HITECH Frequently Asked Privacy, Security Questions: Part 3

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Editor's note: This is the third and final installment of a three-part series reviewing AHIMA's HITECH frequently asked questions.

Later this month the healthcare industry will mark the one-year anniversary of compliance with the final HITECH Omnibus Rule. During the last year, preparations for implementation and compliance have brought forth challenges and many questions left to interpretation. This article concludes a three-part series discussing the most commonly asked questions regarding compliance requirements surrounding the final HITECH Omnibus Rule, released in January 2013.

The final Omnibus Rule expanded some of HIPAA's original requirements involving privacy, security, and enforcement, and finalized breach notification rules as well as the Genetic Information Nondiscrimination Act (GINA). The effective date of the final rule was March 26, 2013, though entities and business associates had 180 days to meet compliance by September 23, 2013.

This series installment highlights the updated requirements and provides answers to questions regarding decedent protected health information (PHI), the release of immunization records to schools, and the enhanced request for restrictions requirements.

Decedent Personal Health Information Changes

Requirements for the HIPAA-based protection of decedent information were changed by the Omnibus Rule. The definition of PHI itself has been changed to reflect the new requirement that any individually identifiable health information of a person deceased more than 50 years is no longer considered PHI under the HIPAA Privacy Rule.[1] The final rule does not override or interfere with state or other laws providing greater protections and this change has no impact on a covered entity's disclosures permitted by other provisions under the Privacy Rule. Also, the final rule clarifies that the new rule doesn't require covered entities to retain records for 50 years.

In addition to changing the protections given to decedent records, changes have been made regarding disclosures of decedent records to family members and others involved in a patient's care. A provision in the final rule now permits entities to disclose a decedent's PHI to family members and others who were involved in the care or payment for care of a decedent prior to death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.

For example, a healthcare provider can describe the circumstances that led to an individual's death or provide billing information to a decedent's sibling. This does not include past unrelated medical problems. These disclosures are permitted but not required. If the covered entity is uncomfortable with a release request, believes the disclosure to be inappropriate, or doubts the identity of the requestor, the final decision on whether to release the information lies with the covered entity, according to the rule.

Decedent PHI FAQs

Q: When it comes to decedent records, if state law says that a personal representative is required to be given access to a patient's records, should one follow state law assuming pre-emption applies and the most stringent law takes precedence (i.e., state law that is more restrictive)?

A: Yes, because the disclosure is required by law and therefore permitted by HIPAA at 45 C.F.R. §164.512(a). Because there is no conflict between state law and HIPAA, there is no need to determine if HIPAA pre-empts the state law. If the state law indicates who is the personal representative but does not limit disclosure to others, then the covered entity may disclose PHI to persons who were involved in care or payment and are not the personal representative if the information is relevant to their involvement (i.e., relates to the episode of care) and the decedent had not expressed contrary wishes.

Q: If an individual, prior to death, expresses a preference to not release any information to a personal representative, family, or friend, how is the covered entity to document this?

A: This is an operational question that one must implement at their specific facility. The Privacy Rule does not direct the industry how to document the information, it only requires that facilities do document it and then honor the request. A personal representative generally has a right to access the decedent's information, regardless of the decedent's wishes. So, if an individual expresses this preference prior to death, the individual should have any legal documentation updated to reflect that change.

Immunization Information Changes

The "Disclosure of Student Immunizations to Schools" provision of the final rule permits a covered entity to disclose proof of immunization to a school where state or other law requires it prior to admitting a student. Written authorization is no longer required, but an agreement must still be obtained, which can be oral. The agreement must come from a parent or guardian, or other person acting in *loco parentis*, or directly from the individual (adult or emancipated minor). Agreements must be documented, but no signature by the parent is required.

It is up to the covered entity to decide what information needs to be captured regarding the agreement. Documentation must make clear an agreement was obtained as permitted under this provision, and written or e-mail requests are acceptable. The agreement is considered effective until revoked by the parent, guardian, or other person acting in *loco parentis*, or by the individual himself (adult or emancipated minor). The agreement is not to be treated the same as a HIPAA-compliant authorization. It is up to each school to determine the appropriate individual to receive and manage the receipt of immunization records.

Immunization FAQs

Q: The sexually transmitted disease HPV can be included in a minor's protected health information. Does the HIPAA change, which permits the release of immunizations with a verbal agreement, exclude releasing HPV vaccinations?

A: Only where states require immunizations for admittance to a school may immunization information be released. Only the immunizations required by that state for individuals to be admitted to a school should be released.

Q: Do organizations still have to account for the disclosure of immunization information as a non-compliant authorization?

A: Actually, covered entities did not need to account for the disclosure before, meaning entities did not need to include it in an accounting of disclosures but will need to do so now due to the change in the law. Previously, an authorization was required in all cases for disclosure of immunizations to schools. The change in the law now permits release with a verbal agreement. The accounting of disclosures provision accepts disclosures pursuant to an authorization. Now, if certain criteria are met, no authorization is required to disclose student immunization records to a school. The disclosure, which is treated as a disclosure for a public health activity, would no longer fall under an exception to the accounting of disclosures rule and, therefore, would need to be included in an accounting of disclosures. The disclosure would also be subject to accounting under the proposed modifications to the accounting of disclosures provision, since public health disclosures remain subject to accounting.

For immunization releases, HIPAA requires agreement but not an "authorization." Prior disclosures of immunization records were "pursuant to an authorization as provided in §164.508" and therefore were exempted from accounting. But disclosures

that fit under the new exception will not be pursuant to an authorization provided for in 164.508. Rather, they will fall under the public health permission at 164.512(b).

Request for Restrictions Changes

Under the rule section "Right to Request a Restriction of Uses and Disclosures," covered entities must agree to an individual's request to restrict disclosure of PHI to the individual's health plan when:

- The disclosure is for the purpose of payment or healthcare operations and is not otherwise required by law
- The protected information pertains to a healthcare item or service which has been paid for in full by someone other than the health plan

Request for Restrictions FAQs

Q: If a patient elects to pay out-of-pocket, even if they are covered by Medicare, does a claim get filed with Medicare?

A: The US Department of Health and Human Services (HHS) provided the following guidance: "With respect to Medicare, it is our understanding that when a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of section 1848(g)(4) of the Social Security Act (the Act), which requires when charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then a claim must be submitted to Medicare. However, there is an exception to this rule where a beneficiary refuses to authorize the submission of a bill to Medicare. Then a Medicare provider is not required to submit a claim to Medicare for the covered service and may accept an out-of-pocket payment for the service from the beneficiary. The limits on what the provider may collect from the beneficiary continue to apply to charges for the covered service, notwithstanding the absence of a claim to Medicare."

Q: What happens if an out-of-pocket service is accidently forwarded to a health plan? Does this apply only to health plans and not providers?

A: If the information is released after a restriction has been requested and paid for in advance, the provider may be subject to criminal penalties, civil money penalties, or corrective action for making an impermissible disclosure under the Privacy Rule. More details to this answer can be found in the full FAQ list available on AHIMA's website.

Q: If a patient has requested a restriction of PHI to the payer and has paid out-of-pocket for the service, how should subsequent service for the original service be handled?

A: If the patient returns for follow-up care and the information from the original restriction is necessary to obtain payment for the follow-up care, the patient would once again have to pay out-of-pocket for the current service (the follow-up care) to ensure the information is not sent to a health payer. If the patient does not pay out-of-pocket for the follow-up care, the provider may send to the health plan all information necessary to obtain payment for such follow-up care (even if such information includes information about the original service that was paid out-of-pocket by the consumer).

Q: What if the patient needs a prescription filled based on the service that has been paid out-of-pocket and requested to be restricted from the payer? How should the restriction be handled? Who's responsible for notifying the pharmacy/pharmacist to not bill the payer?

A: The patient can receive a paper prescription rather than an electronic one and take it to the pharmacy to be filled. The patient should notify the pharmacy/pharmacist of any requested restriction and pay for the prescription out-of-pocket.

Notes

1. AHIMA. "Analysis of Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rule." January 25, 2013.

2. Ibid.

Read More

More FAQs Online
www.ahima.org

To read all of AHIMA's frequently asked questions regarding the HITECH-HIPAA Omnibus Rule included in this article series, visit www.ahima.org/topics/psc.

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