HIPAA FAQ

Some states have additional specific requirements that can be checked through the Board of Healing Arts/Medical Board or Hospital Association. KAMMCO recommendations include:

1. Can covered healthcare providers share protected health information about patients for treatment purposes?

A facility or medical practice's Notice of Privacy Practices (NPP) is required to inform the patient how the practice intends to use and disclose protected health information (PHI). If the patient has received your notice and has signed an acknowledgment of receipt of Notice of Privacy Practices, you may share information with other healthcare providers related to treatment, payment, and operations (TPO).

2. Is the release of medical records related to mental health or drug and alcohol treatment handled any differently than the release of other types of medical treatment?

Patients who have received treatment in a mental health facility or drug & alcohol treatment facility must sign an authorization specific to the release of those records. If the patient has talked to their primary care physician about depression or drug and alcohol use in the course of other treatment, those records fall under HIPAA guidelines for treatment, payment, and operations.

3. If we receive a request for medical records with a proper authorization, and another physician's records are contained in our chart, must we copy and send those records as well?

Under the federal HIPAA law, 45 C.F.R. 164.501, a designated record set is a group of records maintained by, or for, a covered entity that is used, in whole or in part, by, or for, the covered entity to make decisions about individuals and includes any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by, or for, a covered entity. Therefore, if the person requesting the medical record requests the entire chart, or a portion of the chart, which includes records from another provider, if you have relied upon those records for treatment decisions, those records should be released along with your own medical records.

There is an exception to this general rule. That exception falls under a federal law protecting the records of a patient for drug or alcohol abuse. 42 C.F.R. Part 2. If you have records from another provider which includes records dealing with drug or alcohol abuse, you may not be able to disclose those particular records based upon the federal law preventing such re-disclosure.

4. How often does HIPAA require a patient to sign a medical practice's Notice of Privacy Practices?

A covered healthcare provider who has a direct treatment relationship with a patient is required to make a good faith effort to obtain an individual's acknowledgement of receipt of the notice only at the time the provider delivers the initial service.

5. Is a patient required to pay for a copy of their medical record information?

The HIPAA Privacy Rule permits the covered entity to impose reasonable, cost-based fees. The fee may only include the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed. If the patient agreed to receive a summary of explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary explanation. The fee may not include costs associated with searching for, and retrieval of, the requested information. See 45 C.F.R. 164.524(c).

MEDICAL RECORDS FAQ

Some states have additional specific requirements that can be checked through the Board of Healing Arts/Medical Board or Hospital Association. KAMMCO recommendations include:

1. I have received a records request from an attorney. What do I do?

Make sure you read the entire records request. Check to see what the attorney is asking for, and who the attorney is representing. Check to see if the records request includes a HIPAA-compliant authorization from the patient to release the protected health information (PHI). If there is no supporting authorization, call the attorney's office to tell them you will not be able to send the records. If you need assistance determining if there is proper authorization, contact KAMMCO and we will review the request with you.

2. I have received a subpoena. What do I do?

Pay special attention to what the subpoena is commanding. Some subpoenas are an order to appear, while others are simply an order for production of records. Check to see who issued the subpoena. If the subpoena was signed by a judge, which makes it a court order, you must comply with the subpoena. If the subpoena was issued by an attorney or clerk of the court, you will need one of the following:

- A court order, signed by a judge;
- A HIPAA-compliant patient authorization;
- Satisfactory assurances in the subpoena plus an exception to Kansas law allowing the disclosure; or,
- An exception under HIPAA and state allowing the disclosure.

If none of these are present, hire an attorney to object to the subpoena.

If you receive a subpoena to appear for testimony, it is still necessary to have the proper authorization to release PHI. If you do not have the proper authorization, you still MUST appear on the date and time stated in the subpoena. You will likely be given a court order upon your appearance authorizing the release of patient information, so it is important to bring the patient's information with you.

If desired, KAMMCO will provide an attorney to accompany you when subpoenaed to testify, regardless of whether your medical care is at issue.

For help in determining if you have the proper documents to release patient information, contact KAMMCO.

3. Who can get the records of a deceased patient?

First, determine if an estate has been opened by the court for the deceased patient. If so, the court will have named an executor or administrator of the estate. If there is an executor or administrator named, then this is the only person who may get the records of the deceased patient, absent a court order.

However, often no estate has been opened or will be opened. In this case, the next-of-kin, in line of descent, are entitled to access and authorize release of the medical records of the deceased patient. Under next-of-kin rules, if there is a spouse, then the spouse can get the records and no one else, absent a court order. If there is no spouse, then any adult child of the deceased patient may get the records. If there are no adult children, then the patient's parents may get a copy of the records. Finally, if there are no parents, then the patient's siblings may get the records.

Document your reasoning in allowing access to the medical records by the person requesting the medical records. Also, document some reasonable attempt to prove that the person is who they claim to be. For example, you could check a driver's license, check the chart to see if next-of-kin were named, or verify matching last names.

4. The Board of Nursing or the Board of Healing Arts has subpoenaed a patient record. May I release the information?

Licensing boards, such as the Board of Healing Arts and the Board of Nursing, have a right to request protected health information (PHI) in investigating potential or existing disciplinary actions against a licensee. If you receive a request

for PHI from a licensing board, you may release the information after verifying and documenting that the Board needs the information as part of investigation of the licensee. HIPAA does not preclude the release of records under such circumstances if you have determined that the purpose of the release is for healthcare operations, such as investigating disciplinary actions, by the healthcare oversight agency, including the Board of Nursing or the Board of Healing Arts.

5. I have been asked to release the patient medical record, with proper authorization. Do I have to release other providers' records I have in my chart?

Under the federal HIPAA law, 45 C.F.R. 164.501, a designated record set is a group of records maintained by, or for, a covered entity that is used, in whole or in part, by, or for, the covered entity to make decisions about individuals and includes any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by, or for, a covered entity.

Therefore, if the person requesting the medical record requests the entire chart, or a portion of the chart, which includes records from another provider, if you have relied upon those records for treatment decisions, those records should be released along with your own medical records.

There is an exception to this general rule. That exception falls under a federal law protecting the records of a patient for drug or alcohol abuse. 42 C.F.R. Part 2.

Should you determine that the release of the records is inappropriate, you should state there are records you are not at liberty to release. You do not need to disclose the other provider, the origin of the records, the type of treatment involved, or the reason for the non-disclosure.

6. How long do I have to keep medical records?

Physicians keep medical records for ten (10) years from the date of last treatment. This includes minors and deceased patients.

Hospitals keep medical records for ten (10) years after the date of last discharge of the patient, or one (1) year beyond the date the minor patient reaches the age of majority, whichever is longer. A hospital must maintain a summary of medical records that are destroyed.

This summary shall be retained on file for at least twenty-five (25) years and shall include the following information:

- The name, age, and date of birth of the patient;
- The name of the patient's nearest relative;
- The name of the attending and consulting practitioners;
- Any surgical procedure and date, if applicable; and,
- The final diagnosis.

7. How long am I required to keep charts of inactive patients?

Each physician shall maintain the patient record for a minimum of ten (10) years from the last date the physician provided services to the patient.

8. Am I required to keep inactive charts on site?

No, a physician may designate an entity, another physician, or healthcare facility to maintain the record so long as the record is stored in a manner that allows access to the record and maintains confidentiality.

9. What are the requirements for electronic medical records?

Patient records may be stored by an electronic data system, so long as the electronic record is an exact duplication of the paper record, the entry is authenticated and unalterable, and the record can be reproduced in paper form, if requested. An electronic indicate if there are existing original documents or information not included in the electronic record.

10. Can I destroy the paper copies once they are entered into the electronic record?

Paper records may be destroyed once they are entered into an electronic record, if the electronic record is an exact replication of the information on the paper record, and the record can be reproduced in paper form from the electronic record, if requested.

11. I am terminating my practice. What do I do with patient records?

Patient records should be stored upon termination of practice, and the physician is required to notify the Board of Healing Arts/Medical Board, within thirty (30) days of terminating the practice:

- The location where the patient records are stored;
- If the physician has designated an agent to maintain the records, the name, telephone number, and mailing address of the agent; and,
- The date on which the patient records are scheduled to be destroyed.

12. How much should I charge for copying patient records?

Under the HIPAA Privacy Rule, a covered entity may impose "reasonable," cost-based fees for copying medical records. The fee may include only the cost of copying (including supplies and labor) and postage, if the patient requests the copy be mailed. If the patient has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary of explanation. The fee may not include costs associated with searching for and retrieving the requested information. See, 45 C.F.R. 164.524(c).

13. A patient has requested a records transfer, but still owes our practice for prior services. Can we demand payment before transferring the records?

A physician should furnish a copy of a patient's medical record upon receipt of a signed release. Release of a medical record cannot be conditioned upon payment of a medical debt. However, a statement that the physician may charge a reasonable fee for the costs of retrieving and reproducing the record. It is not a violation to demand pre-payment of this fee when the request comes directly from the patient rather than from another provider.

PATIENT RELATIONS FAQ

Some states have additional specific requirements that can be checked through the Board of Healing Arts/Medical Board or Hospital Association. KAMMCO recommendations include:

1. How do I deal with a patient complaint?

Instead of immediately responding to an angry patient, first determine the actual reason for the patient's dissatisfaction. The most common cause of patient dissatisfaction is some type of surprise, usually stemming from the outcome of the patient's treatment or the amount of the patient's bill.

After you have determined why the patient is angry, the best practice is to deal with the situation directly. Often a patient simply wants attention or an answer and his or her anger dissipates once they receive a response.

If a patient has a complaint about a particular physician or staff member, responses should be made promptly and in the form requested by the patient (e.g., letter or telephone call).

If a particular situation is especially difficult, you may want to draft a response to the patient and ask KAMMCO to review it before sending it to the patient.

2. What if a patient requests a refund or a write-off of his or her bill?

Because every situation is different, there are no set guidelines for whether or not to refund or write off a patient's bill. Often a patient who does not have to pay for what he or she feels is unwarranted, will accept the waiver as restitution and interpret it as a gesture of good will. However, some patients may interpret it as an admission of liability, so the risks and benefits should be weighed carefully before making such a decision.

If, in fact, you do decide to write off the patient's bill, it is important to emphasize that you are doing so from a customer service standpoint. Also, it is a good idea to have the patient sign a release of claims form, which is an agreement between the patient and physician stating that in exchange for the physician writing off the patient's charges, the patient is waiving his or her right to bring a claim related to the incident at issue.

3. What if a patient fails to show up for follow-up appointments?

If a patient cancels or is a no-show for an appointment, be sure to note in the patient's chart that he or she did not keep the appointment. If the patient does not call to reschedule, the patient should be contacted by telephone, reminding them of the importance of keeping their appointments. If the patient does not respond, you may want to send a letter to the patient, depending on the nature of the missed appointment. If it is an important follow-up appointment for a condition that requires continued care, send a letter to the patient outlining the importance of seeking continued medical attention for their condition, and leaving contact information for your facility. Be sure to include a copy of the letter in the patient's chart.

4. For what reasons can I dismiss a patient?

A patient can be dismissed for any number of reasons, including noncompliance by the patient, failure to pay his or her bill, or a breakdown of the physician/patient relationship.

It is important to evaluate where the patient is in his or her care when considering dismissal. If the patient's care will be interrupted by dismissing the patient, it is recommended that you see the patient through the end of the current treatment to avoid abandonment issues.

- Special consideration should be given to patients who are pregnant, undergoing surgery, or who have chronic illnesses. It is important to evaluate where the patient is in his or her course of treatment before dismissal.

5. Do I have to tell the patient why I am dismissing them?

It is not required that a physician tell a patient why he or she is being terminated from the practice. Often, it is not recommended that the patient be informed of the reason, as this may inflame the patient and complicate an already sensitive situation.

6. What process should I follow when terminating a patient?

Notify the patient, in writing, of your intent to terminate him or her from your practice. The letter should include:

- A statement advising the patient of the actual termination date, which is typically thirty (30) days from the date of the letter;
- If appropriate, a statement advising the patient that his/her condition warrants continued treatment by another physician;
- A statement advising the patient that the termination applies to all members of your group, if applicable;
- A statement explaining that should you be called upon to treat the patient in the emergency room, you will treat the patient, but it is not a re-establishment of the physician/patient relationship; and
- An offer to send copies of the patient's medical records to his or her new physician pursuant to a signed authorization.

The letter should be sent by both regular mail, address service requested, and certified mail, return receipt requested. A copy of the letter should be placed in the patient's chart.