What are the best practices for managing mental/behavioral health records and psychotherapy notes?

When approaching the sensitive subject of behavioral/mental healthcare it is important to determine which treatments, processes, and records are being discussed. This document will provide a clear distinction between mental health records, which are part of a patient’s overall medical record, and psychotherapy notes which are provided special consideration under HIPAA Privacy Law and considered to be separate pieces of information. It is imperative that healthcare administrators and practitioners do not consider the extra privacy protections afforded to psychotherapy notes as applicable to general mental health records. Should inappropriate use of these exceptions be applied, the overall care and health of the patient may be at risk. As with any other HIPAA regulations, certain circumstances occur in which state laws supersede the regulations set by federal law. Health organizations should read and understand their state’s laws, an example of this situation will be discussed in this document. This document is not meant to be legal counsel, rather it is a general guide to understanding the intricacies of HIPAA regulation.

Mental Health Records vs Psychotherapy Notes

According to the Department of Health and Human Services’ (HHS) documentation covering frequently asked questions related to the management of protected health information (PHI) and psychotherapy notes:

“Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections.”¹

If providers were required to extend extra protection to a patient’s mental health records, which are to be considered part of their general medical record, then HHS would have made a clear distinction between mental health records and the general health records. Instead, the definition was drawn between psychotherapy notes and the medical record. Reading further into the documentation provided by HHS, a clear definition of psychotherapy notes is expressed:

“The Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient’s medical record.”

¹ HIPAA Privacy Rule Information Related to Mental Health
Read again, “...separate from the rest of the patient’s medical record.” Important exceptions to psychotherapy notes can be found with further examination of the text but examples include, medical prescriptions, session start and stop times, frequency of treatment, or results of clinical tests. Psychotherapy notes also do not include summaries of diagnosis, symptoms, prognosis, etc. These exceptions are pieces of information which are considered to be mental health records, and thus part of the patient’s general medical record. As organizations continue to implement protocols for managing their medical records, they must understand that records related to treating mental or behavioral health do not receive extra protection under the HIPAA Privacy Rule. Best practices state that these records be stored within the patient’s medical chart. Organizations should read and understand the above definition of psychotherapy notes and store the notes separately from the patient’s medical records (which includes behavioral and mental health records).

If an organization wishes to store the psychotherapy notes within their electronic medical records (EMR) system, then special naming and filing standards should be documented and communicated. Staff members should be trained on the differences between psychotherapy notes and mental health records. Mental health records should be coded as such and included in the patient’s electronic record. The psychotherapy notes should then receive an individualized designation which communicates the relevant patient while not being added to that patient’s general medical record.

An example can help to illustrate why a patient’s mental health records (part of their general health record) are different than psychotherapy notes related to their treatment:

John has been playing tennis for years and loves the game. One day, John begins feeling pain in his elbow, so he decides he needs to see his doctor. After seeing John, Dr. Smith documents the visit in John’s general medical record. This information includes medication prescribed, symptoms, prognosis, diagnosis, and any other relevant medical information.

A few months later, John begins to experience what he believes to be depression. He goes to his local community health clinic to seek counseling from a mental health professional. John’s medical record is transferred to the clinic where the community health providers take possession of the PHI.

After John’s first counseling session, the mental health professional prescribes him with an anti-depressant, documents the diagnosis of depression, and enters this information along with the start and stop times of the counseling session into John’s medical record. The new information is marked as mental/behavioral health and is considered part of John’s medical record.

The notes taken by the mental health professional which led them to determine the diagnosis and prescription, considered to be psychotherapy notes, for John are kept separately from the medical record which contains the information described above. These notes are still stored in the EMR, however they are clearly marked in a fashion consistent with the clinic’s policies and are not part of John’s general medical record.
A month later, John needs a copy of his medical record for personal use. John submits a written request for his full medical record to the health clinic. The clinic processes the request and releases to John his full medical record. The information sent to John includes everything related to his elbow treatment and the information specified above as mental/behavioral health records. The psychotherapy notes are not included by John’s provider as the mental health professional has determined that it is not in John’s best interest to receive this information. Under federal law, this is a completely compliant and appropriate release by the provider. The provider also carries no burden for notifying John that the psychotherapy notes related to his treatment exist (this lack of burden applies to most states, some states carry stricter rules which override HIPAA).

The information John receives is sufficient for further treatment by another provider and goes on his way to happy and healthy life.

An in-depth analysis of why the release of information is within full compliance of HIPAA and patient access follows.

**Patient Access to Psychotherapy Notes**

As dictated by HIPAA, a patient must always be allowed to having access to their medical record within a timely manner and without undue burden. If the maintenance and contents of mental health professional’s notes fall within the definition of “psychotherapy notes” as defined in the Privacy Rule, then they are not to be considered part of a patient’s medical record. Since psychotherapy notes fall under this Privacy Rule exception, covered entities are not under an obligation to release to a patient psychotherapy notes pertaining to their treatment. It is of great importance that the psychotherapy notes are maintained separately or clearly noted as separate from the patient’s medical record, if this step is not taken then the Privacy Rule exception does not apply and a records custodian must include the notes when releasing information.

**Third Party Requesters**

If a third party requester is seeking to obtain medical records from the healthcare organization then the records custodian should follow their normal protocol in seeking the required authorization. If psychotherapy notes relating to the requested records are also present at the organization, an organization must seek separate patient authorization, which specifically states that psychotherapy notes may be included, before releasing the notes to the third party requester. This is of paramount importance as the inappropriate release of psychotherapy notes would not only be noncompliant but it may have undesirable effects on the related patient.

**Professional Discretion and Extenuating Circumstances**

The term “professional discretion” is used throughout medical records regulatory law. This term is leaned upon heavily within the rules governing psychotherapy notes. Circumstances pertaining to family access to psychotherapy notes, law enforcement inquiries, and third party requesters are especially dependent on this caveat to determine compliance. The importance of professional discretion serves to indicate how critical it is
that organizations maintain a well-articulated system for the storage of psychotherapy notes. An example of professional discretion playing a part in the release of psychotherapy notes would be if a provider felt that there was an imminent threat of a patient causing harm to themselves or others. A provider must use their professional discretion to determine if the situation meets the requirements for disclosure of psychotherapy notes to law enforcement for the purpose of prevention.

**HIV/AIDs Related Records**

HIPAA’s federal regulatory standards consider HIV/AIDs related medical records to be a part of patient’s overall medical record. State by state exceptions do exist, one of which is discussed below. When a patient is seeking to have their medical record released, HIPAA requires that records custodians adhere to their “duty to warn”. DataFile Technologies fulfills this requirement by including the appropriate notice to patients on our authorization form. It contains this language:

“I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.”

This information is made available to the patient not only to keep with regulations, but also to help improve the patient experience through education. Should a patient not wish for this information to be included in the released information, they have the option to restrict the desired records.

**California Medical Record Law**

Under Federal HIPAA regulations, if a state’s laws are determined to provide more stringent protection for a patient’s PHI, then those laws will take precedent over HIPAA regulation. California is a prime example of a state which provides more stringent privacy protection to patients in certain circumstances. For example, sensitive records such as mental/behavioral health and HIV/AIDs information are governed more stringently in California than they are on the federal level.

Unlike federal regulation, which requires that mental/behavioral health records are sent as part as part of the general record to a patient upon request, California law allows for a physician to use their professional discretion to withhold the mental health records from the patient.³ Remember, this description is not addressing psychotherapy notes. Psychotherapy notes are separate from mental health records and governed under HIPAA standards. If a physician exercises this option, the following three steps must be taken:

1. The physician must include in the patient’s medical record a note which explains the reasoning used for refusing the patient a copy of their mental health record. This includes a specific description of the possible adverse consequences.

³ The Medical Board of California – Patient Access to Medical Records
Conclusion

DataFile Technologies wants our clients to understand the difference between mental/behavioral health records and psychotherapy notes as defined by HIPAA. A misinterpretation of this information will not allow for the most streamlined workflows possible when processing records for release of information or incoming document filing. DataFile will discuss with our clients how they wish to label mental/behavioral records within their patients’ medical records. DataFile’s documentation and processes will adjust to individual states when extra patient authorization is required for such information to be released.

The example of California is discussed at length along with the implications of HIV/AIDS as a result of our desire to communicate to readers that we are experts in medical records management. DataFile Technologies will always strive to supply advice which leads our clients to the most streamlined and compliant workflows possible while keeping patient care as the priority.

4 The Medical Board of California – Patient Access to Medical Records
5 California Health and Safety Code. Section 120980 (g)
6 California Health and Safety Code. Section 120985 (a)