 620.030, is relatively simple and uncontroversial; it applies to medical professionals of all types. Adult abuse, however, is more complex. The duty to report abuse of an adult is codified at KRS 209.030, however, the definition of “adult” for this chapter does not include all adults. Specifically, KRS 209.020 defines an adult as “(a) [a] person, eighteen (18) years of age or older, who because of mental or physical dysfunctioning, is unable to manage his own resources or carry out the activity of daily living or protect himself from neglect, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services; or (b) [a] person without regard to age who is the victim if abuse and neglect inflicted by a spouse.” In other words, someone who is so mentally or physically disabled as to be unable to exercise independent actions, or someone who is abused by a spouse. As spouse is not otherwise defined in Kentucky statutes, the law will revert back to the common-law usage, which is that a spouse is one’s legal husband or wife. Since Kentucky does not recognize common-law marriage, a medical professional would only be permitted under HIPAA to report abuse of someone who is in fact in a marriage recognized by Kentucky law, not other individuals who are in domestic or family relationships, if the victim is 18 or older and apparently competent. While law enforcement officers (through their agencies) are required to report the abuse of all incidents of domestic violence and abuse involving family members, members of unmarried couples and household members⁵, under KRS 403.785, of which they have knowledge, medical professionals will not be allowed to report any instances of abuse that do not fall under KRS 620.030, KRS 209.030 and KRS 194A.709. (The latter refers to residents in long-term or assisted care facilities, and who would also, in most cases, fall under KRS 209.030.)

Any medical professional who holds a license or is regulated by the Commonwealth is required to report suspected insurance fraud. (KRS 304.47-050) Although the statute isn’t specific, presumably they are permitted to share sufficient information as to enable the Department of Insurance to make a decision concerning an investigation. The Department of Insurance is then permitted to make requests to the insurer, and the insurer is required (and thus protected under HIPAA) to provide the requested information in a timely manner.

With regards to general public health reporting standards, Kentucky law requires that reports be made of HIV-positive test results, to the state Cabinet for Public Health, although there is a provision for anonymity. Chapter 211 generally covers these issues, both for HIV and for other sexually-transmitted diseases. State Public Health is also authorized to take such action as the department

⁵ Note that this statute does not define “household members.” In *Ireland v. Davis*, 957 S.W.2d 310 (Ky.App. 1997), the court held that the term unmarried couple “refers to two people engaged in an intimate relationship and would not include roommates.” Therefore, it is unclear whether a court would hold that roommates (whether same gender or opposite gender) would be covered under “household members” or not. A recent case, *Barnett v. Wiley*, 2003 WL 1936582 (Ky.) indicates that the Kentucky Supreme Court is inclined to consider that the term “household members” to be “persons who are cohabiting in the same place.”

deems necessary to monitor the spread of infectious and contagious diseases and to initiate quarantine and isolation as needed, and to report such diseases as designated by regulation to the appropriate authorities. (KRS 214.010, KRS 214.020, KRS 214.645 and 902 KAR 2.020). Medical laboratories may also be required by the Cabinet for Public Health to make certain reports. (KRS 333.130). This last statute may be problematical in that the federal statute suggests that only mandatory reporting will be allowed under HIPAA – and the Kentucky statutory language suggests, at least, that the order for reporting may be done on a case by case basis from Public Health, rather than by statute or regulation, because of the time needed to have even a new regulation passed. (An example is the potential SARS epidemic – since right now, SARS is not on the mandatory reporting list in Kentucky. However, SARS was added to the federal quarantinable communicable disease list as of April 4, 2003. This does not in and of itself require reporting, but presumably issues regarding SARS will be handled under the public health exception to the law.)

Certain issues also arise with prisoners and individuals who are arrested and in custody, with regard to specified diseases. KRS 71.130 states that prisoners shall be tested for infectious diseases under appropriate circumstances, and test results may be shared with those who have a need to know the prisoner's health status. (However, all other privacy protections remain in place for these prisoners.) KRS 510.320 states that defendants shall be tested for HIV upon conviction for crimes in which sexual contact is an element, and the results of such tests shall be shared with victims and others specified by the statute. There is no equivalent provision for other sexually-transmitted diseases, although a judge may order such testing on an individual basis if deemed appropriate. In addition, a criminal defendant or inmate who bites another inmate, a correctional officer or other public servant may be ordered by the court to undergo testing for a variety of contagious diseases, and the results of such testing shared with the victim (KRS 438.250).

Physicians are required, under KRS 258.065, to report, within 12 hours of "first professional attendance" dog, cat and other animal bites to the local health department.⁶

While Kentucky law does not require pharmacists and physicians who suspect drug abusers or "doctor shoppers" to report, they must allow law enforcement to inspect their records (KRS 218A.230). Records may be seized upon the presentation of the appropriate court order. (KRS 315.220 permits designated enforcement agents of the Board of Pharmacy to make such inspections and seizures, at their sole discretion, as well, but states that the records will otherwise remain confidential.) CEs that allow law enforcement to inspect records of any type are required to document this disclosure and to notify the patient concerning

⁶ In fact, every person bitten, even if no physician is involved, is required to report bites. Failure to report bites is a violation under KRS 258.990.

the disclosure. It is anticipated that CEs will develop their own procedures to document and notify when necessary.

LAW ENFORCEMENT SPECIFIC

CEs will be required to release information pursuant to court orders, search warrants, summons and subpoenas. Search warrants for such information must specifically list the documents required. Subpoenas duces tecum, signed by judicial officers, for the production of documents may also be used,⁷ and finally, grand juries may request the production of medical records. (Summons are not used in Kentucky for the production of records.) Law enforcement agencies that investigate administrative violations may also use these court orders to request production of documents. In each case, the CE is expected to release only the documents specified by the order or the minimum amount needed to satisfy the purpose of the request. Officers are cautioned to give a great deal of thought as to what they need when requesting search warrants and court orders, to ensure that they are able to obtain the desired information.

HIPAA also permits the release of a limited amount of information in response to a law enforcement officer's request for the purpose of identifying or locating a suspect, fugitive, witness or missing person. (The CE is not required to make this disclosure, but they may do so if they choose.) Certain limited information may be released, such as name, address, DOB, SSN, blood type, injury, treatment, death (if appropriate) and distinguishing physical characteristics. Information as to the analysis of body fluids or tissues (such as blood alcohol) may not be released under this provision, although the officer may request a separate sample of these fluids under KRS 189A.103, as in the case of DUI, for example. (In this situation, the medical provider will be extracting the sample, but not performing the analysis of the sample, so HIPAA provisions will presumably not apply to the testing agency. The state lab would not qualify as a CE.) An example might be law enforcement officers making the rounds of hospitals searching for a missing person or material witness; the officer would be allowed to share information with the hospital concerning a name or description and if the hospital does in fact have a person in the hospital, the hospital would be permitted to share the information listed above with the officer.

The most problematic exception deals with a law enforcement officer's request for medical information concerning the victim of a crime or a wreck. If the individual agrees, of course, information may be shared with the officer, but if the victim is incapable of agreeing, the officer must 1) represent that such information is necessary to determine if a violation of law occurred by some person other than the victim, and that such information is not intended to be used against the victim, and 2) the officer represents that the law enforcement needs

⁷ The language of the regulation indicates that subpoenas duces tecum signed only by a requesting attorney, as is common in many civil cases, will not be honored, absent a court order or a specific consent from the patient for such documents.

would be materially and adversely affected by waiting until the victim is in a position to agree, and 3) that the disclosure is in the best interests of the victim. CEs are being advised to get this information in writing from the officer, and to develop an internal process to evaluate if the disclosure is appropriate. This process may prove to be cumbersome and time-consuming for officers in emergency situations, and the process for each medical provider may prove to be different. Agencies are encouraged to discuss the matter in advance with local medical providers, especially with hospital emergency rooms and EMS responders, and learn in advance what requirements they will need to meet and what procedures will be in place to get a release of information. At best, officers may find themselves facing delays in getting information about victims until the medical providers can satisfy themselves as to the immediate need.

However, if an officer is present at an injury call, and overhears medical or other information while assisting EMS, that is considered an “incidental disclosure.” An officer who is summoned into a residence because an EMS crew member, who is lawfully in the residence, has spotted something that may be evidence of a crime may be able to argue that the provisions of Hazelwood v. Com., 8 S.W.3d 886 (Ky.App., 1999) which permits the law enforcement officer to be summoned by another public safety officer who is lawfully at the scene and has inadvertently come across contraband to secure the contraband.⁸ Certainly, contraband is not “protected health information.”

There are also a few situations that apply to law enforcement in which a CE is not required to seek authorization before making a disclosure to law enforcement.⁹ In these cases, the CE will be taking the initiative, not responding, necessarily, to a request from law enforcement. These exceptions include when the disclosure is necessary to “prevent or lessen a serious and imminent threat to the health or safety of a person or the public,” to individuals who are threatened (including the law enforcement agency that may be able to mitigate the threat), or “because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim.” However, it should be noted that the CE is not required to disclose any information in this situation, but is only permitted to disclose by HIPAA, and that each CE will develop their own criteria and procedures to disclose such information. The law will require that the CE inform the patient that they have made such a disclosure, unless the CE believes that notifying the individual would place the patient or someone else at further risk. (As an example, if the apparent perpetrator is present, it would not be required, nor would it be advisable, for the medical provider to tell the patient that law enforcement has been notified.)

On a related note, Kentucky is one of a minority of states that does not require medical providers to report to law enforcement injuries connected to firearms or

⁸ In Hazelwood, a firefighter responding to a fire scene found marijuana.

⁹ 45 C.F.R. §164.512(j)

other deadly weapons, such as knives. Public Health collects statistics on such injuries, but this information is “de-identified,” which means that it is not possible to connect a report to a particular individual; this type of data collection is permitted under HIPAA. The law is unclear if medical providers will be able to make such reports, although if they believe the injury fits another exception to the law, it will be permitted. Certainly, if an officer becomes aware of the injury, they may investigate it, and the officer may request information under the law enforcement exception, but if the law enforcement agency is not aware of the injury, hospitals and other medical providers may find themselves unwilling to risk making the report. Again, this is an issue that agencies should discuss in advance with local medical providers. One example that might illustrate this particular issue is a patient presenting at the hospital with a bullet wound. If the patient states that it was “an accident” and they do not want law enforcement to be notified, and the doctor believes, from the angle of the penetration, that it could not have been a self-inflicted accidental injury, the medical provider (doctor/hospital) must make a decision as to whether this disclosure is permitted.

While the implementation of HIPAA became effective as of April 14, 2003, it is anticipated that questions will continue to arise related to the interpretation of this law. Officers and agencies are encouraged to discuss the ramifications of HIPAA with local prosecutors and legal advisors, and to communicate their concerns and share problems that have arisen locally with their local legal advisors and with the Kentucky Department of Criminal Justice Training.

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