Position Statement on Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment

Approved by the Board of Trustees, November 2002
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The following American Psychiatric Association (APA) position statement has been developed in response to the federal Department of Health and Human Services (HHS) final Privacy Rule's provision that health-care "providers" (health-care professionals and facilities) disclose only the "minimum necessary" information for a given purpose. The Final Rule clarifies that "providers" may make their own determination about what is the "minimum necessary" information for a specific purpose, and also invites "professional organizations, working with their members, to assess the effects of the standards and develop policies and procedures to come into compliance with them." (p. 82472) The Rule also states that this standard is "intended to reflect and be consistent with, not override, professional judgment and standards." (P 82544)

The following guidelines are based on the cumulative professional experience of APA members with respect to current practice and the necessity of privacy for effective psychiatric care. These guidelines are based on the principle that standards for "minimum necessary" disclosure of psychiatric information to third-party payers should not exceed standards generally accepted in other medical specialties.

These guidelines address the specific delimited set of information that is necessary to process a typical claim, and therefore constitutes the minimum necessary information that may be disclosed to third party payers under the HHS Privacy Rule.

This is not a policy position about how much/what information should be documented in the record about mental-health treatment and psychotherapy. Documentation guidelines, consistent with the HHS Privacy Rule, regarding general mental-health treatment records and psychotherapy notes will be addressed in a separate document. Material in psychotherapy notes, as defined in the HIPAA Privacy Rule, is not disclosed to third-party payers.

The purpose of this document is to specify the particular items of information that the APA believes fall within the "minimum necessary" criteria for routine processing of typical insurance claims for psychiatric treatment. Psychiatrists should also familiarize themselves with applicable state statutes, which may impose additional and/or different requirements with regard to the protection of confidentiality and privacy.

The APA's guidelines for "minimum necessary" are in three parts:

1. outpatient treatment that has been authorized for payment,
2. outpatient treatment requiring pre-authorization, and
3. inpatient treatment.

#1: Outpatient treatment that has been pre-authorized for payment (including sessions that do not require any pre-authorization by payer).

The first part of the "minimum necessary" guidelines for third-party payers, which follows below, concerns outpatient treatment that has been pre-authorized for payment or outpatient treatment that is not subject to pre-authorization.

Minimum necessary information:

The following information is deemed the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to process a routine claim for outpatient psychiatric services that are not subject to additional preauthorization. The guideline is based on the current "837" Standard claim and the protocol for disclosures to third party payers mandated in the Washington DC and New Jersey third-party, mental health privacy statutes (attached). These statutes place explicit limits on disclosure to payers of information related to mental health treatment. The restriction on disclosure to payers in these statutes has been endorsed by the U.S. Surgeon General in his *Report on Mental Health* (December 1999, Chapter 7).

- Patient's name, address, date of birth, insurance information/ID number. [*Note: If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required.*]
- Patient's diagnosis, by current ICD code (currently ICD-9-CM)
- Date(s), type and location of service
- Condition's date of onset (if different than date of service)
- Procedure code— CPT code
- Charges
- Clinician's name, ID number (i.e. SSN or EIN, and/or clinician's provider number)
- Clinician's address
- Facility where services were performed (i.e., office, hospital, clinic)

If a payer cannot make a determination based on the above information, it may then request the provider to disclose additional information, limited to the following:

- Patient's status (i.e., voluntary, involuntary)
- Functional status (impairment described as none, mild, moderate or severe)
- Level of distress (described as none, mild, moderate or severe)
- Prognosis— the estimated minimum duration of the treatment for which the claim has been submitted.

#2: Outpatient treatment that requires authorization for payment.

The second part of the "minimum necessary" guidelines for third-party payers, which follows below, concerns outpatient treatment that requires authorization for payment of outpatient treatment. This includes prospective or retrospective reviews for this purpose.

Minimum necessary information:

The following information is deemed the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to authorize payment for outpatient psychiatric services. The guideline is based on the HCFA 1500 Claim Form, the Washington, DC and New Jersey peer review laws, and the current 837 Standard claim. Consistent with the Rule's "minimum necessary" provision, clinical information disclosed to payers for pre-authorization purposes will be used/disclosed by only those individuals who perform the review. The only information disclosed to payers' administrative personnel should be administrative billing information on the current 837 Standard claim. .

Administrative billing information:

- Patient's name, address, date of birth, insurance information/ID number. [*Note: If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required.*]
- Patient's diagnosis by current ICD code (currently ICD-9-CM)
- Clinician's name, ID number (i.e., SSN or EIN, and/or clinician's provider number) and address
- Facility where services were performed (i.e. office, hospital, clinic)
- Date(s), type and location of service – current and planned
- Condition's date of onset (if different than date of service)
- Procedure code–CPT code
- Charges

Clinical information for authorization of benefits:

- Treatment planned—CPT code(s), including recommended/expected frequency
- Currently on psychiatric medications? Y/N
- Patient's status (i.e., voluntary, involuntary)
- Functional status (impairment: none, mild, moderate or severe) or Axis V (GAF)
  - Current
  - Highest in past year
  - Estimated GAF at treatment's completion (would address treatment goal)
- Level of distress (none, mild, moderate or severe) or Axis IV rating
- Prognosis—the estimated minimum duration of the treatment for which authorization is sought

#3: Minimum necessary information for inpatient psychiatric treatment.

The third part of the "minimum necessary" guidelines for third-party payers, which follows below, concerns inpatient treatment that requires authorization for payment.

Minimum necessary information:

The following information is deemed the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to authorize payment for inpatient psychiatric services. Consistent with the Rule's "minimum necessary" provision, clinical information disclosed to payers for pre-authorization purposes will be used/disclosed by only those individuals who perform the review. The only information disclosed to payers' administrative personnel should be administrative billing information on the Current 837 Standard claim.

Administrative Billing Information

- Patient's name, address, date of birth, insurance information/ID number. [*Note: If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required.*]
- Patient's diagnosis, by current ICD code (currently ICD-9-CM)
- Condition's date of onset, (if different than date of service)
- Clinician's name, ID number (i.e. SSN or EIN, and/or provider number) and address
- Facility where services were performed (i.e., office, hospital, clinic)
- Date(s), type and location of service—current and planned
- Procedure code—E&M code(s), or CPT code for ECT
- Charges

Clinical Information for Review

- Patient's status (i.e., voluntary, involuntary)
- Functional status (impairment: none, mild, moderate or severe) or Axis V:
  - Current
  - Highest in past year
  - Estimated GAF at discharge
- Level of distress (none, mild, moderate or severe) or Axis IV:
- Current Risk Factors
  - At risk for harm to self Y/N
  - At risk for harm to others Y/N
  - Currently on psychiatric medications Y/N
  - At risk for medical complications Y/N

- Other--specify
- Treatment planned: E&M code(s), or CPT code for ECT, including recommended/expected frequency and duration
- Response to treatment, patient's progress, or revision in treatment plan (for authorization of additional treatment). Describe briefly:
- Inpatient treatment goal(s)
- Prognosis—the estimated minimum duration of inpatient treatment for which authorization is sought

Procedure for requesting additional information:

The preceding guidelines should be sufficient in providing the necessary information to the insurer in almost every case for the purposes previously described. In rare cases, following disclosure of the above information, if the third-party payer 1) questions the patient's entitlement to benefits, or the amount of payment requested, or 2) has reasonable cause to believe the treatment in question may be neither usual, customary nor reasonable, the APA recommends the following procedure:

> The disputed question/issue should be referred for an independent review by a qualified psychiatrist who is independent of the insurer, whose cost will be borne by the insurer. This reviewer will be given access to the clinical information necessary for the review. However, only the reviewer's determination (and no additional clinical information) shall be disclosed by the treating psychiatrist or the reviewer to the insurer for this purpose. Privacy statutes in New Jersey and the District of Columbia (as interpreted and implemented in D.C. through year 2000) provide a long-standing, workable model for such a procedure.

References:

NJ REV STAT. secs. 45:14B-31, et. seq.

Surgeon General's Report on Mental Health (Chapter 7) December 1999.

D.C. CODE sec. 7-1202.07 (as in effect through September 30, 2002)

Further Reading:

Hennessy & Hennessy, An Economic and clinical rationale for changing utilization review practices for outpatient. Psychotherapy, v24(3): 340.

New Jersey Revised Statute

45:14B-31. Definitions

As used in this act:

a. "Administrative information" means a patient's name, age, sex, address, educational status, identifying number, date of onset of difficulty, date of initial consultation, dates and character of sessions (individual or group), and fees;

b. "Diagnostic information" means therapeutic characterizations which are of the types that are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM III), of the American Psychiatric Association, or other professionally recognized diagnostic manual;

c. "Disclose" means to communicate any information in any form;

d. "Independent professional review committee" means that group of licensed psychologists established pursuant to section 14 of this act by the State Board of Psychological Examiners;

e. "Third-party payor" means any provider of benefits for psychological services, including but not limited to insurance carriers and employers, whether on an indemnity, reimbursement, service or prepaid basis, but excluding governmental agencies;

f. "Usual, customary or reasonable." In applying this standard the following definitions are applicable:

(1) "Usual" means a practice in keeping with the particular psychologist's general mode of operation;

(2) "Customary" means that range of usual practices provided by psychologists of similar education, experience, and orientation within a similar geographic or socioeconomic area;

(3) "Reasonable" means that there is an acceptable probability that the patient will realize a significant benefit from the continuation of the psychological treatment.

In applying the standards of "usual, customary, and reasonable," the following guidelines are applicable: If a psychological treatment is "usual" or "customary," an inference that the treatment is also "reasonable" is warranted. If the treatment is neither "usual" nor "customary," then it shall satisfy the criterion of "reasonable."

L. 1985, c. 256, s. 1.

45:14B-32. Disclosure to third-party payor

A patient who is receiving or has received treatment from a licensed, practicing psychologist may be requested to authorize the psychologist to disclose certain confidential information to a third-party payor for the purpose of obtaining benefits from the third-party payor for psychological services, if the disclosure is pursuant to a valid authorization as described in section 6 of this act and the information is limited to:

a. Administrative information;

b. Diagnostic information;

c. The status of the patient (voluntary or involuntary; inpatient or outpatient);

d. The reason for continuing psychological services, limited to an assessment of the patient's current level of functioning and level of distress (both described by the terms mild, moderate, severe or extreme);

e. A prognosis, limited to the estimated minimal time during which treatment might continue.

L. 1985, c. 256, s. 2.

45:14B-33. Independent review

If the third-party payor has reasonable cause to believe that the psychological treatment in question may be neither usual, customary nor reasonable, the third-party payor may request, and compensate reasonably for, an independent review of the psychological treatment by an independent professional review committee. The request shall be made in writing to the treating psychologist. No third-party payor having such reasonable cause shall terminate benefits without following the procedures set forth in section 4 of this act.

L. 1985, c. 256, s. 3.

DISTRICT OF COLUMBIA OFFICIAL CODE 2001 EDITION
DIVISION I. GOVERNMENT OF DISTRICT.
TITLE 7. HUMAN HEALTH CARE AND SAFETY.
SUBTITLE C. MENTAL HEALTH.
CHAPTER 12. MENTAL HEALTH INFORMATION.
SUBCHAPTER II. DISCLOSURES WITH THE CLIENT'S CONSENT.

Current through October 2, 2001

§ 7-1202.07. Limited disclosure to 3rd-party payors.

(a) A mental health professional or mental health facility may disclose to a 3rd-party payor mental health information necessary to determine the client's entitlement to, or the amount of, payment benefits for professional services rendered; provided, that the disclosure is pursuant to a valid authorization and that the information to be disclosed is limited to:

(1) Administrative information;

(2) Diagnostic information;

(3) The status of the client (voluntary or involuntary);

(4) The reason for admission or continuing treatment; and

(5) A prognosis limited to the estimated time during which treatment might continue.

(b) In the event the 3rd-party payor questions the client's entitlement to or the amount of payment benefits following disclosure under subsection (a) of this section, the 3rd-party payor may, pursuant to a valid authorization, request an independent review of the client's record of mental health information by a mental health professional or professionals. Mental health information disclosed for the purpose of review shall not be disclosed to the 3rd-party payor.

CREDIT(S)
2001 Main Volume (Mar. 3, 1979, D.C. Law 2-136, § 207, 25 DCR 5055.)

HISTORICAL AND STATUTORY NOTES
Prior Codifications 1981 Ed., § 6-2017. 1973 Ed., § 6-1621.

Legislative History of Laws
For legislative history of D.C. Law 2-136, see Historical and Statutory Notes following § 7-1201.01.