The Psychotherapist-Patient Privilege: Are Patients Victims in the Investigation of Medicaid Fraud?

I. Introduction

To discourage abuse of the Medicaid system of public reimbursement for medical services rendered to indigents,[1] Congress has authorized the establishment of state Medicaid fraud control units.[2] One function of these units is to investigate and prosecute providers of psychotherapeutic services, among others, for fraudulent billing practices.[3] Acting by authority of vague federal and state access-to-documentation requirements,[4] some units have requested extensive disclosure of psychotherapists' patient records, including notes and diagnoses, for investigative purposes.[5]

Therapists have sought to prevent this disclosure, invoking their patients' constitutional privacy rights and states' statutory physician-patient or psychotherapist-patient privileges. Courts have responded inconsistently, some declining to recognize any protection for patient records, others differing on the extent of constitutional or statutory protection available. The resulting uncertainty as to the bounds of the law may, as much as actual disclosure, detrimentally affect the treatment of emotional and mental disorders. To minimize any harm, mental health professionals need clear and consistent judicial definition of states' rights of access to documentation in Medicaid fraud investigations of psychotherapists.

This Note will examine psychotherapists' standing to defend their patients' confidentiality rights and the possibility of waiver of these rights

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[1] H. R. Rep. No. 393(II), 95th Cong., 1st Sess. 79, *reprinted in* 1977 U.S. Code Cong. & Admin. News 3039, 3082.

[2] 42 U.S.C. § 1396b(q)(3) (1982).

[3] *Id.*

[4] *See, e.g.*, 42 U.S.C. § 1396(a)(27) (1982); 42 C.F.R. § 431.107(b) (1984); Mass. Admin. Code tit. 106, § 450.205(A) (1983).

[5] Psychotherapy has been defined as any mode of psychiatric treatment, including "uncovering, exploratory and reconstructive therapy, limited goal therapy, and psychoanalysis, its most intensive form." Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 Wayne L. Rev. 175, 184 n.35 (1960). The Advisory Committee on Federal Rules of Evidence, in a proposed but never codified provision for a psychotherapist-patient privilege, defined a psychotherapist as either:

> (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.

56 F.R.D. 183, 240 (1972). The committee in its notes stated an intent to limit the definition strictly to medical doctors and licensed psychologists. *Id.* at 243. Social workers and other counselors "purporting to render psychotherapeutic aid" were excluded. *Id.*

by patients who sign a standard contractual Medicaid release. This Note will also suggest the appropriate scope of protection of records generated in the psychotherapist-patient relationship.

II. Background: Statutorily Permissible Access to Medicaid Providers' Documents

In 1965, Congress created the Medicaid program[6] to ensure the availability of medical assistance to low-income citizens who are age 65 or over, blind, disabled, or members of families with dependent children.[7] Medicaid plans are jointly financed by the federal and state governments and administered by the states.[8] To avail itself of matching federal Medicaid funds, each state must establish, within broad federal guidelines, procedures for the administration and operation of its own plan.[9]

One federal requirement is that of adequate documentation of services provided to Medicaid recipients.[10] A state must obtain from every provider[11] an agreement "(A) to keep such records *as are necessary fully to disclose* the extent of the services provided . . . and (B) to furnish the State agency or the Secretary [administering the plan] with *such information*, regarding any payments claimed by such [provider] . . . *as the State agency or the Secretary may* from time to time *request*."[12] With this nonspecific language,[13] the federal statute gives states seemingly unlimited discretion in determining the adequacy of documentation.[14]

Congress has mandated that the purposes for disclosure be "directly connected with the administration" of a state's Medicaid plan.[15] However,

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[6]42 U.S.C. § 1396 (1982).

[7]42 C.F.R. § 430.0 (1985).

[8]*Id.*

[9]*Id.* Should the state plan not comply with the federal requirements and administrative guidelines, federal funds may be withheld. 45 C.F.R. § 201.6 (1984).

[10]42 U.S.C. § 1396a(a)(27) (1982).

[11]A provider is "an individual or entity which furnishes items or services for which payment is claimed under Medicaid." 42 C.F.R. § 455.300(a) (1985). Each state, within broad federal guidelines, determines the types and ranges of services for which it will permit Medicaid reimbursement. 42 C.F.R. § 430.0(a) (1985).

[12]42 U.S.C. § 1396(a)(27) (1982) (emphasis added).

[13]Courts have expressed frustration with the task of interpreting the Medicaid statute: "The Medicaid statute . . . is an aggravated assault on the English language, resistant to attempts to understand it. The statute is complicated and murky, not only difficult to administer and to interpret, but a poor example to those who would like to use plain and simple expressions." Friedman v. Berger, 409 F. Supp. 1225, 1225-26 (S.D.N.Y. 1976).

[14]Ohio v. Collins (*In Re* Madeline Marie Nursing Homes), 694 F.2d 433, 447 (6th Cir. 1982); Commonwealth v. Kobrin, 395 Mass. 284, 290, 479 N.E.2d 674, 679 (1985). The Sixth Circuit Court of Appeals noted that a state's documentation requirements are limited in that they may not be arbitrary or capricious or deprive a provider of due process. *Madeline Marie*, 694 F.2d at 447.

[15]42 C.F.R. § 431.301 (1985).

this limitation does not protect the records of a provider subjected to a Medicaid fraud investigation. Congress has specified that a state may require disclosure for the purpose of "[c]onducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan."[16]

To discourage provider abuse of the Medicaid program, Congress, in 1978, authorized the establishment of state Medicaid fraud control units, empowered to investigate and prosecute all aspects of fraud in connection with the Medicaid program.[17] These units, should they deem a provider's records useful in an investigation, have the same statutory rights of access as state agencies.[18] Thirty-six states have established Medicaid fraud control units in the offices of their attorneys general.[19] Armed with experience and increased sophistication, these units are now investigating psychotherapists' alleged misconduct,[20] creating a need for precise definition of governmental and individual rights as to disclosure of potentially sensitive and highly personal records of patient treatments.

III. Grounds for Protection of Patients' Interests

A. Standing

Generally, to establish standing to litigate a claim, a party must demonstrate a "personal stake" in the outcome of the case.[21] To establish this stake, the party must show, first, a distinct injury to himself and, second, a causal connection between that injury and the action being litigated.[22]

Given this rule, it would seem that patients, as the potential injured parties, must themselves litigate the question of confidentiality rights; therapists, who claim no personal abrogation of rights, should not have standing to assert the privacy rights of other individuals. However, state and federal courts have demonstrated a willingness to recognize psychotherapists' standing to protect their patients' confidentiality interests during fraud investigations.[23]

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[16]42 C.F.R. § 431.302 (1985).

[17]42 U.S.C. § 1396(q)(3) (1982).

[18]42 C.F.R. § 455.21(a)(2)(iii) (1984).

[19]Fisher, *Confidentiality is a Casualty in War on Medical Fraud*, Am. Psychological A. Monitor, June, 1985, at 40, col. 2.

[20]*Id.* at col. 1.

[21]Duke Power Co. v. Carolina Envtl. Study Group, Inc., 438 U.S. 59, 72 (1978).

[22]*Id.*

[23]*See In re* Zuniga, 714 F.2d 632, 641 n.8 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983); Hawaii Psychiatric Soc'y v. Ariyoshi, 481 F. Supp. 1028, 1037 (D. Hawaii 1979); Chidester v. Needles, 353 N.W.2d 849, 851 (Iowa 1984); Commonwealth v. Kobrin, 395 Mass. 284, 287 n.8, 479 N.E.2d 674, 677 n.8 (1985).

In *Chidester v. Needles*,[24] the Supreme Court of Iowa sidestepped the potential standing problem. In that case, involving investigation of a clinic providing psychological services to Medicaid recipients, the court noted that the state had failed to challenge the doctors' rights to raise the issues of patient privilege and rights of privacy.[25] In the absence of that contention, the court explicitly declined to address the issue of standing.[26]

In *In re Zuniga*,[27] the Sixth Circuit Court of Appeals recognized two psychiatrists' standing to assert their patients' rights against disclosure in an insurance fraud investigation.[28] Though it did not explain its decision, the court apparently relied on case law[29] and the proposed, but never codified, Rule 504(c) of the Federal Rules of Evidence.[30] Proposed Rule 504(c), a psychotherapist-patient privilege rule, recognized a therapist's right to claim protection of communications on a patient's behalf.[31] Promulgated by the United States Supreme Court, Rule 504 was criticized for excluding all but psychotherapists from the traditional doctor-patient privilege.[32] Rule 504 and all seven other proposed privilege rules were ultimately replaced by one uncontroversial, open-ended rule, to facilitate passage of the entire rules package.[33] Still, Rule 504 is a significant indication of the high court's preference in issues involving the psychotherapist-patient privilege. As such, the rule should carry substantial weight when courts consider therapists' standing to assert their patients' rights.

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[24]353 N.W.2d 849 (Iowa 1984).

[25]*Id.* at 851.

[26]*Id.*

[27]14 F.2d 632 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983).

[28]*Id.* at 641 n.8.

[29]*Id.*

[30]*Id.* at 636-37.

[31]56 F.R.D. 183, 241 (1972). Rule 504 read, in part, "The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority so to do is presumed in the absence of evidence to the contrary." *Id.*

[32]S. REP. No. 1277, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS 7051, 7053.

[33]*Id.* The proposed privilege rules were replaced by Rule 501, which reads:

> Except as otherwise required by the Constitution of the United States as provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

FED. R. EVID. 501.

The United States District Court for the District of Hawaii, in *Hawaii Psychiatric Society v. Ariyoshi*,[34] took a more pragmatic approach to the issue of standing. In that case, plaintiffs Virgil Willis, Jr., a psychologist, and the Hawaii Psychiatric Society sought to enjoin the enforcement of a state statute permitting administrative searches of Medicaid providers' offices and records.[35] The court reasoned that disclosure of therapy records and files materially affects the rights of Medicaid beneficiaries.[36] It further recognized that Medicaid recipients might have no effective means to prevent violation of those rights in that patients might not know of a violation until after the information has been divulged and the damage done.[37] By comparison, psychotherapists have both the opportunity and the incentive to protect recipient-patients with whom they have developed a professional relationship.[38] Therefore, the court concluded, therapists should logically be recognized as having standing to assert their patients' rights.[39]

B. The Right of Privacy as Protection Against Disclosure

The constitutional right of privacy was first recognized by the Supreme Court of the United States in 1965.[40] In 1972, the Court defined it as the individual's right to make certain fundamental decisions free from governmental compulsion[41] and later described it as a fourteenth amendment right tied to a "concept of personal liberty and restrictions upon state action . . . ."[42]

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[34]481 F. Supp. 1028 (D. Hawaii 1979).

[35]*Id.* at 1035.

[36]*Id.* at 1037.

[37]*Id.*

[38]*Id.*

[39]*Id.*; *see also* Barrows v. Jackson, 346 U.S. 249, 257 (1953) (white property owner permitted to raise black purchaser's rights); Eisenstadt v. Baird, 405 U.S. 438, 443-46 (1972) (physician convicted of providing contraceptives permitted to raise recipients' rights in defense). The court in *Hawaii Psychiatric Society* considered only a physician's standing to assert a patient's constitutional right of privacy. 481 F. Supp. at 1037. In *Commonwealth v. Kobrin*, another Medicaid fraud investigation case, the Supreme Judicial Court of Massachusetts invoked the *Hawaii Psychiatric Society* rationale to determine that a psychiatrist had standing to assert his patients' statutory psychotherapist-patient privilege. *Kobrin*, 395 Mass. at 287 n.8, 479 N.E.2d at 677 n.8.

[40]Griswold v. Connecticut, 381 U.S. 479, 485 (1965).

[41]Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

[42]Roe v. Wade, 410 U.S. 113, 153 (1973). In the context of psychotherapy, the right has been defined as:

> no more, and certainly no less, than the freedom of the individual to pick and choose for himself the time and circumstances under which, and most importantly, the extent to which, his attitudes, beliefs, behavior and opinions are to be shared with or withheld from others. The right to privacy is, therefore, a positive claim

The Supreme Court has recognized two conceptual strands to the still embryonic right of privacy.[43] The first is the individual's interest in autonomy — independence in making certain kinds of important decisions.[44] The second is his interest in confidentiality — avoidance of disclosure of personal matters.[45] A patient's interest in protecting psychotherapeutic records falls within either of these privacy strands.

The first, the right of autonomy, includes freedom to make decisions pertaining to psychiatric care "without unjustified governmental interference."[46] The decisions to seek help from a psychiatrist or psychologist and to share openly one's thoughts and experiences with a therapist lie within a "cluster of constitutionally protected choices."[47] If a patient fears public disclosure of the highly personal information often revealed in psychotherapy, he might feel compelled to be less candid with his therapist[48] or to shun treatment altogether.[49] Thus, governmentally compelled exposure might negatively affect a patient's right to choose a course of action.[50]

Governmental interference with these vital decisions can also affect a patient's other fundamental rights. By discouraging effective treatment, the government hinders an individual's cognition, thought, and decision-making processes.[51] The resulting emotional imbalance may interfere with a person's rights in marriage and family life, as well as the freedoms of religion, speech, and the press.[52] Governmentally compelled release

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> to a status of personal dignity — a claim for freedom, if you will, but freedom of a very special kind.

Lora v. Board of Educ., 74 F.R.D. 565, 571 (E.D.N.Y. 1977) (quoting Ruebhausen & Brim, *Privacy and Behavioral Research*, 65 COLUM. L. REV. 1184, 1188-89 (1965)).

[43]Whalen v. Roe, 429 U.S. 589, 598-600 (1977).

[44]*Id.* at 599.

[45]*Id.* at 599-600.

[46]Hawaii Psychiatric Soc'y v. Ariyoshi, 481 F. Supp. 1028, 1039 (D. Hawaii 1979); *see also* Caesar v. Mountanos, 542 F.2d 1064 (9th Cir. 1976) (Hufstedler, J., dissenting in part), *cert. denied*, 430 U.S. 954 (1977).

[47]*Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1038 (quoting Carey v. Population Servs. Int'l, 431 U.S. 678, 685 (1977)). The court noted psychotherapeutic confidences often pertain to areas already recognized as constitutionally protected, listing family, marriage, parenthood and sexuality as examples. *Id.*

[48]Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1, 24-25 (1980).

> As patients become less open in psychotherapy, the therapist has less information with which to assist the patient. In fact, the ideas, fantasies, and fears that a patient may be least likely to disclose without the assurance of confidentiality may be among the most important to communicate to the therapist.

Id. at 25.

[49]*Id.* at 24.

[50]*Id.*

[51]*Id.* at 22.

[52]*Id.*

of records of a patient's psychotherapeutic treatment clearly intrudes on the individual's right of autonomy.

Such a release may even more clearly intrude on the second strand of the privacy right — the right to keep personal matters confidential. Public disclosure of "the most intimate and embarrassing details of a patient's life . . . may well strip him of much of his own sense of dignity."[53] Exposure of intensely personal confidences, observations and diagnoses causes "a loss of the power individuals treasure to reveal or conceal their personality or their emotions as they see fit, from intimacy to solitude."[54]

However, the Supreme Court has recognized that disclosure of potentially harmful or unfavorable medical information is at times necessary to the functioning of the modern medical system.[55] Because insurance companies and public health agencies must work with a certain amount of private data,[56] limited governmental intrusion into the protected zones of privacy is permissible when properly justified.[57]

To determine the justifiability of an abrogation of a therapy patient's privacy rights, courts must balance the state interests served by disclosure with the intrusion into a patient's privacy.[58] This amorphous balancing test gives courts freedom rationally to reach a conclusion at either end of the privacy spectrum.

One can argue that the Supreme Court has recognized a compelling state interest in acquiring all relevant evidence to ensure the fair administration of justice.[59] Medicaid fraud investigations are instigated to bring to justice providers criminally misappropriating taxpayers' dollars for personal gain.[60] Because individual privacy rights must yield to a compelling state interest in fair, thorough investigations, therapists' patient

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[53]*Lora*, 74 F.R.D. at 571.

[54]McKenna v. Fargo, 451 F. Supp. 1355, 1381 (D.N.J. 1978).

[55]*Whalen*, 429 U.S. at 602.

[56]*Id.*

[57]*Caesar*, 542 F.2d at 1067.

[58]*Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1043. The U.S. District Court for the District of Hawaii applied a "compelling state interest" test in determining the allowable level of intrusion under the autonomy strand and a balancing test under the confidentiality strand. *Id.* Other courts, less exacting but perhaps as effective in their analysis of privacy rights in psychotherapeutic relationships, have smudged the line between the two concepts and simply applied a balancing test to determine a general right against intrusion. *See* Caesar v. Mountanos, 542 F.2d 1064 (9th Cir. 1976), *cert. denied*, 430 U.S. 954 (1977); Miller v. Colonial Refrigerated Transp., Inc., 81 F.R.D. 741 (M.D. Pa. 1979); Lora v. Board of Educ., 74 F.R.D. 565 (E.D.N.Y. 1977); People v. Stritzinger, 34 Cal. 3d 505, 668 P.2d 738, 194 Cal. Rptr. 431 (1983).

[59]United States v. Nixon, 418 U.S. 683, 709 (1974); Branzburg v. Hayes, 408 U.S. 665, 695-701 (1972).

[60]Camperlengo v. Blum, 56 N.Y.2d 251, 255, 436 N.E.2d 1299, 1301, 451 N.Y.S.2d 697, 699 (1982).

files, containing information possibly vital to the administration of criminal justice, should be disclosed.[61]

This dogmatic approach, in effect, emasculates the right of privacy.[62] It does not appear to be an approach the Supreme Court would endorse. Rather, the Court would probably consider a number of relevant factors in order to balance the state's interests with the individual's privacy concerns, as it did in *Whalen v. Roe*.[63] The appellants in *Whalen* sought to enjoin the enforcement of a New York statute establishing a centralized computer file of the names and addresses of persons who had purchased, by prescription, drugs which, though legal, had a substantial potential for abuse, for example, opium, cocaine, or amphetamines.[64] Appellants, patients legally purchasing the drugs, feared a centralized record would discourage legal use of the medicines by creating user fears of stigmatization as addicts.[65]

The Court considered several factors in balancing the state's interest in disclosure versus the plaintiffs' privacy interests. Because of the limited disclosure sought, the adequacy of safeguards to prevent unauthorized disclosure, the state's demonstrated need for the records, and the lack of potential harm to the patient or to his relationship with his physician, the balance swung in favor of the state.[66]

In psychotherapist-patient cases, lower courts have applied similar factors:[67] (1) the extent to which the scope of the information requested has been limited to minimize any intrusion or risk of psychological harm;[68] (2) the safeguards established to ensure continued confidentiality

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[61]Chidester v. Needles, 353 N.W.2d 849, 853 (Iowa 1984).

[62]*Smith*, *supra* note 48, at 34.

[63]429 U.S. 589 (1977).

[64]*Id.* at 590-93.

[65]*Id.* at 595-96.

[66]*Id.* at 596-604.

[67]*See* Caesar v. Mountanos, 542 F.2d 1064 (9th Cir. 1976), *cert. denied*, 430 U.S. 954 (1977) (psychiatrist required to testify when former patient has placed her emotional health in issue, waived her privilege, and given psychiatrist permission to testify); Hawaii Psychiatric Soc'y v. Ariyoshi, 481 F. Supp. 1028 (D. Hawaii 1979) (state enjoined from enforcing its administrative statute authorizing searches of Medicaid providers' offices and records); Lora v. Board of Educ., 74 F.R.D. 565 (E.D.N.Y. 1977) (randomly selected records of anonymous emotionally handicapped school children may be disclosed to determine validity of racial discrimination charges); Commonwealth v. Kobrin, 395 Mass. 284, 479 N.E.2d 674 (1985) (disclosure of psychotherapist's records limited for purpose of Medicaid fraud investigation).

[68]*Caesar*, 542 F.2d at 1069; *Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1039; *Lora*, 74 F.R.D. at 579. The District Court of Hawaii noted that even disclosure only to government personnel may be too harmful to warrant instrusion because the records might contain highly personal communications or descriptions of embarrassing or illegal conduct. *Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1041.

of and limited access to the material sought;[69] and (3) the necessity (as opposed to desirability) to the litigation of the information gained by contested means.[70] In cases involving psychotherapy records, great weight should be given to patients' privacy rights because of the highly sensitive nature of the data sought.[71] As the sensitivity of the information increases, so should the state's burden to justify an intrusion.[72]

C. *The Psychotherapist-Patient Privilege as Protection*

The psychotherapist-patient privilege, an exception to the rule that courts must receive all evidence in a judicial proceeding,[73] is an outgrowth of the physician-patient privilege.[74] A majority of states have physician-patient privilege statutes similar to the act first passed in New York in 1828,[75] but those statutes offer little protection to psychotherapists. So many exceptions have been created to permit disclosure of medical information, whether in the public interest or to prevent fraud, that the privilege is now virtually useless.[76]

The psychotherapist-patient privilege, in contrast, has received broad support within the legal community. It has been incorporated into a

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[69]*Lora*, 74 F.R.D. at 579; *Kobrin*, 395 Mass. at 294-95, 479 N.E.2d at 681. The Supreme Judicial Court of Massachusetts established innovative safeguards, providing for *in camera* inspection of the records, and detailing the types of data which could be disclosed and those types which could not. *Id.* For a full discussion of the Kobrin decision, *see infra* notes 147-62 and accompanying text.

[70]*Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1045; *Lora*, 74 F.R.D. at 579; *Kobrin*, 395 Mass. at 292, 479 N.E.2d at 680. The District Court of Hawaii determined that details of patients' problems are not necessary to ascertain whether a psychiatrist is rendering services at the times and for the amounts claimed. *Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1042.

[71]*Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1043.

[72]*Id.*

[73]8 J. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2192 (1983).

[74]Comment, *Evidence: The Psychotherapist-Patient Privilege Under Federal Rule of Evidence 501*, 23 WASHBURN L.J. 706, 707 (1984).

[75]The current New York statute provides that:

> Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing, licensed practical nursing or dentistry shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity. The relationship of a physician and patient shall exist between a medical corporation . . . a professional service corporation . . . and the patients to whom they respectively render professional medical services.

N.Y. CIV. PRAC. LAW § 4504 (McKinney Supp. 1984). *See, e.g.*, N.C. GEN. STAT. § 8-53 (Supp. 1981); OHIO REV. CODE ANN. § 2317.02(B) (Page Supp. 1985); OR. REV. STAT. § 40.235 (1983); 42 PA. CONS. STAT. ANN. § 5929 (Purdon 1983); UTAH CODE ANN. § 78-24-8 (Supp. 1985); *see also* Comment, *supra* note 74, at 708.

[76]56 F.R.D. 183, 241 (1970).

majority of state codes[77] and was included in the 1972 proposed Rules of Evidence approved by the Supreme Court[78] — rules from which a physician-patient privilege was notably absent.[79]

Proposed Rule 504 of the Federal Rules of Evidence defined the psychotherapist-patient privilege as an individual's right to "refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of

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[77]*See, e.g.*, ALA. CODE § 34-26-2 (1985) (Psychiatrist and psychologist-patient privilege); ALASKA STAT. § 08.86.200 (1982) (Psychologist); ARIZ. REV. STAT. ANN. § 32-2085 (Supp. 1985) (Psychologist); ARK. STAT. ANN. § 28-1001: Rule 503 (1979) (Psychotherapist); CAL. EVID. CODE §§ 1010 *et. seq.* (West Supp. 1986) (Psychotherapist); COLO. REV. STAT. § 12-43-120 (1985) (Psychologist); COLO. REV. STAT. § 13-90-107(1)(g) (Supp. 1985) (Psychologist); CONN. GEN. STAT. ANN. § 52-146d *et. seq.* (West Supp. 1985) (Psychiatrist); DEL. CODE ANN. UNIF. RULES OF EVID., RULE 503 (Supp. 1984) (Psychotherapist); FLA. STAT. ANN. § 90.503 (West 1979) (Psychotherapist); GA. CODE ANN. § 38-418 (Supp. 1982) (Psychiatrist); GA. CODE ANN. § 84-3118 (Harrison Supp. 1982) (Psychologist); HAWAII REV. STAT. § 626-1, RULE 504.1 (Psychologist); IDAHO CODE § 54-2314 (1979) (Psychologist); ILL. ANN. STAT. ch. 111, § 5306 (Smith-Hurd Supp. 1985) (Psychologist); IND. CODE ANN. § 25-33-1-17 (West Supp. 1985) (Psychologist); KY. REV. STAT. § 421.215 (1971) (Psychiatrist); KY. REV. STAT. § 319.111 (1983) (Psychologist); ME. R. EVID. 503 (1985) (Psychotherapist); MD. CTS. & JUD. PROC. CODE ANN. § 9-109 (1984) (Psychiatrist and psychologist); MASS. GEN. LAWS ANN. ch. 233, § 20B (West 1986) (Psychotherapist); MICH. COMP. LAWS ANN. § 330.1750 (West Supp. 1985) (Psychiatrist and psychologist); MINN. STAT. ANN. § 595.02(g) (West Supp. 1986) (Psychologist); MISS. CODE ANN. § 73-31-29 (1972) (Paychologist); MO. ANN. STAT. § 337.055 (Vernon Supp. 1985) (Psychologist); MONT. CODE ANN. § 26-1-807 (1985) (Psychologist); N.H. REV. STAT. ANN. § 330-A: 19 (1984) (Psychologist); N.J. STAT. ANN. § 45: 14B-28 (Supp. 1985) (Psychologist); N.M. STAT. ANN. § 61-9-18 (Supp. 1984) (Psychologist); N.M. R. EVID. 504 (1983) (Psychotherapist); N.Y. CIV. PRAC. LAW § 4507 (McKinney Supp. 1984) (Psychologist); N.C. GEN. STAT. § 8-53.3 (1985) (Psychologist); OHIO REV. CODE ANN. § 4732.19 (Page Supp. 1985) (Psychologist); OR. REV. STAT. § 40.230 (1983) (Psychotherapist); 42 PA. CONS. STAT. ANN. § 5944 (Purdon 1982) (Psychologist); TENN. CODE ANN. § 63-11-213 (1982) (Psychologist); TENN. CODE ANN. § 24-1-107 (1980) (Psychiatrist); UTAH CODE ANN. § 58-25-8 (Supp. 1985) (Psychologist); VA. CODE § 8.01-400.2 (1984) (Psychologist); WASH. REV. CODE ANN. § 18.83.110 (1978) (Psychologist); WYO. STAT. § 33-27-103 (1977) (Psychologist). The following states have incorporated a therapist-patient privilege into other privilege statutes: IOWA CODE ANN. § 622.10 (West Supp. 1985); LA. REV. STAT. ANN. § 13:3734 (West Supp. 1985); NEV. REV. STAT. § 49.215 (1985); N.D. RULE EVID. 503 (Supp. 1985); OKLA. STAT. ANN. tit. 12, § 2503 (West Supp. 1985); S.D. CODIFIED LAWS ANN. § 19-13-7 (1979); VT. RULE EVID. 503 (1983); WIS. STAT. ANN. § 905.04 (West Supp. 1985); *see also* D.C. CODE ANN. § 14-307 (1981). These statutes may not afford as much protection for therapist-patient records as would a separate privilege. For example, in Miller v. Colonial Refrigerated Transp., Inc., 81 F.R.D. 741 (M.D. Pa. 1979), the district court found a *psychiatrist* seeking protection of his patient records did not fall within the ambit of the state's *psychologist*-patient privilege. *Id.* at 744. Rather, the medical therapist was forced to seek relief under the state's physician-patient privilege statute, which prohibited disclosure of communications "which shall tend to blacken the character of the patient . . . ." That phrase had been interpreted in a 1925 decision to refer to a "loathsome disease." Because mental health problems were not such a "disease," the psychiatrist's records, unlike a psychologist's, were not protected. *Id.* at 743.

his mental or emotional condition . . . ."[80] Except for three circumstances — when examination was ordered by a judge, when communications were relevant to a condition that was an element of a claim or defense, or in proceedings for hospitalization[81] — the privilege was to be inviolate as to "legally coerced disclosure."[82]

Because this tightly constructed federal privilege was not codified,[83] therapists and their patients must rely on federal case law[84] and judicial interpretation of varying state statutes[85] for protection of confidences.

D. Patients' Waiver of Protection

Psychotherapist-patient confidences are protected to encourage the development and continuation of a relationship deemed highly beneficial to society.[86] However, patients may waive their protective rights or privileges, either by voluntary disclosure or consent to disclose.[87]

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[78]56 F.R.D. at 240.

[79]*See id.* at 241-42. The psychotherapist-patient privilege, unlike the physician-patient privilege, meets all four of Wigmore's criteria for justification of an evidentiary exception: (1) that communications originate in confidence that they will not be revealed; (2) that confidentiality is essential to the relationship; (3) that the relationship should be fostered; and (4) that potential injury is greater than the benefit gained by disclosure. 8 J. WIGMORE, *supra* note 73, at § 2285.

[80]56 F.R.D. at 241.

[81]*Id.*

[82]*Id.* at 244.

[83]Congress expressed concern not that the proposed privileges were too liberal, but that they were unacceptably constrictive, providing for only a "partial doctor-patient privilege," a narrowed husband-wife privilege, and no newsreporter's privilege whatsoever. S. Rep. No. 1277, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & ADMIN. NEWS 7051, 7053. *But see* United States v. Witt, 542 F. Supp. 696, 698 (S.D.N.Y.), *aff'd*, 697 F.2d 301 (2d Cir. 1982), in which the federal district court took notice that Congress had "expressly refused" to endorse a psychotherapist-patient privilege. This would appear to be a convenient misreading of congressional intent in substituting Rule 501, for the purpose of reaching a desirable decision in a specific case.

[84]*See In re* Zuniga, 714 F.2d 632 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983); *In re* Pebsworth, 705 F.2d 261 (7th Cir. 1983); *In re* Doe, 97 F.R.D. 640 (S.D.N.Y. 1982); Lora v. Board of Educ., 74 F.R.D. 565 (E.D.N.Y. 1977); United States *ex rel* Edney v. Smith, 425 F. Supp. 1038 (E.D.N.Y. 1976). All of the above cases recognize a federal common law privilege. *But see* United States v. Witt, 542 F. Supp. 696 (S.D.N.Y.), *aff'd*, 697 F.2d 301 (2d Cir. 1982); Felber v. Foote, 321 F. Supp. 85 (D. Conn. 1970).

[85]*See supra* note 77 for state psychotherapist-patient privilege statutes.

[86]56 F.R.D. at 258; *In re* Zuniga, 714 F.2d 632, 638 (6th Cir. 1983), *cert. denied*, 464 U.S. 983 (1983); *see also* Hawaii Psychiatric Soc'y v. Ariyoshi, 481 F. Supp. 1028 (D. Hawaii 1979).

[87]*In re* Zuniga, 714 F.2d at 640; *In re* Pebsworth, 705 F.2d 261, 262 (7th Cir. 1983); Henry v. Lewis, 102 A.D.2d 430, 435, 478 N.Y.S.2d 263, 268 (1984).

Under traditional waiver doctrines, disclosure of confidential communications to any third party constitutes waiver of one's rights to protection, regardless of purpose or circumstance.[88] This strict approach was applied to insurance billing investigations in *In re Zuniga*.[89] Two psychotherapists, claiming patient privileges, refused to deliver subpoenaed records of patients' names, appointment dates and session lengths.[90] The Sixth Circuit Court of Appeals ordered compliance, ruling that the patients had waived all rights to confidentiality by giving the data to their insurance carrier, a party outside the therapist-patient relationship.[91]

Similarly, the Seventh Circuit Court of Appeals, in *In re Pebsworth*,[92] permitted disclosure of a psychotherapist's patients' identities, appointment dates and, in some cases, diagnoses for an insurance fraud investigation.[93] The court determined that a patient's express authorization to disclose information to an insurer for reimbursement purposes was, in effect, an all-encompassing waiver of privilege.[94] It reasoned that a privilege exists only when a patient intends for the communication to be confidential,[95] implying that an insurance authorization demonstrates a lack of the requisite intent. It noted that, by submitting to reimbursement procedures, patients had already permitted "numerous employees in a large, anonymous corporation" to intrude on their privacy.[96] The court apparently did not recognize any patient right to choose to disclose information only to specific parties for a limited purpose.[97]

Despite their strict adherence to the traditional rule, both the *Zuniga* and the *Pebsworth* courts seemed unsure that the waiver doctrine could be applied consistently in cases involving psychotherapists' fraud.[98] Justice

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[88] *In re* Pebsworth, 705 F.2d at 263.

[89] 714 F.2d 632.

[90] *Id.* at 640.

[91] *Id.*

[92] 705 F.2d 261.

[93] *Id.* at 262-64.

[94] *Id.* at 262.

[95] *Id.* at 263, *citing* Lora v. Board of Educ., 74 F.R.D. 565, 585 (E.D.N.Y. 1977).

[96] *In re* Pebsworth, 705 F.2d at 264.

[97] *Id.* at 263; *see also* McCormick, Evidence § 103 & n.3 (3d ed. 1984) (insurance policy authorization to disclose terminates privilege for all purposes, including court proceedings).

[98] *In re* Zuniga, 714 F.2d at 640-41; *In re* Pebsworth, 705 F.2d at 263.

> While we might well have decided differently if the information sought under the subpoena involved detailed psychological profiles of patients or substantive accounts of therapy sessions, it cannot be said that the subsequent disclosure of such fragmentary data as is involved here as part of the insurance company's legal duties in assisting a federal criminal investigation would be beyond the contemplation of the patients' waiver.

Id.

William P. Gray, in his *Pebsworth* concurrence, articulated valid causes for this uncertainty, asserting that "traditional waiver doctrines are inappropriate in the context of present-day medical insurance."[99] He reasoned that by easing the financial strain that might discourage one from seeking needed treatment, insurance plans, like physician-patient privileges, encourage the establishment of psychotherapist-patient relationships necessary for the protection of one's mental health.[100] Though a patient may, out of economic necessity, consent to disclosure to a medical insurer, it does not necessarily follow that he has voluntarily consented to disclosure for unrelated purposes, such as aiding a criminal investigation.[101]

Within the modern medical service structure, insurance carriers are accepted and at times indispensable parties to treatment processes. As such, they should be treated like nurses in a physician-patient relationship or secretaries and paralegals in an attorney-client relationship.[102] Insurers' knowledge of communications should not destroy the privilege of confidentiality.[103] An authorization to release data to determine benefits payable should be limited to the express terms of the provision.[104] Unless specifically stated, it should not run to an investigator of fraudulent claims.[105]

This analysis is particularly true in the case of Medicaid recipients' disclosure agreements. An indigent patient's signature on a release form should not be characterized as a knowing waiver of his interests in confidentiality.[106] As the United States District Court for the District of Hawaii stated in *Hawaii Psychiatric Society v. Ariyoshi*,[107] "It is far more likely that, if he reads the form at all, a patient would assume that the records would include only billing information and similar nonconfidential matters."[108] Even if a recipient fully understood the impli-

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[99]*In re* Pebsworth, 705 F.2d at 264 (Gray, J., concurring).

[100]*Id.*

[101]*Id.*

[102]*Id.*

[103]*Id.*

[104]*Henry*, 102 A.D.2d at 435, 478 N.Y.S.2d at 268.

[105]*Id.*

[106]*Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1045. Because the Medicaid program is state administered and each state promulgates its own forms, Medicaid applicant releases vary from state to state. A release might read like the Indiana provision: "I agree to undergo any examinations necessary to establish my eligibility for financial and/or medical assistance. I authorize any physician, hospital, or other provider of care to release any medical information about me, if requested by the County Welfare Department." Application for Medical Assistance, State Form 1267R4/DPW Form 2 (Rev.3-84), prescribed by the Indiana Department of Public Welfare. The applicant must "X" a box next to this statement and eight other provisions to indicate understanding and agreement.

[107]481 F. Supp. 1028 (D. Hawaii 1979).

[108]*Id.* at 1045.

cations of the authorization, his waiver could not fairly be characterized as a voluntary waiver. For an indigent, the choice between a loss of confidentiality rights and a loss of health for lack of medical attention is in reality no choice at all. As the court in *Hawaii Psychiatric Society* determined, neither a patient's nor a therapist's participation in the Medicaid program or agreement to make records available is equivalent to implicit waiver of the right of confidentiality.[109]

E. The Scope of Protection

Courts seem reluctant to define clearly the bounds of protection for information obtained in a psychotherapeutic relationship.[110] This reluctance has given rise to conflicting interpretations regarding the bounds of the psychotherapist-patient privilege.

For example, in *Chidester v. Needles*,[111] the Iowa Supreme Court reached a conclusion that would permit wholesale disclosure of all patient profiles, though only administrative data were at issue in the case.[112] In contrast, both the Sixth Circuit, in *In re Zuniga*,[113] and the Seventh Circuit, in *In re Pebsworth*,[114] permitted surrender of administrative records, but suggested they would not be as receptive to a request to disclose psychological profiles.[115] The District Court of Hawaii, in *Hawaii Psychiatric Society*,[116] protected all records from unwarranted seizure,[117] but left open the possibility of access to any documents reasonably requested.[118]

The confusion these decisions engender can cripple a therapeutic relationship. A patient's fear that all he says or all that is learned from what he says might be publicly revealed might cause him to hold back or withdraw from the therapy process.[119] A therapist's fear of governmental review of his records and the "highly personal and sensitive concerns of patients"

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[109]*Id.*

[110]*See In re* Zuniga, 714 F.2d 632, 639 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983).

[111]353 N.W.2d 849 (Iowa 1984).

[112]*See infra* notes 124-127 and accompanying text for a complete discussion of the Chidester decision.

[113]714 F.2d 632.

[114]705 F.2d 261.

[115]*In re* Zuniga, 714 F.2d at 640-41; *In re* Pebsworth, 705 F.2d at 263.

[116]481 F. Supp. 1028.

[117]*Id.* at 1039.

[118]*Id.* at 1042.

[119]The Sixth Circuit Court of Appeals, in *In re Zuniga*, quoted Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955) (quoting GUTTMACHER & WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952)):

> " 'The psychiatric patient . . . exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients . . . know that this is what will be expected of

therein[120] might result in his making less thorough notations[121] or in his keeping two sets of patient records, one less accessible than the other.[122]

Like actual disclosure, then, uncertainty as to the limits of protection can hinder effective therapy. Therapists need consistent guidelines and limits to prevent any unintended and unnecessary inroads on the privacy of therapeutic relationships.

1. Lack of Definition Encourages Unwarranted Intrusion. — Though the federal Medicaid statutes indicate a congressional concern for patients' confidentiality rights,[123] they offer little guidance in defining the limits of permissible intrusion. In the absence of congressional restraints, courts have at times unnecessarily eroded Medicaid patients' privacy and confidentiality rights.

For example, in *Chidester*, a county attorney obtained a subpoena for a psychological clinic's appointment books, ledger cards and copies of Medicaid billings for a fraud investigation.[124] The clinic refused to comply, invoking a physician-patient privilege.[125] Strictly construing statutory language, the Iowa Supreme Court found that the privilege extending protection to professionals "giving testimony" applied only to oral testimony; documents revealing therapists' knowledge were not protected by law.[126] Following decisions of other jurisdictions, the court

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> them . . . . It would be too much to expect them to do so if they knew that all they say — and all that the psychiatrist learns from what they say — may be revealed to the whole world from a witness stand.' "

714 F.2d at 638.

[120] *Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1039.

[121] *Id.*; Commonwealth v. Kobrin, 395 Mass. 284, 292 n.15, 479 N.E.2d 674, 680 n.15 (1985).

[122] "Some clinicians . . . attempt to compromise between the demands of professional standards and those of the courts. Personnel at university counseling centers are sometimes told to keep detailed records at home and only minimal records at the office . . . ." Fisher, *supra* note 19, at 39, col. 4.

[123] 42 U.S.C. 1396a(a)(7) (1982). Congress has required that states formulate safeguards that protect, at a minimum, recipients' "(1) Names and addresses; (2) Medical services provided; (3) Social and economic conditions or circumstances; (4) Agency evaluation of personal information; and (5) Medical data, including diagnosis and past history of disease or disability." 42 C.F.R. § 431.305 (1985).

[124] *Chidester*, 353 N.W.2d at 851. No detailed records of diagnoses or prognoses of the patients were requested, but the subpoenaed ledger cards did bear coded diagnostic information. *Id.*

[125] *Id.* The clinic also asserted its patients' rights of privacy. *Id.*

[126] *Id.* at 852. The Iowa physician-patient privilege statute reads, in part:

> A practicing . . . mental health professional . . . shall not be allowed, in giving testimony, to disclose any confidential communication properly entrusted to the person in the person's professional capacity, and necessary and proper to enable the person to discharge the functions of the person's office according to the usual course of practice or discipline.

could have found the limited information sought to be outside the scope of a physician-patient privilege, leaving intact protection for the more sensitive aspects of therapy.[127] In choosing to address a potential statutory construction problem, the Iowa Supreme Court unnecessarily compromised the confidentiality vital to a psychotherapeutic relationship.

In *In re Grand Jury Investigation*,[128] the state argued that the supremacy clause of the Constitution rendered Rhode Island's statutory privilege inoperative in the Medicaid fraud investigation of a physician.[129] The state supreme court agreed.[130] It held that the privilege statute must yield to federal law because, if implemented, it would prevent complete accomplishment of the statutorily expressed congressional intent to provide access to all necessary documentation.[131] Therefore, the court permitted disclosure of all records generated from the physician's relationships with Medicaid patients.[132] The court also indicated that further on in litigation, with a showing of materiality, relevance, or necessity, the investigating unit could obtain other related patient records.[133]

Though federal Medicaid documentation requirements do indicate a congressional intent to create an exception to patient privilege rules,[134] the *Chidester* and *In re Grand Jury Investigation* decisions, allowing unrestricted disclosure, unreasonably expand that exception. Certainly, verification of the rendering of services for which reimbursement is sought is necessary to the continued viability of the Medicaid program.[135] Patients must tolerate some infringement of their rights in the interest of accurate investigations ensuring appropriate expenditure of funds.[136] However, this infringement should be no greater than necessary for

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[127] *See infra* notes 143-46 and accompanying text.

[128] 441 A.2d 525 (R.I. 1982).

[129] *Id.* at 528.

[130] *Id.* at 529.

[131] *Id.* at 531.

[132] *Id.*

[133] *Id.*

[134] 42 U.S.C. § 1396a(a)(27) (1982); 42 C.F.R. § 431.17(b) (1985).

[135] *Kobrin*, 395 Mass. at 290, 479 N.E.2d at 678-79.

[136] Camperlengo v. Blum, 56 N.Y.2d 251, 255-56, 436 N.E.2d 1299, 1301, 451 N.Y.S.2d 697, 699 (1982). Despite its dicta concerning limitations on disclosure, the Court of Appeals of New York permitted wholesale disclosure of a psychiatrist's patient records apparently because the doctor failed to claim that the scope of the subpoena was overly broad. *Id. See also Kobrin*, 395 Mass. at 293, 479 N.E.2d at 681. The Supreme Court, Appellate Division, of New York seems to have misinterpreted *Camperlengo* in Doe v. Kuriansky, 91 A.D.2d 1068, 458 N.Y.S.2d 678 (1983). Citing *Camperlengo* as support for the proposition that statutory privileges are inapplicable in a Medicaid fraud investigation, the court permitted full disclosure of Medicaid patients' records in a grand jury investigation of a provider-hospital's fraudulent practices. *Id.* of a provider-hospital's fraudulent practices. *Id.*

"effective oversight" of the Medicaid program.[137] Both the federal need for information and the patient's need for confidentiality may be adequately satisfied by prudent limitation of the scope of disclosure.[138] The federal disclosure requirements need not be construed as mandating the complete abrogation of a patient's privilege.

2. Workable Guidelines for Limited Access. — Before gaining acess to a therapist's documents, an investigating unit should be required to meet three criteria. First, it should make some showing of an " 'individualized, articulable suspicion' " of fraud.[139] An adequate showing might be made based on a "tip" (an informant's allegation of misconduct) or on a statistical analysis of the Medicaid billings of a randomly selected provider.[140] Second, the unit should show that the information is not reasonably available from another source.[141] Third, it should show that the information requested is clearly relevant to the issue before the court.[142]

In Medicaid fraud investigations of psychotherapists, the critical issue before the court is whether specific claimed services were rendered on the dates and for such lengths of time as a therapist has represented.[143] Courts generally agree that to verify rendition of services, fraud investigators must have access to patient identities and the dates and lengths of treatment sessions.[144] They also agree that release of this data does not violate patients' confidentiality interests.[145] Thus, they have concluded, this data is not protected by constitutional privacy rights or by statutory privilege.[146]

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[137]*Camperlengo*, 56 N.Y.2d at 256, 436 N.E.2d at 1301, 451 N.Y.S.2d at 699.

[138]*See Kobrin*, 395 Mass. at 284, 479 N.E.2d at 674. *But see In re* Grand Jury Investigation, 441 A.2d 525. This case involved a physician (rather than a psychotherapist) seeking protection under a variation of the disfavored physician-patient privilege. *Id.* at 527.

[139]*Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1050.

[140]Fisher, *supra* note 19, at 39, cols. 1-2.

[141]Smith, *supra* note 48, at 36.

[142]*Id.*; Caesar v. Mountanos, 542 F.2d at 1075 (Hufstedler, J., dissenting in part).

[143]*Kobrin*, 395 Mass at 292, 479 N.E.2d at 680.

[144]*In re* Zuniga, 714 F.2d 632; *In re* Pebsworth, 705 F.2d 261; *Kobrin*, 395 Mass. 284, 479 N.E.2d 674; *see also* Simpson v. Braider, 104 F.R.D. 512 (D.D.C. 1985) (discussing the psychotherapist-patient privilege in a patient-litigant context); Henry v. Lewis, 102 A.D.2d 430, 478 N.Y.S.2d 263 (1984) (considering the effect of a physician-patient privilege on an insurance fraud investigation).

[145]*In re* Zuniga, 714 F.2d 632; *In re* Pebsworth, 705 F.2d 261; *Kobrin*, 395 Mass. 284, 479 N.E.2d 674; *see also Simpson*, 104 F.R.D. 512; *Henry*, 102 A.D.2d 430, 478 N.Y.S.2d 263.

[146]*In re* Zuniga, 714 F.2d 632; *In re* Pebsworth, 705 F.2d 261; *Kobrin*, 395 Mass. 284, 479 N.E.2d 647; *see also Simpson*, 104 F.R.D. 512; *Henry*, 102 A.D.2d 430, 478 N.Y.S.2d 263.

Those courts recognizing confidentiality rights agree that records of patient conversations are protected.[147] As the Supreme Judicial Court of Massachusetts reasoned in *Commonwealth v. Kobrin*,[148] knowledge of a patient's thoughts, emotions, or descriptions of conduct does not help an investigator verify rendition of a service.[149]

It is more difficult to ascertain the appropriate level of protection for information falling between the two extremes of administrative data and patient conversations. In *Kobrin*, the court attempted to define precisely the scope of protection for this information within the context of a Medicaid fraud investigation.

In that case, the Massachusetts fraud control unit had requested the subpoena of all patient records, medical histories, diagnostic and treatment records, worksheets, X-rays, X-ray records, test results, laboratory results, laboratory invoices, and records of medications administered or prescribed, including strength, dosage and regimen.[150]

The court permitted disclosure of records documenting the times and lengths of patient appointments and the fees charged.[151] It also permitted disclosure of documentation of somatic therapies — physical treatments such as medication or electroconvulsive therapy.[152] Investigators would need this information to verify the provision of physical services for which a therapist had requested reimbursement.

Though the court denied the state access to records of patient conversations, it provided that a judge could release to the state a physical description of those notations.[153] He could, "for example, inform the [state] that the psychiatrist's record of a particular date includes a one-page, handwritten report of a psychotherapy session . . . . If the medical record is devoid of such notations, the judge may so indicate."[154] Such a description could aid investigators, for example, in determining the validity of "tips" without needlessly encroaching upon a patient's privacy zone.[155]

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[147]*Kobrin*, 395 Mass. at 295, 479 N.E.2d at 682; *see also* Miller v. Colonial Refrigerated Transp., Inc., 81 F.R.D. 741, 743 (M.D. Pa. 1974) (psychotherapist-patient privilege in a patient-litigant situation); *Henry*, 102 A.D.2d at 432, 478 N.Y.S.2d at 266 (physician-patient privilege in an insurance fraud investigation).

[148]395 Mass 284, 479 N.E.2d 674.

[149]*Id.* at 292, 479 N.E.2d at 680; *see also Hawaii Psychiatric Soc'y*, 481 F. Supp. at 1042.

[150]*Kobrin*, 395 Mass. at 285 n.2, 479 N.E.2d at 676 n.2.

[151]*Id.* at 294, 479 N.E.2d at 681.

[152]*Id.*

[153]*Id.* at 295, 479 N.E.2d at 682.

[154]*Id.*

[155]Often in an audit, a therapist's relatively innocuous appointment books and billing records are sufficient to prove or disprove any fraudulent practices. Fisher, *supra* note 19, at 39, cols. 1-2. Tips are less easily dispensed with. Arthur Friedman, of the office

The *Kobrin* court permitted the disclosure of patient diagnoses, treatment plans and recommendations, and psychiatrists' "observations of objective indicia of emotional disturbance . . . ."[156] Objective indicia, as defined by the court, may include but are not limited to: "disturbance of sleep or appetite; anergia; impaired concentration or memory; hopelessness; anxiety or panic; dissociative states; hallucinations; labile or flattened affect; or somatic symptoms such as headaches."[157] The court also provided for release of "objective accounts of the patient's past medical and psychiatric histories . . . ."[158]

Though the court did not explain its reasons for allowing disclosure of this more sensitive data, there are at least two possible justifications. First, the information might be valuable in determining the appropriateness or quality of care. However, as the *Kobrin* court noted, those issues are not a part of Medicaid fraud investigations.[159] Rather, they fall within the province of state licensing of health agencies.[160]

Second, with access to this detailed data, fraud investigators could perhaps better identify doctored records or nonexistent clientele — the more specific the notations on problems and future courses of treatment, the more likely a patient truly exists. Assuming this type of contribution could be made to a fraud investigation, that contribution still must be balanced with a patient's rights of privacy and needs for confidentiality before disclosure is permitted.

Release of diagnoses, treatment plans and patient histories would intrude significantly on an individual's privacy. As a practical matter, it is difficult to separate diagnoses, recommendations and indications of emotional disturbance from a patient's confidential communications.[161] After all, a therapist's notes and observations are simply information gained from a patient to which is applied professional knowledge and experience.[162] In weighing the sensitivity of this information, the potential for embarrassment or harm to the individual, and the value of an

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of the Inspector General of the Massachusetts Department of Health and Human Services, hypothesized:

> [T]he psychiatrist's secretary, whom he's just fired, comes to you with a list of all the patients that he has never seen, but whose names have been written down in an appointment book and on billing cards . . . . And she tells you that she knows he keeps detailed notes on the patients he does see . . . .

Id. at 39, col. 2.

[156] *Kobrin*, 395 Mass. at 295, 479 N.E.2d at 681.

[157] *Id.* at 295 n.18, 479 N.E.2d at 681-82 n.18.

[158] *Id.* The court stated these histories could "include earlier hospitalizations, treatments and diagnoses but . . . not . . . patient conversations." *Id.*

[159] *Id.* at 292-93, 479 N.E.2d at 680.

[160] 42 U.S.C. 1396a(a)(33) (1983).

[161] *Simpson*, 104 F.R.D. at 521-22.

[162] *Id.*

effective therapeutic relationship to the individual and to society as a whole against the value of the information in verifying the rendition of therapeutic services, the patient's interests should mitigate against release of these records.

IV. Conclusion

Protection of a patient's confidentiality rights is vital to the establishment and successful development of a psychotherapist-patient relationship. Without assurances of confidentiality, a patient may not feel free to seek medical assistance or to discuss openly his problems with a therapist.

Access to patient records is vital to effective oversight of Medicaid providers. Without a therapist's records of services rendered, investigative units cannot efficiently and accurately verify the validity of Medicaid providers' claims.

If three criteria for disclosure are met, a proper balance between these seemingly irreconcilable interests can be struck with minimal harm to the needs of either party. First, fraud control units should be required to demonstrate a reason for suspecting fraud by a therapist under investigation. Second, units should be required to show that the information sought cannot be obtained from other sources. Third, disclosure should be strictly limited to information relevant to a determination that specific services were provided on the dates and for the lengths of time therapists have claimed. This last criterion can be achieved through *in camera* inspection and selective disclosure of those documents reasonably requested.

Administrative data and documentation of physical services rendered should be available to investigation units. These details are basic to a determination of the validity of therapists' claims and only minimally encroach on a patient's privacy. Similarly, physical descriptions of a therapist's notes, while revealing nothing about the nature of a patient's visit, may well be a valuable aid to affirmation of the rendition of therapeutic services on a particular date and for the length of time claimed.

However, publication of diagnoses, treatment plans, patient histories and "objective indicia of emotional disturbance" could subject a patient to embarrassment, humiliation or other harm, seriously violating his rights of confidentiality and autonomy and compromising his state-conferred psychotherapist-patient privilege. In contrast, this information would add little to a verification that services were provided where patient names, appointment schedules, billing records, notations of physical services and physical descriptions of session notes had been made available. The state interest in disclosure, then, should not overcome a patient's constitutional and statutory rights to confidentiality. This information should be protected from release.

In conclusion, both investigating units and patients must tolerate some compromise of their needs in Medicaid fraud investigations. By well-considered, consistent limitation of the scope of disclosure, courts can ensure that the Medicaid program retains its viability and provides a valuable public service without inflicting unwarranted harm on those who seek its assistance.

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