

## **ALWAYS CONSULT LEGAL ADVICE**

### **PSYCHOTHERAPY CHART NOTES AND THE HIPAA PRIVACY REGULATION**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) outlines five regulations which will significantly change the manner in which health care information is collected, transmitted and protected. Once such regulation relating to privacy becomes effective in April 2003.

Since the Privacy Regulation pertains to oral and written communication as well as electronic, it affects most healthcare providers.

Under this regulation, providers will be required to post detailed privacy policies in a conspicuous place to advise patients of their rights, including the right to request their personal medical record.

HIPAA access to medical records is much more permissive than current law, except with regard to psychotherapy notes.

Mental health professionals are permitted to maintain psychotherapy notes separately from the rest of the chart. These psychotherapy notes may represent personal notes used to record or analyze group, individual or family therapy, and unlike the rest of the chart do not have to be disclosed to the patient.

However, under the HIPAA Privacy Regulations, psychotherapy notes are secured by a specific authorization, not by a general consent.

Non-psychotherapy notes are maintained in the patient's chart; any items falling into the non-psychotherapy notes category must be disclosed to the health plan and also to the patient, with only a general consent.

With patient authorization (specific disclosure with expiration and/or revocation rights) psychotherapy notes may also be disclosed to the health plan.

By HIPAA definition, "non-psychotherapy notes" include notes relating to:

- Diagnosis
- Functional status
- Treatment plan
- Progress notes
- Medications
- Prognosis
- Symptoms
- Treatment encounters, and
- Clinical tests

One alternative for behavioral health providers is to maintain notes for the patient and the health plan in one part of the chart, and psychotherapy notes for the professional provider as the "creator" and the health plan in another part of the chart.

Under some circumstances non-psychotherapy notes may be sufficient to meet health plan needs for documentation. However, the quality of record keeping varies widely and access to psychotherapy notes may be necessary to make payment on some claims.