CCH Healthcare Compliance LETTER

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Letters to the Editor

The CCH Healthcare Compliance team welcomes comments or questions regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinsks@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.

Healthcare HR survey shows unions maintain a stable presence

by Judith A. Tichenor, J.D., L.C.S.W., Contributing Editor

Unions are continuing to express their presence in the healthcare employment community, according to the 21st Labor Activity Report presented by the American Society for Healthcare Human Resource Administration (ASHHRA) at its recent 2003 annual conference. The report indicates that, while union election wins continue to decline since peaking in 1999, the percentage of times unions have won has steadily risen. According to the report, this may be an indication that unions are "strategically targeting their battles," with a greater focus on choosing more receptive organizations to target. Also, union organizers may be getting more sophisticated in knowing and understanding their targets, while hospitals may be getting "less vigorous" in their response to union organizing.

The report further states that the total percentage of survey respondents who indicated current unionizing activity remained stable from a previous report (12.3 percent for the 21st report versus 11.6 percent for the 19th report). However, 50 respondents reported union activity (versus 36 from the previous year), a 39-percent increase. Also on the rise was the number of bargaining units targeted, with the 50 survey respondents identifying 103 bargaining units. In the previous year, only 37 bargaining units were identified. Service employees, in conjunction with registered nurses, were the largest bargaining units, sharing a joint total of 44 percent of the responses. The largest overall increase in an identified bargaining unit was among registered nurses, with a 238-percent increase in responses, and professional employees, which had a 250-percent increase.

The survey indicated that the Service Employee International Union (SEIU) most frequently targeted hospitals, with 153 petitions. Other unions showing high activity in the healthcare arena included the California Nurses Association (an affiliate of the United Food and Commercial Workers union), with 31 petitions; the American Federation of Teachers (six petitions) and the American Nurses Association (five petitions). The unions reportedly used offsite meetings (15.2 percent) most frequently as a tactic to organize employees, followed by vocal employee advocates (12.1 percent), leaflets/handouts (11.3 percent), one-on-one selective contact by employees (10.9 percent) and by unions (9.4 percent), and home visits (8.8 percent).

According to the survey, the unions' organizing efforts focused on benefits and pay as the top issues (14.6 percent and 13.9 percent, respectively). These issues were followed closely by staffing (11 percent), respect and recognition (9.8 percent), leadership (9.1 percent), and lack of employee input (7.7 percent).

The 2003 ASHHRA conference was held from August 17th to 20th in Denver, Colorado. ■

CCH Chicago Bureau, October 27, 2003

New EMTALA regs require changes to on-call procedures

by Catherine Hubbard, MA, Contributing Editor

The new Emergency Medical Treatment and Labor Act (EMTALA) regulations, effective November 10, will require hospitals to change their on-call rosters, according to Jane Conard, senior counsel to Intermountain Health Care, Salt Lake City, Utah, and Suzie Draper, corporate compliance and privacy officer at Intermountain Health Care. They spoke at the fall Health Care Compliance Association/American Health Lawyers Association conference in Washington, D.C.

The Centers for Medicare & Medicaid Services (CMS) regulations released on September 9 are the final version of proposed regulations published in May 2002. "There aren't a lot of new surprises, but there are a few," said Conard. The new regulations clarify that a hospital must keep a list of physicians that are on call to stabilize patients in the ER. "Physicians must respond within a reasonable period of time or else the hospital and physician may be in violation," she said.

The regulations also clarify that physicians are not required to be on call 24-7. The feds have acknowledged that if there are only a few specialists (between one and three), then the facility should determine a call schedule that best meets the needs of the patients. Previously, the regs contained a "rule of three," for hospitals that had three specialists. Under the previous rule, each specialist was to be on call every third night and third weekend, she noted.

The regulations also clarify that a specialist may be on call at two different facilities at the same time. "This clarification is a mixed blessing," said Conard. It acknowledges problems facilities face in rural or physician shortage areas, but it removes any leverage a hospital might have to encourage specialists to provide full call service, she said. "More and more hospitals are being backed into a corner," she said, noting that most hospitals now pay for physicians to be on call. This can lead to budget problems for the hospital, she said. "When specialists are being paid simply to be available," she said, "the question is, who is going to foot that bill?"

Also clarified is the definition of a dedicated emergency department (DED), which includes not only the ER, but also any place that has a labor and delivery department or a psychiatric department open to the public, said Conard. In addition, the regs clarify that an urgent care center may be considered a DED if the center is operated through the hospital's Medicare number, regardless of whether it's on-site or off, she said.

> **"The new regulations clarify that a hospital must keep a list of physicians that are on call to stabilize patients in the ER."**

Areas where EMTALA doesn't apply. EMTALA does not apply to off-campus, hospital-based facilities that do not provide emergency care, Conard added. Therefore, services like dialysis and physical therapy are not within EMTALA. However, staff will need to know how to handle an emergency, she said. "You will need to have policies in place to have inpatients provide basic first aid and call 911 in case of an emergency."

The regulations also do not apply to inpatients, Conard noted. "Once a patient has been admitted, then EMTALA is no longer applicable." Outpatients that come for a scheduled service are not subject to EMTALA—unless, of course, they have an accident while at the facility, she noted.

In addition, patients coming to the ER for non-emergency care are not subject to EMTALA. "[When] a parent shows up at 8:00 PM and says, 'My son has to have his sports physical so that he can play tomorrow,' that is not subject to EMTALA."

Preparing for a state survey. To be ready for a state visit, hospitals should make sure they have all of the medical records in one location, said Draper. "If you don't have the full picture, you can cause yourself grief when the state surveyor visits. Make sure you have all of the medical records, both electronic and paper, in one place."

Draper also recommended that hospitals document all transfers. She noted that often patients are transferred from hospital to hospital or physician to physician without proper documentation.

Surveyors will ask whether:

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EMTALA (cont.)

- A medical screening exam (MSE) was provided by a qualified medical person, as defined in the hospital's rules and regulations.
- Treatment was provided to minimize the risks of transfer.
- The physician signed the certification.
- The hospital obtained consent of the receiving hospital to accept the transfer.
- There was a delay in the MSE or in the stabilizing of treatment in order to inquire about payment status.

During the exit conference, the administration needs to have a presence, Draper said. She suggested the administration take notes, ask questions if the requirements are unclear, request reference tags to requirements that are discussed and note any suggestions for changes to policies, forms or processes. The administration can make an audiotape as long as it makes a copy available to the surveyors, she noted.

A QIO review will be needed to determine whether the screening exam and stabilizing treatment was appropriate, whether the patient had an emergency medical condition, and whether transfers were appropriate, including those of pregnant woman, said Conard. "You need to be sure you have strict criteria for labor and delivery." She added that hospitals need to ensure nurses are trained to screen pregnant women for readiness to deliver.

Plan of correction. A hospital found in violation needs to develop a plan of correction, which should include a cover letter, Conard said. "This is not an admission of guilt," she emphasized. "Make sure you have made a statement as clear as possible. And make sure it's realistic." Hospitals should aim to stay within the minimum of the law, she noted.

The plan should state:

- How the systemic problem that caused the deficiency will be corrected.
- How the hospital will prevent the problem from recurring. "Say how you will notify your ER staff that there's been a change in your on-call roster. This is an area that can get you really tripped up," she warned.
- Information from the hospital's internal investigation.
- What steps have been taken to resolve the violation.
- How the hospital has monitored compliance with the plan of correction. ■

CCH Chicago Bureau, October 31, 2003

Fraud & Abuse

Pharmacist indicted for Medicaid fraud

by Sharon Sofinski

The U.S. Attorney for the District of Colorado recently announced the arrest of pharmacist Dien Ngoc Nguyen for healthcare fraud, illegally dispensing controlled substances, and filing false tax returns.

Charges filed. According to the indictment, Nguyen did not purchase sufficient supplies of prescription drugs from legitimate distributors to support the bills he submitted to the Colorado Medicaid program. The indictment charges that Nguyen billed and received payments from Medicaid totaling at least $458,699 for prescription drugs that he did not supply to Medicaid recipients.

In addition, Nguyen allegedly conspired to dispense and distribute Schedule II and III controlled substances, including dilaudid and hydrocodone, by filling fraudulent prescriptions for those drugs. Nguyen also faces charges of filing false income tax returns for 1998 and 1999.

The Federal Bureau of Investigation (FBI), the IRS Criminal Investigation division, the Criminal Enforcement Division of the Food and Drug Administration, and the Medicaid Fraud Control Unit in the Colorado Attorney General's Office participated in this investigation.

"Health care fraud harms everyone," said James D. Vickery, Special Agent in charge of the IRS Criminal Investigation. "It creates an untaxed economy that uses legitimate businesses to launder illegal proceeds, and increases the cost of legitimate health care."

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2004 OIG Work Plan: Beyond the basics

by Bill Dacey, MHA, MBA, CPC

Although we have come to see some elements of the Health and Human Services (HHS)/Office of the Inspector General (OIG) Work Plan as perennials, there appears to be a theme emerging. For the last three years the Plan has been characterized by a mix of old and new items, but this latest year appears to include somewhat more sophisticated Plan elements.

This year the carryover items from the 2003 Plan are E/M visits, Consults and "Incident-to" related concerns. Incident-to has now made the list four years running. Those elements that either persist or are being added often have a distinct fiscal theme; these are the areas that have a significant financial impact on the Medicare program. Inclusion in the Plan fairly guarantees that an item or area has fiscal heft or offers an obvious insult to system integrity.

Familiar Plan elements such as Teaching Physician issues and Bone Densitometry are gone for now, replaced in the latter case with diagnostic tests in general. The 2004 list is actually well balanced with mainstream coding and billing concerns, potential coding abuse situations, and monitoring of outright fraud and non-compliant activities.

What is new is the level of sophistication related to two of the new items: Use of Modifier –25 and Use of Modifiers with the National Correct Coding Initiative Edits. What we have here are efforts to detect incorrect payments masked by use of CPT coding conventions and mechanisms. These types of reviews are aimed at those providers who know how to use the CPT coding and billing system—to their benefit. Certainly there is room for interpretation as to correct application of these modifiers, but OIG is also on to something here as this area is also ripe for inspection.

The Perennial Items: E/M by Any Other Name

Three items make the list for at least the third year running: Coding of E/M services, Consultations and Services Incident-to. The consults are a subset of the E/M codes and those services most likely billed as incident-to are also E/M. Let's update these first.

No mystery about why these items remain on the list. In the description for the general E/M element OIG points out that Medicare allowed over $23 billion for these services in 2001. When this element was first added in 2002, the number was $18 billion. In two years we have seen close to a 30-percent increase in this area—and problems with these codes persist. This year the item specifies "an assessment of the adequacy of controls to identify physicians with aberrant coding patterns, specifically coding disproportionately high volumes of high-level evaluation and management codes that result in greater Medicare reimbursement." Although OIG gets marks for effort here, this approach may prove difficult.

In order to determine "aberrant patterns," there needs to be some sense of the norm in order to detect outliers. The fact that so many physicians under-report their services, due to either fear or lack of understanding, skews current coding profile curves towards the left. This would have the effect of making those that code more accurately, or higher in the case of most primary care providers, appear to be shifted more towards the right. These "false positive" standard deviations from the "norm" may trigger audit activity in areas where it isn't needed. Certainly some sophisticated profiling is needed here, and at the provider specialty level.

The second comment here indicates that OIG will also "assess the accuracy and carrier monitoring of E/M coding." The accuracy of coding is up to the providers again but it is of interest that OIG does not yet appear to have complete confidence in the carriers to carry out such reviews on their own. In the early days of E/M auditing, then HCFA had promised that one quarter of one percent of all E/M visits would be reviewed; these figures have never been approached.

Whether E/M is being reviewed by OIG or carriers, the importance of monitoring these services on the federal "to-do list" is clear. For those who need the annual OIG Plan as an indicator of what compliance items to watch in your practice, here it is again—E/M in all its forms. These codes remain the single largest source of Medicare Part B payments to physicians.

Consults, Again

For the third year those E/M codes devoted to consults have made the Plan. The text points out that Medicare allowed consultation charges in the area of $2 billion during the year 2000. This language is unchanged since the 2002 Plan. By now the 2002 consult numbers should be in. These would provide an interesting comparison but they are not provided here.

This year the element mentions that "we will determine the primary reasons for any inappropriate billing." Once again, the reason for OIG interest is quite clear. But it should

also be clear why this is still being done incorrectly—the physicians still don't get the difference between a consult and a new patient. As mentioned in our review of previous Work Plans, these codes have been the subject of many carrier bulletins, and education on the proper use of these codes has also been promoted for some time. By now it would seem that all providers must have been told at least once how these codes are supposed to be used. By now it would appear that any misuse here would have to fall under the category of "willful disregard" or "deliberate ignorance"—it has just been going on for too long and in most cases it is not an accident that the result financially favors the provider. If even ten percent of consults billed should have been coded as new patients, we are talking about tens of millions of dollars spent inappropriately.

Incident-to: The Fourth Generation

The final area included in the plan that may be generally regarded as part of E/M is the Incident-to element. Here again OIG seems to be searching for the handle, as one of the comments is that "little information is available on the types of services being billed, questions persist about the quality and appropriateness of these billings." This is most interesting given that one year ago, in Medicare Transmittal 1776, CMS essentially either broadened the Incident-to concept or partially mixed it up with collaborative services in the hospital setting. In any event, the result has been increased use of physician billing for services that are a combination of two provider types, physician and other non-physician practitioner. It almost appears that internal guidance is needed before external review will be effective.

"The 2004 list is actually well balanced with mainstream coding and billing concerns, potential coding abuse situations, and monitoring of outright fraud and non-compliant activities."

Modifiers Make the Scene

The two new items of greatest interest to this author are those that involve modifiers. The first is "The Use of Modifier –25," the second is "Use of Modifiers with National Correct Coding Initiative Edits." We had stated above that these Plan items represented a new level of review—that inspection here will begin to uncover inappropriate activities engaged in by those providers who really know how to use the coding system. And as true as this may be, there will, unfortunately, also be those who use the coding properly per AMA guidance, but run afoul of Medicare-specific policy.

In general, modifier –25 is used when an E/M visit is performed in the same visit as a small procedure or other service. The core issue with modifier –25 is whether or not the "significant, separate, identifiable E/M service" is really that separate from the procedure. In many instances a provider will simply "tack on" a low-level E/M visit to a starred procedure thinking that since a starred procedure doesn't include any E/M, they are entitled to one! This is incorrect, and these practitioners need to be identified and corrected. The removal of the starred procedure designation in the 2004 CPT book may also help correct this behavior.

However, a second issue arises with modifier –25; it pertains to how Medicare views the "relatedness" of the E/M and procedure. The CPT book specifically states that "different diagnoses are not required" for the E/M code and the procedure, but most Medicare carriers will bundle the visit if the diagnosis codes are "related" enough. This policy flies in the face of CPT convention—in fact, the linkage of the CPT and ICD-9-CM systems at this level sets a dangerous precedent. The fact is that physicians should be paid by the work they perform, not the reason for which they do it. Certainly any payer has the right to not cover one of the services, but to bundle them and inform the beneficiary that they also need not pay is a perversion of the system.

The review of modifier –25 will hopefully uncover the former situation with "extra" visits being billed, but there is also likely to be some controversy over "relatedness" by diagnosis—and this should lead to a policy review, not a provider review.

The second modifier issue is titled, "Use of Modifiers with National Correct Coding Initiative (CCI) Edits." This element takes aim at modifier –59, a modifier whose sole purpose in being created was to interrupt CCI edits and preserve full payment for secondary, but unrelated, surgical procedures. Once again the issue at hand may be the "separateness" of the two procedures, not unlike the modifier –25 concern.

Different states have reported that Medicare carriers have different interpretations of when modifier –59 versus modifier –51 should be used, but that is a discussion for another day. The key difference between these two modifiers is how "distinct" are the procedures. Once again we may be running into terminology/semantics issues between the AMA CPT book and Federal payers; the CPT book uses the words "separate site, separate incision, separate injury," but the name of the modifier is "Distinct procedural service."

This review could lead any number of places, but perhaps the best outcome would be a standard federal definition or application of modifier –59 versus –51. For example, an orthopedic surgeon performs arthroscopic surgery on various compartments of the knee. Are the compartments separate sites? Distinct from one another? It depends on your interpre-

tation. OIG may be unraveling more than it had anticipated by delving this deep into the mechanics of surgical coding. This one will be interesting.

Other Items

The remaining seven items can't really be categorized precisely. Some are issues that address potential abuse, a couple appear to be probing for general utilization or coverage concerns, while a couple more are looking at more clerical or potential fraud situations.

On the outright abuse side we have Care Plan Oversight, Radiation Therapy Services and Ordering Physicians Excluded form Medicare. Medicare has identified close to a 300-percent increase in billings for Care Plan Oversight between 2000 and 2001. Although it is quite possible that these services previously went unbilled, it is surely worth looking at to see if they are in fact being performed. The requirements for billing these services are not as easy as may first appear.

Likewise with Radiation Therapy Services; the codes for billing these are somewhat vague and it is not surprising that some carriers have detected a high percentage of overpayments here. It may be less of an over-coding situation—and more of an under-documenting situation—but it's worth a look. The last of these areas, Excluded Physicians Ordering Services, is pure fraud monitoring. There probably isn't much of it, but any amount is too much.

Two items appear geared towards coverage/necessity issues: ESRD Monthly Capitation Payment Relative-Value Units and Billing for Diagnostic Tests. In the former case OIG is working in tandem with CMS to possibly revise the way professional services for ESRD services are paid. Currently there is a capitated payment for one month's worth of professional services related to ESRD treatment and management. This item proposes to measure the actual amount of physician services provided.

CMS has already proposed to eliminate the capitated payment in favor of a "face-to-face" minimum of four visits. This item will provide further data for that initiative.

The Billing for Diagnostic Tests item is also geared towards coverage as it targets a variety of diagnostic tests, specifically nerve conduction studies, to determine whether or not they were medically necessary. Some tests underwent upwards of a 35-percent increase, and in typical fashion OIG wants to know why. A common theme with these reviews is whether or not tests are in fact more screening than related to a specific complaint or concern. Medicare is, after all, not set up as a comprehensive preventive health care entity but geared more towards the catastrophic health care model.

"The 2004 plan weighs in heavily on those high-revenue items that are a mainstay of the Medicare Fund Budget."

The final two items are Place of Service Errors and "Long-Distance" Physician Claims. The former is aimed at proper payments based on place of service reporting and is rather straightforward. The latter looks at claims for services where face-to-face visits occur at a significant distance from the beneficiary's home. This looks to be a sweep for general fraud plus some better understanding of beneficiaries' utilization patterns. The last sentence in this item also references potential improved program integrity controls in this regard.

In summary, the 2004 plan weighs in heavily on those high-revenue items that are a mainstay of the Medicare Fund Budget, includes the normal smattering of fraud/utilization concerns and for the first time ventures deeper into coding waters with a probe into the world of modifier usage. Hopefully, in addition to a small yield of fraud that can be eliminated, the reviewers will also encounter some of those Medicare program coverage and carrier direction issues that need some retooling. A little self-examination is good for the system as well.

The 2004 list of physician target areas is as follows:

2004 OIG Work Plan—Physicians

- Consultations
- Coding of Evaluation and Management Services
- Use of Modifier –25
- Use of Modifiers with National Correct Coding Initiative Edits
- ESRD Monthly Capitation Payment Relative Value Units
- Place of Service Errors
- "Long Distance" Physician Claims
- Care Plan Oversight
- Billing for Diagnostic Tests
- Radiation Therapy Services
- Services and Supplies "Incident-to" Physicians' Services
- Ordering Physicians Excluded from Medicare

For Details of the Plan see http://www.hhs.gov/oig/ under Work Plans. ■

Bill founded The Dacey Group, Inc. to address physician needs relative to coding and compliance. Through physician profile analysis and extensive exposure to physician documentation practices, Bill has become nationally recognized in both coding and compliance. As Director of Coding and Reimbursement, and later a Vice President of Compliance for a large integrated healthcare system, Bill had oversight responsibilities for over 500 physicians with annual revenues in excess of $350 million. Bill is on the Editorial Advisory Board of the CCH Healthcare Compliance Letter as well as The National Advisory Board of the American Academy of Professional Coders (AAPC). Bill can be reached at Bill@Daceygroup.com or 704-827-3333.

Fraud & Abuse (cont.)

Possible sentences. If Nguyen is convicted of these crimes, he will face

- up to a ten-year prison sentence and/or a $250,000 fine for each of the six counts of healthcare fraud;
- a five-year prison sentence and/or a $250,000 fine for each of the seven counts of dispensing or distributing a Schedule III controlled substance;
- up to 20 years in prison and/or a $1,000,000 fine for each of the seven counts of dispensing or distributing a Schedule II controlled substance, and for one count of conspiracy to dispense or distribute a controlled substance; and
- no more than three years in prison and/or a $100,000 fine for each of the two counts of filing false income tax returns. ■

CCH Chicago Bureau, October 17, 2003

HIPAA

HIPAA anti-fraud provisions broadly applied

by Richard C. Sarhaddi, Esq., Contributing Editor

Congress included anti-fraud provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in response to the rampant health care fraud perpetrated every year, which costs public and private payers annually. The anti-fraud provisions specifically criminalize *any* fraud perpetrated on a public or private payer. See 18 U.S.C. § 1347. In a case of first impression, the Court of Appeals for the Second Circuit was asked to decide who the law applies to—was it intended to apply only to health care providers who engage in health care fraud, or to any person engaged in this type of conduct?

The Court of Appeals for the Second Circuit held that the anti-fraud statute applies to *anyone* engaged in defrauding a public or private health care payer. The court affirmed the convictions and sentences of three defendant-appellants who were found guilty of health care fraud in violation of 18 U.S.C. § 1347. The three defendant-appellants were involved in an insurance fraud scheme in which they participated in staged car accidents as passengers and fabricated personal injury claims to take advantage of New York's no-fault automobile insurance system.

As part of the sophisticated scheme, the defendants were recruited to participate as passengers in cars that were deliberately crashed into other vehicles. After the accidents, the recruits were referred, in exchange for a fee, to various medical clinics in New York City. They then assigned their no-fault insurance benefits to the health care clinics, which directly billed the insurance companies. After these steps, the recruits filed their own civil suits for their bogus injuries. The participants used the fictitious medical records generated by the clinics to support their personal injury claims and obtained settlements from insurance companies.

"The Court of Appeals for the Second Circuit held that the anti-fraud statute applies to *anyone* engaged in defrauding a public or private health care payer."

The defendants appealed their convictions based on theories that the statute (1) solely applies to fraud committed by health care professionals, and (2) that the New York State no-fault automobile insurance program is not a "health care benefit program" within the meaning of the statute. In interpreting the statute and applying rules of statutory construction, the court found that the statute unambiguously applies to any person who purposely endeavors to defraud a health care benefit program, and is, therefore, not limited to health care professionals. In addition, the court found that the New York State no-fault insurance program qualifies as a health care benefit program under its broad definition because it provided the defendant-appellants with a medical benefit as a result of the vehicle owners' no-fault insurance contracts. ■

U.S. v. Lucien, et al., ¶102,043

HUD homeless plan stirs controversy

by Jennifer Carsen, J.D., Contributing Editor

The Department of Housing and Urban Development (HUD) has announced plans to implement a Homeless Management Information System (HMIS). An HMIS is a computerized data collection application designed to capture client-level information over time on the characteristics and service needs of the homeless

Under the HMIS, homeless clients seeking housing or services would be asked for personal identifying information, such as name, date of birth, and Social Security number. At the time the information is collected, the client would be given an explanation of how the information would be used, how it would be protected, and the advantages of providing accurate information. Local providers would be required to report this data on a regular basis to a central data storage facility.

HUD says an HMIS would provide significant opportunities to improve access to, and delivery of, services for homeless people. It would accurately describe the scope of homelessness and the effectiveness of efforts to ameliorate it. It would also strengthen community planning and resource allocation, streamline referrals, and enhance intra-agency coordination.

In a letter to HUD, however, the Health Privacy Project (HPP) has criticized the HMIS plan as overly broad and intrusive. All programs requiring an assessment of client needs would be required to ask clients about sensitive areas such as physical or mental disabilities, general health status, pregnancy status, HIV/AIDS status, and behavioral health status.

HPP says the proposed guidelines exceed statutory authority and that the invasive questions will prevent the homeless from receiving adequate medical care. Additionally, says HPP, sensitive medical information collected by many service providers may not be sufficiently protected under existing privacy laws. HPP is urging HUD to "substantially" scale back the proposal so as to only collect information that will aid homeless service providers and their clients without creating barriers to treatment and services.

Founded in 1997, The Health Privacy Project is dedicated to raising public awareness of the importance of ensuring health privacy in order to improve health care access and quality. A copy of its letter to HUD is at http://www.healthprivacy.org/info-url_nocat2303/info-url_nocat_show.htm?doc_id=195970. A copy of the Federal Register notice about HUD's implementation of HMIS is at http://www.hud.gov/offices/cpd/homeless/rulesandregs/fr4848-n-01.pdf. ■

CCH Chicago Bureau, October 29, 2003

Colorado AG releases HIPAA law enforcement opinion

by Jennifer Carsen, J.D., Contributing Editor

Ken Salazar, the Attorney General of Colorado, has released an opinion (Formal Opinion No. 03-06, 2003) describing the types of health information that may be disclosed under HIPAA to law enforcement officials. Salazar wrote the opinion at the request of a Colorado State Patrol lieutenant.

Colorado's law enforcement personnel sometimes require medical information that is covered by HIPAA protections in order to carry out their public safety functions, says Salazar. Highlights of the disclosure rules include the following:

- Providers are required under Colorado law to report certain bullet and other wounds and injuries to law enforcement if they believe a criminal act is involved. HIPAA expressly permits these types of mandatory law enforcement disclosures. The statutory duty to report injuries overrides the physician-patient privilege, which would ordinarily protect information observed by a doctor during an examination.
- Disclosures of limited identifying information are permitted in response to an official inquiry from law enforcement to identify or locate a suspect, fugitive, material witness, or missing person, as well as disclosures concerning the victim of a crime. Other disclosures required by state law and expressly allowed by HIPAA include responses to court orders and warrants, subpoenas or summons issued by a judicial officer, and civil or investigative demands authorized by law.
- Health care providers may voluntarily alert law enforcement of a suspicious death or a crime on their premises. The following disclosures to law enforcement can be made by a heath care provider without an official request: disclosures required by law; to report a suspicious death; to report crime on the premises; and during a medical emergency about a crime, victim, or suspect.
- Emergency medical personnel may advise law enforcement officials of information concerning the nature and commission of a crime and the location of the crime, victims, or perpetrators.
- HIPAA permits disclosures to law enforcement to avert a serious threat to public health or safety and to report child abuse or neglect, domestic violence, and adult abuse and neglect.

HIPAA preempts contrary state laws relating to the privacy of individually identifiable health information, but it does not preempt state laws that more strictly protect the disclosure of medical information, says Salazar. Also, HIPAA does not preempt state laws that provide for reports of disease, injury, child abuse, birth, or death. It does not preempt Colorado laws that require health care providers to notify law enforcement of bullet wounds and other injuries resulting from criminal conduct. ■

CCH Chicago Bureau, October 28, 2003