Unsolicited Test Results

From time to time, physicians and other healthcare providers find themselves in receipt of diagnostic test results they did not order for their patient, or for individuals who are not even patients of the practice at all. Such results could be anything from laboratory or pathology reports to screening and other diagnostic tests. Medical consumers are presented with many options to undergo screening type tests without provider involvement or referral. Mobile or freestanding vendors, churches, health fairs and even employers offer an assortment of free or reduced cost health screenings, usually sending results to the provider identified by the patient. Occasionally, emergency department patients will request that their diagnostic work-up be copied to their personal provider as well. Accordingly, there are many sources from which a provider or practice may receive unsolicited test results.

When in receipt of an unsolicited test, be aware that even the non-ordering provider presumably has some limited duty to ensure follow-up, depending on the circumstances. Generally, there are two broad categories to be addressed – patients and non-patients.

Established Patients

When an unsolicited test is received regarding an established patient of the practice, whether recently active or not, you should handle that test in the same manner as you would if you had personally ordered the test, including contacting the patient and arranging for any appropriate follow-up care. Be sure you have a system in place that requires your personal review before they are entered into the medical record (even if the test results are marked by the lab or diagnostic facility as “normal”). Of course, critical or time-sensitive abnormal test results should be handled expeditiously. As you know, many “normal” or within range results on a lab report may be actually abnormal or even dangerous depending on the patient’s condition (think HCT, INR, PSA). Some lab reports don’t even list a normal range because the expected result depends on many factors including the patient’s gender, age, specific condition, etc., so the non-ordering provider may not be able to identify abnormal results on behalf of the ordering provider.

Sometimes the provider is simply cc’d by the lab or the healthcare facility and it may be difficult to determine if the original ordering provider has handled the result. In those instances, the best practice is to contact the ordering provider/facility and ensure their receipt of the result. Also consider directing the lab/facility not to copy you on tests you do not order without consulting you first.

Non-Patients

Receipt of an unsolicited test result for a person who is not a patient of your practice presents a different challenge. First, immediately make direct contact with the source of

the test result, preferably by phone, to rule out misspellings, patient name changes, or any other typo or mistake that prevents proper identification of an individual who may actually be one of your patients. In addition to the foregoing, other explanations for being unable to match a test result to a patient would include practice mergers, provider relocation, business name changes, etc. The initial phone call will alert the test source that there is a communication problem or misidentification that needs appropriate follow-up. The initial phone call may also be important if the test result is abnormal and time sensitive or life threatening. If applicable, be sure that any concern or urgency is addressed in that initial phone call.

It is recommended that this notification be accomplished by BOTH a phone call and a written document. Phone communication with the test source allows them to take immediate action to re-direct the test result to the proper provider. The test source may also have an independent obligation to contact the individual. The original test report should be mailed or faxed back to the originator of the report with a dated notation written on it, or with an accompanying statement, informing the source that the individual is not a patient of your practice and that you are not the appropriate party to receive the report or test result. A copy of the report with your notation or statement should be placed in a general office file titled “Unsolicited Reports”. The details of the conversation should be recorded (name, date, time). Critical or time sensitive abnormal test results should be expedited through the above notification process. In the event the test results or report are emergent, it would be appropriate to make efforts to contact the non-patient directly if timely contact with the originator of the report is not possible.

The above recommendation with regard to non-patients may appear unnecessarily burdensome. Timely and appropriate notification to the source of the unsolicited test result remains the prudent course to take in these situations. However, it is always good medicine to make sure miscommunication does not result in harm. Also, while there appears to be no obvious legal obligation to act on unsolicited test results for non-patients, no one desires to be the test case for such an extension of liability.

This guideline is not intended to cover all situations that may arise with regard to unsolicited tests. For unique circumstances let reason, patient safety and good business sense be your guide. Some states have statutes conferring immunity on physicians who receive unsolicited test results. Virginia has such a statute covering an assortment of situations with various conditions and exceptions. However, even Virginia’s statute does not confer immunity if “…the physician has reason to know that in order to manage the specific mental or physical condition of the patient, review of or action on the pending results is needed”.

Please contact an SVMIC claims attorney for any medical/legal concerns.

Considerations When Disclosing Adverse Events

Healthcare professionals pride themselves on achieving high levels of excellence, if not routine near-perfection, in the care they provide. When an adverse event occurs, facing a patient and his or her family members can be challenging, especially when the adverse event resulted from an error. Approaching disclosures of adverse medical events with deliberation can reduce risk for providers and anxiety for patients.

Adverse events are typically described as an unintended injury caused by medical care that necessitates additional treatment or causing a disability at the time of discharge. The disclosure of adverse events has been the subject of ongoing debate within the medical community for decades. To some extent, the debate is influenced by societal and cultural considerations. As our society increasingly expects transparency in various aspects of life, a healthcare provider's failure to disclose an adverse event is likely to be viewed by a jury as, at best, secretive, and, at worst, deceptive. In some cases, a patient may claim that a physician's failure to disclose an adverse event was an attempt to conceal what happened. An allegation of fraudulent concealment - if proven - could result in the imposition of punitive damages and eviscerate noneconomic damage caps.

Some adverse events are preventable; others are not, even when the treatment provided was within or exceeded the standard care. While other considerations surround discussions with patients about unexpected outcomes that do not result in an injury, physicians should be prepared to discuss an adverse event—particularly one that could have been prevented—with a patient and his or her family. In these situations, physicians should be mindful of AMA Code of Medical Ethics Opinions on Patient Safety 8.12, which states in part:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

When confronted with an adverse event, physicians should be aware of the benefits and risks of discussions about these occurrences and be thoughtful in how these discussions should occur with patients and their families.

Perhaps chief among the benefits of open dialogue with patients and their families about an adverse event is fostering trust. While conversations regarding an adverse event can be challenging, patients may feel shut out or discouraged by a lack of communication. A frustrated patient may believe that the only avenue to obtain the information sought is through the discovery process in litigation. In some cases, post-event discussions will satisfy a patient's desire for information. Even in instances where a patient proceeds with a lawsuit after an adverse event disclosure, these conversations allow providers to disclose, on their terms, before suit is filed and while memories are still relatively fresh, the same information which is likely to be uncovered in subsequent litigation. Additionally, a patient or family member that is inclined to pursue a lawsuit as a result of an adverse event is likely to do so regardless of whether information about the adverse event is disclosed. A physician who is forthcoming with facts at the time of an adverse event may be viewed more favorably by a jury in contrast to a physician perceived as having information he or she conceals from a patient.

When discussing adverse events with patients, it is important that the provider is clear about the facts surrounding what happened. This is particularly a concern when an investigation is ongoing at the time of the discussion, and all of the facts have not been ascertained. There is also the risk of disclosing information that may be protected by attorney-client privilege or quality improvement committee privilege. Appropriate training may help mitigate this risk. The reality is that the majority of patients experiencing an unexpected result do not file a lawsuit, even when negligent care is suspected to be the cause of the adverse outcome. However, there is an inherent risk that discussing an adverse event may be perceived by a potential plaintiff as a concession of guilt to professional negligence. While some strategies can be employed to reduce this risk, patients' perceptions of an admission of liability by the disclosing provider may be difficult to avoid, particularly when the adverse event could have been prevented.

Providers and healthcare organizations must engage in discussions with patients regarding adverse events in a thoughtful manner. Organizations should determine who will communicate with the patient and his or her family and establish a procedure for initiating these discussions. While there may be apparent benefits of the treating physician communicating with the family, the familiarity of the physician may be outweighed by the physician's inability to communicate effectively following an adverse event. If a patient has been unsatisfied with the care he or she received even before the adverse event, the physician may not be the best communicator in that situation. The physician should be present for the discussion, but it may be advisable for someone else, such as a risk manager or practice administrator, to do most of the talking. In contrast, if the patient has had a long and satisfactory relationship with a physician, the one-on-one interaction directly with the physician may be beneficial.

Facts concerning the event must be accurately and concisely stated in terms the patient can understand and, to the extent possible, the patient's understanding of the facts should be confirmed. If facts are unestablished or under investigation, any discussions regarding such circumstances should be clearly qualified that the information is unconfirmed and

subject to further investigation. If remedial measures are discussed with the patient, care should be given not to exaggerate or overpromise what has been done or will be done to prevent similar incidents from occurring in the future.

Anyone communicating with the patient should have a clear understanding that liability should not be conceded during a discussion about an adverse event. It can be difficult however for both providers and patients to distinguish between statements communicating empathy, support and interest in the patient's well-being and statements expressing regret for why something has happened. Clear and thoughtful words conveying these often delicate messages must be used. For example, contrast "We are all hoping for a better outcome here and I am going to do what I can to the patient back on the track to a full recovery" with "This result should not have happened. It was a mistake because of my oversight." It is advisable to consult with your professional liability insurance company and perhaps legal counsel before having a discussion with a patient or his or her family about an adverse event. If compensation to a patient is an appropriate consideration following an adverse event, such an offer should only be made following such consultation.

Those involved with the discussion should remember that the conversation may not remain private between the parties present. Statements made during the conversation may be shared with other friends and family members or even on social media posts. The conversation should be documented by the physician, risk manager, or administrator in objective terms. Any care-related aspects of the discussion should be documented in the medical record. If any memorandum memorializing the discussion is made separately outside of the medical record, maintaining objectivity and reciting the discussion accurately, without including implications or unstated impressions, is important, as the document may be discoverable in litigation. Consultation with legal counsel may be helpful in properly documenting the discussion regarding the adverse event.

While beyond the scope of this article, yet intrinsically related to the topic of adverse event disclosures, healthcare providers must be familiar with their administrative and, in some cases, legal duties to report sentinel events and other adverse occurrences within their organization. Providers should be aware of what constitutes a reportable incident for the organization and the provider's obligation to promptly report such an occurrence. Healthcare organizations should provide recurring training and periodic reminders on procedures and expectations for reporting events, including identifying whom within the organization should be the first point of contact for such reports.

Whether reasonably preventable or not, adverse events are unavoidable in medicine. When handled correctly, disclosures of adverse events provide physicians an opportunity to foster trust with patients through transparency and a chance to explain, largely on the physician's own terms, these inevitably difficult situations.

Avoid the Overtime Blues in Your Practice

Perhaps no one in your practice deliberately abuses overtime. Then again, if you make overtime pay available to employees on a regular basis, who could blame them for grabbing the opportunity? Not only can overtime cost you money, but it may also bring legal liabilities if you fail to manage it with care.

It's true that medical practices can be overwhelmingly busy with unpredictable patient demands. Yet, overtime shouldn't be a fact of life. Consider that if only four staff members are kept an hour beyond their full-time work schedule every day, you'll rack up thousands of dollars in overtime costs each year. If your practice is like most, then staff salaries are already the biggest portion of your overhead expenses.

Here's a run-down of when you're obligated to pay overtime and some strategies to avoid, or at least reduce, the need to use overtime in the first place while continuing to accommodate patients and deliver exceptional service.

Understand obligations. If an employee qualifies for overtime, pay it. It's the law. The pay must be at least one and one-half times the employee's regular rate of pay. Don't be tempted to use 'time off in lieu' of overtime to avoid those obligations. Time off in lieu of overtime is currently prohibited for private sector workers covered by overtime laws. If you don't follow the law, you may find yourself getting a call from your state's labor law regulators, an employee's attorney, or both.

Know the terminology. 'Covered nonexempt employees' means just that: not exempt from getting overtime. The federal Department of Labor's Wage and Hour Division says that 'covered nonexempt employees' must receive overtime pay for hours worked over 40 hours in a workweek. An office manager (and certain other positions) may indeed be exempt, but just calling someone 'manager,' or 'consultant' doesn't necessarily exempt them from federal or state overtime laws. Department of Labor regulations define the types of executive, administrative, professional and outside sales employees who may be exempt from the overtime provisions of the Fair Labor Standards Act (FSLA). To see more about who could be exempt or non-exempt, see the Department of Labor's website.

Clarify the workweek. Labor law defines the workweek as a fixed and regularly recurring period of 168 hours – seven consecutive 24-hour periods. Your practice can define its own workweek within those parameters, and it need not coincide with the traditional Monday-through-Friday week. While your week may begin and end on any day and hour of day, you cannot change your workweek each week or two just to avoid paying overtime. You also are not allowed to average an employee's hours over a two-week period.

Avoid misperceptions. Federal law defines when you have to pay overtime and to whom, but it does not restrict the number of hours that employees 16 years or older may be asked to work during any workweek (except for medical residents, transportation workers and certain others). The FSLA also does not require you to pay overtime to those who work on weekends, holidays, or regular days of rest unless these hours are in excess of 40 hours in the workweek. Of course, the reality is that for weekend and holiday work you may need to pay extra to attract the employees you want.

Don't forget the state. If your state is one of the several states with overtime laws, then any employees subject to both state and the federal overtime rules are entitled to overtime pay at whichever is the higher-paying standard.

Avoid abuse. Recognize that overtime can be abused. Overtime is lucrative, so it's not uncommon to see employees seek it out. In a pinch, such as end-of-month charge entry, it can be quite valuable to have employees who are able and willing to put in a few extra hours. But don't allow workers to stretch their eight-hour days into 10 hours which, at time-and-a-half, means they are getting paid for 11 hours. An effective time and attendance system can help you manage overtime. Use the familiar punch clocks, biometric time clocks, paper sign-in sheets – whatever works best for you.

Require approval. Establish a protocol that all overtime hours must be approved by a supervisor. Make sure supervisors get clear direction about when overtime is justified. Supervisors also must know to document all overtime hours accrued each pay period and the reasons for them. At least every quarter, those reports should be reviewed by top-level managers.

Charge back. Consider allocating overtime costs to the physicians who create overtime by frequently running behind, turning in charges only at the end of the month, or other behaviors that can rack up support staff overtime.

Get creative. One way to avoid overtime could be to expand office hours beyond the traditional business hours. For example, many practices have success by establishing a 7 a.m. start time and staggering work shifts so that patients can continue to be seen over the lunch hour. Perhaps you can take it a step further by creating a new staffing model such as four 10-hour days – or compressing the 40 hours into four-and-a-half days with Friday afternoons off. These creative hours may do more than allow you to stem overtime, they can also mean a happier – and more productive – staff.

Schedule thoughtfully. At the very least, pay careful attention to scheduling practices. If your busiest physician has only one nurse available on Friday afternoons, you are just contributing to overtime usage.

Finally, don't forget about using part-timers, either to cover extra-busy clinical hours or to fill in when regular staff request leave time. After all, if you're paying 150 percent per hour for the extra work, why not hire someone on a part-time basis to fill this need – it may well save your practice money as well as headaches.

More information from the U.S. Department of Labor:

General guidance

Wage and Hour Division information for employers

"Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales and Computer Employees," July 26, 2017

Physician Compensation Plans

Physician compensation in a private solo practice is simple: The physician receives any profits after expenses are paid as compensation. The physician generally takes a monthly draw and has periodic bonus distributions. When two or more physicians join the practice, the compensation variables change. Open communication and planning can help avoid conflicts that might arise from one partner feeling as though the compensation formula is unequitable.

Understanding the physician group culture is one of the most important elements when designing a compensation formula. How does the group communicate? Is there a shared vision, and what are the norms that help shape the way the group operates? This helps the group determine what is important and what they want to incentivize in a compensation formula. For example, Medical Practice Services consulted with a urology group that distributed everything equally. To learn more about the practice and culture, we interviewed each of the physicians to determine what was important to them. They had a strong team-based approach that they wanted to maintain, which tied into the equitable distribution of compensation.

Every group should spend some time assessing the financials and key performance indicators before addressing physician compensation. This includes reviewing each physician's productivity by assessing his or her charges and payments. It may also be helpful to review worked RVUs or encounters as a productivity measure. Additionally, every group should review their accounts receivable and collection ratios to determine if the revenue cycle is efficient.

Medical Practice Services consulted with a multispecialty group to assist with recommendations regarding compensation design. In this process, we learned that there were changes in their billing operations within the last year; they had outsourced their billing and then they brought it back in house. Their collection ratios were below industry benchmarks. We recommended that they spend more resources improving collections before attempting to redistribute compensation. Finally, we recommended that the group spend some time reviewing the income statement. The income statement should easily reflect the overhead, which is the expense before allocating physician expenses. If the financials and key performance indicators are not optimal, then variations in compensation design will not benefit the group.

Before developing a new compensation formula, it is important to spend some time assessing the physicians' understanding of the current formula and what they hope to achieve with it. During this process, the group may identify any unique expenses or revenue associated with a provider in the group. Other considerations involve allocating profits from advanced practitioners, ancillary services, and value-based payments. Groups

should consult with legal counsel to ensure that ancillary profit distributions comply with Stark regulations. Many payers reimburse value-based payments at the tax ID level. Some groups allocate the value-based payments internally based on their patient panel or on quality performance metrics. Some options for allocating advanced practitioner profits include distributing revenue after only direct salary and benefits are covered or including a percentage of the general overhead to the provider.

There are many different compensation formula structures. Most involve a distribution of physician compensation by allocating a portion of the expenses equally and a portion by productivity. Some groups may be very detailed in their approach, allocating all revenue and expense directly to the physician. The downside to this approach is that it takes more accounting resources to allocate everything at the physician level. On the other end of the spectrum is the group that pays every physician equally. This works well for a group where each physician has a similar expense and productivity structure. However, conflicts arise when one physician wants to slow down, work more, or utilize additional services. In larger groups with multiple departments and services, it is common to have a system of allocating shared administrative expenses equally, while allocating site expenses based on physician productivity and overhead at that site.

Some groups allocate expenses entirely on productivity. The downside to this approach is that the highest producer in the group pays more overhead expenses. Another option involves allocating a percentage of the expenses equally and a percentage based on productivity. In general, about 80% of the cost within a medical group is fixed cost or cost that does not change with patient volume. Some examples include rent, employees, and utilities. About 20% of the expense within a practice is variable which changes with volume. Supplies, both administrative and medical, are some examples of variable expenses. Groups can use this as a starting point for discussion.

Finally, it is best to keep the compensation formula simple and easy to understand. Keep in mind what you are trying to incentivize, as the formula will influence the group’s culture. The more productivity-based the formula is structured, the less team-oriented the group will be. Conversely, an equal distribution of compensation in the group does not benefit the physician who wants to work more to earn additional income. Finding the right physician income distribution formula depends on the dynamics of the group. Once you have completed your compensation analysis, continue to evaluate but do not let the monthly financial minutia derail your strategic objectives. Focus on patient care, improving operations, and building your practice. In return, you will earn more compensation.

Quality Payment Program Update

Physicians who bill more than $90,000 in total allowed Medicare Part B charges need to ensure successful participation in the Quality Payment Program (QPP). Two pathways are available: submitting data for the Merit-based Incentive Payment System (MIPS) or joining an Advanced Alternative Payment Model (APM). The Centers for Medicare & Medicaid Services (CMS) estimates less than 40% of eligible clinicians (ECs) are required to submit MIPS data, with only 15 points required to avoid the 5% penalty on the table in 2018.

If you are a small practice – defined as 15 ECs or less – there will be a hardship exemption available from the "*Promoting Interoperability*" category (the new name for Advancing Care Information). The exception is granted simply for being small, but other categories include a decertified electronic health record (EHR) system or an EHR system switch midway through the year. The application has yet to be released, but will be due on December 31, 2018.

In 2017, 91% of all MIPS-eligible clinicians participated in the first year of the QPP, according to CMS' announcement last month. "Official" scores will be released sometime in July, although preliminary scores are now available. The high level of participation is welcome by CMS, although it means less money will be distributed as bonuses to participants. With the exception of funds available for "exceptional performers," this budget-neutral program requires the losers feed the winners. Because there are so few losers this year, don't expect a financial windfall.

In the report, CMS provides a look into the crystal ball for the future. Administrator Seema Verma announced: "Under the Bipartisan Budget Act of 2018, we have additional authority to continue our gradual implementation of certain requirements for three more years to further reduce burden in areas of MIPS." This is welcome news for physicians seeking relief from the government's red tape.

Who Can Go the Distance? We'll Find Out in the Long Run

On a hot summer day in 2002, 55-year-old Mr. Adams[1] was working on his farm. When dismounting from the back of his truck, Mr. Adams fell and injured his left leg. He presented to the local ER later that day with complaints of left knee and ankle pain. Mr. Adams had a history of bilateral knee replacements. He told Dr. Jones that he had dislocated and reduced his left knee after the fall. An exam by Dr. Jones showed moderate swelling and tenderness. The radiographic studies were unremarkable. Dr. Jones contacted Mr. Adams' orthopedist, Dr. Smith, who recommended that the patient see him in the office the next day. Mr. Adams was discharged with instructions to follow up with Dr. Smith the next day.

Two days later, Mr. Adams already had a foot drop when he saw Dr. Smith, who diagnosed a peroneal nerve palsy and impending failure of the total knee replacement. The patient was placed in a brace to protect the knee temporarily with the plan to do a total knee revision in the future. Mr. Adams called Dr. Smith's office two days later to report ongoing leg pain and was told that the pain was to be expected with this injury. Three days later Mr. Adams presented to another ER, where he was diagnosed with compartment syndrome and underwent fasciotomies that day. In the following days, Mr. Adams had additional surgery for resection of necrotic tissue. He developed permanent foot drop.

Mr. Adams filed a lawsuit against Dr. Jones and Dr. Smith in July 2004. The case went to trial against Dr. Jones only in June 2014. After a five-day trial, the jury found in favor of Dr. Jones. Why did it take ten years for this case to go to trial and what happened during that decade? What happened to the lawsuit against Dr. Smith?

Within days of the lawsuit being filed, both Dr. Jones and Dr. Smith reported it to SVMIC. We retained an experienced local attorney to defend the doctors. Defense counsel met with the doctors, gathered the medical records and started the process of discovering the facts and putting together a defense plan. The defense attorney contacted potential experts and found supportive physicians who were willing to serve as expert witnesses. Written discovery of the relevant facts was completed and the parties were deposed. Trial of the case was set for the first week of March 2008. Shortly before trial, the plaintiff asked the court for a continuance, which was granted. A new trial date was scheduled for March 2009.

In February of 2009, the plaintiff voluntarily dismissed his case without prejudice, allowing for the possibility of re-filing the case within one year. Mr. Adams re-filed the lawsuit in January 2010. The court set the case for trial to start in June 2014. In March 2012, the plaintiff asked the court to order the parties to meet with a mediator to discuss possible

settlement of the case. The court granted the Order for mediation and the parties met with a mediator in June 2012 in accordance with the court's Order. Believing that the care provided was appropriate, and within the standard of care, neither doctor gave consent to settle the case. SVMIC did not make any settlement offer. About two weeks before the scheduled start of the trial, Mr. Adams dismissed his lawsuit against Dr. Smith, the orthopedist, and proceeded to trial against only Dr. Jones, the ER physician. The jury returned a defense verdict for Dr. Jones following a five-day trial in June 2014.

These cases can, and often do, have an incredibly long lifecycle. The doctors and their defense attorney would have been ready to defend the case at trial at the first opportunity in March 2008, already nearly four years after the lawsuit was filed. Unfortunately, the plaintiff's actions and a backlog of cases on the Court's docket delayed the outcome for several more years. The purpose of this article is not to delve deeply into the details of the medical care or specifically how this case was successfully defended. We can summarize those details by saying that the care was appropriate, the doctors did an excellent job in their defense, and defense counsel was outstanding. The lesson here is to be prepared for the possibility of a long fight. Cases will often move more quickly to a resolution, but situations such as this are fairly common. The good news is that we are here with you for the long run.

[1] All names have been changed for confidentiality

*Article title directly quoted from "The Long Run", Henley & Frey, 1979.

Understanding HIPAA Authorization Forms

Understanding when an authorization form is required to release protected health information (PHI) has been a challenge for the healthcare community since HIPAA required compliance with the Privacy Rule in April of 2003. Generally, a HIPAA-compliant authorization form is not necessary for most uses and disclosures that take place in the average medical practice. However, due to a lack of understanding and a level of fear generated by penalties for HIPAA violations, many practices and other healthcare organizations continue to require patients to complete authorization forms for disclosures that are permitted by the Privacy Rule without a patient's authorization.

In an effort to clear up some of this confusion, the following information describes the circumstances when an authorization is not required, when an authorization is required, and what information must be included for an authorization to be considered HIPAA-compliant.

For starters, a covered entity may not use or disclose PHI except as the Privacy Rule permits or requires; or as authorized by the patient or the patient's personal representative.

Required Disclosures

There are only two situations under the Privacy Rule that require disclosure of an individual's PHI. Covered entities are required to disclose PHI to the patient or the patient's personal representative (under HIPAA, a personal representative has the same rights as the patient) and to Health and Human Services for a compliance investigation or review of an enforcement action. Required disclosures do not require authorization by the patient.

Permitted Uses and Disclosures

There are several types of permitted uses and disclosures of PHI under the Privacy Rule, but for purposes of this article, the focus is on treatment, payment, and health care operations (TPO), specifically treatment disclosures. An authorization form is not required when sharing PHI with other healthcare providers for treatment purposes, even in situations when the healthcare provider did not refer the patient to the practice requesting the information. The Department of Health and Human Services (HHS) has addressed this type of disclosure in one of their frequently asked questions:

Does a physician need a patient's written authorization to send a copy of the patient's medical record to a specialist or other health care provider who will treat the patient?

Answer: No. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501.

Patient Authorized Uses and Disclosures

Generally, a covered entity may not use or disclose an individual's PHI without an authorization unless the use or disclosure is otherwise permitted or required under HIPAA, as described above. There are also circumstances when an authorization is specifically required. The use or disclosure of psychotherapy notes, using PHI for marketing purposes and the sale of PHI all require a patient's authorization. When an authorization is required, certain language must be included in order for it to be considered valid under the Privacy Rule.

For an authorization to be considered valid, the following core elements must be included:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion
- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure
- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure
- A description of each purpose of the requested use or disclosure
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- Signature of the individual and date (If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.)

In addition to the core elements, the following required statements must be included:

- The individual's right to revoke the authorization in writing and instructions for how to do so (Instructions may be included on the authorization form or in the covered entity's Notice of Privacy Practices.)
- The inability of the covered entity to condition treatment on the authorization
- The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected

The following circumstances require additional actions beyond the core elements and required statements above. If the covered entity is going to receive payment specifically for the use or disclosure of patient information, then a statement to that effect must be included on the authorization form. If the authorization is for the covered entity's own use (i.e., marketing), a copy of the signed authorization must be given to each patient and a copy must be kept by the covered entity.

Using PHI for Marketing Purposes

Some healthcare organizations are using patient information for promotional purposes. The use of patient photos, testimonials, or other patient information to promote or market a practice, whether online or in print, requires a signed HIPAA-compliant authorization form from the patient since this type of use or disclosure does not fit the criteria of a permitted or required use or disclosure. Keep in mind that there may be other state/federal laws that relate to using an individual's photo or likeness for promotional purposes**. It is recommended that covered entities seek advice from legal counsel familiar with using patient information for marketing/advertising purposes to ensure that all laws are being followed appropriately.**

Treatment Disclosures/Disclosures to the Patient

The typical uses and disclosures of PHI for most healthcare providers relate to the patient's treatment and payments from health plans. In these cases, it is not necessary to have the patient sign an authorization form. However, a practice may choose to have a policy on disclosures that is more stringent than the Privacy Rule, such as requiring a patient to sign a medical records release prior to sending records to another healthcare provider. Having this type of policy is not violating HIPAA, but practices should make sure that this type of policy does not cause an unreasonable burden on the patient or slow down the patient's care, especially since this is not a HIPAA requirement.

When a patient requests a copy of their medical records, some practices require the patient to complete an authorization form or a medical records release. Again, this is not required by HIPAA but a practice may do this as long as it does not cause an unreasonable burden on the patient. For example, if a patient calls and asks for their records to be mailed to their home address, the practice should not require the patient to physically come to the office to fill out an authorization form.

The practice is required to verify the patient's identity prior to releasing PHI. This may be accomplished in writing or verbally. If done verbally, the patient could be asked to verify two or three pieces of information such as their date of birth, last four digits of their social security number or home mailing address. This verification process should be outlined in the practice's policy and procedures for uses and disclosures of PHI. Verbal verification should also be documented in the patient's electronic health record for tracking purposes.

HIPAA's intent is to make it easier for the patient to have access to their PHI, while at the same time protecting the patient's privacy. More information regarding providing individuals with access to their PHI can be found in the SVMIC Education Center.

For more information or questions about the use of authorization forms, contact Rana McSpadden at RanaM@svmic.com.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.