



SECOND EDITION

The Practical Guide to

RELEASE OF INFORMATION

ROI in a HITECH World

ROSE T. DUNN, MBA, RHIA, CPA, CHPS, FACHE
with **BEN BURTON, JD, MBA, RHIA, CHP, CHC**

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After Barnes, Dunn joined Metropolitan Life Insurance Company, where she served as assistant vice president in MetLife's HMO subsidiary. She also has served as chief financial officer of a dual hospital system in Illinois.

Her consulting firm, First Class Solutions, focuses primarily on HIM-related services, including coding support, coding audits, and operations improvement. Dunn also serves as an expert witness for release of information (ROI) lawsuits and advisor to organizations on ROI issues.

Dunn is active in several professional associations, including the American Institute of Certified Public Accountants, American College of Healthcare Executives (ACHE), Healthcare Finance Management Association (HFMA), and AHIMA. She also holds fellowship status in ACHE, AHIMA, and HFMA and is certified in healthcare privacy and security.

About the Authors

She is the author of *Finance Principles for the Health Information Manager*, published by First Class Solutions, Inc.; *More With Less: Best Practices for HIM Directors and Coding Productivity*, published by HCPro, Inc.; and *Haimann's Healthcare Management*, published by Health Administration Press.

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We were fortunate to engage my coauthor Benjamin Burton, JD, MBA, RHIA, CHP, CHC. Mr. Burton updated the work previously authored by Scott A. Edelstein, Esq., who, with support from Douglas A. Grimm wrote the chapters on two important topics: e-discovery and federal preemption of state release of information (ROI) laws. His associate, Douglas A. Grimm, Esq., provided research and writing assistance for those chapters. Additionally, Mr. Burton contributed two new chapters for this edition. Chapter 9 discusses patient portals and ROI activities in the physician practice setting. This new chapter focuses on the unique issues that physician practices encounter with requests for patient information in both paper and electronic environments. Chapter 12 explores the impact of the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule, the HITECH Act, and the new and revised HIPAA rules including, but not limited to, business associate responsibilities, deceased patients' records, and new breach reporting requirements.

Editor Andrea Kraynak thoroughly reviewed the manuscript, offered many valuable suggestions, and kept us on schedule to deliver this book prior to the end of 2015. Many of the downloadable forms and policies in this book came from practitioners who “live and breathe” ROI on a daily basis—Deni Bronsing, privacy officer and health information management coordinator at the Bowen Center in Warsaw, Indiana, and Patricia Tooley, system executive for privacy compliance at Memorial Hermann Healthcare System in Houston.

MediCopy generously provided a way for our readers to easily obtain detailed information about copy cost laws in all 50 states.

Finally, the production staff, copyeditor and proofreader, graphic artists, and cover designer helped keep things running smoothly. They and many others behind the scenes made this book happen. I thank the entire team for their assistance.

Rose T. Dunn

Introduction

Release of information (ROI) has become the focal point of many health information management (HIM) departments and healthcare facilities. Patient interest in the content of their records, concern about identity theft, and an increasingly transient patient population moving throughout the United States and to other countries make preparing and/or transmitting copies of medical records quickly a necessity.

Demands on the ROI team and its function have grown tremendously with the added burden of Recovery Audit Contractors, substance abuse legislation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and e-discovery—the process by which litigants seek, locate, secure, and search electronic data for use as evidence.

A task that was relatively simple in the past has evolved into a far more complex one requiring extensive knowledge of record content and applicable restrictions. It also requires the ability to respond to inquiries with accuracy and sensitivity about information the requestors may access—and information they may not be able to access.

This book addresses these and other challenges.

Chapter 1 provides a foundation. It includes information about the federal laws that govern ROI and a historical overview demonstrating how the function has transitioned from a copy activity to one that requires knowledge of the regulations and the ability to decipher what may or may not be released.

Chapter 2 discusses the ROI process in greater detail and offers guidance with respect to staffing this function.

Chapter 3 explains the necessary resources—policies and procedures, technology, and consumable supplies—and complements the staffing information provided in Chapter 2.

Chapter 4 explains and analyzes various methods of structuring the ROI function.

Chapter 5 explores how to determine the costs of the ROI service.

Chapter 6 offers a case study that examines an organization contemplating the internalization of ROI activities and provides guidance with respect to preparing a business plan for submission to administration.

Chapter 7 includes a detailed discussion of varied and challenging situations that ROI staff members face daily. It offers advice on responding appropriately and with sensitivity.

Chapter 8 provides insight with respect to copy charges and the litigation they inspire.

Chapter 9 explores the use of patient portals and the unique requirements of release of information in a physician practice.

Chapter 10 provides detailed information about a relatively new concept in civil litigation, e-discovery.

Chapter 11 discusses federal preemption of state ROI laws and uses specific examples to explain how to determine which law prevails when state and federal law conflict.

Chapter 12 summarizes the significant points of the HIPAA Omnibus Rule and the HITECH Act and the impact on ROI and disclosure activities.

The Appendixes include the results of a **Medical Records Briefing** 2014 ROI benchmarking survey published in January 2015 as well as a valuable state-by-state guide of medical record copying fees and a table of resources required for ROI.

This book is for HIM department directors and managers in any healthcare setting and office managers in small physician practices. Our goal is to provide sources and guidance for these administrative individuals who direct and oversee the day-to-day activities of ROI.

As always, I welcome your comments and suggestions so that we can make the third edition even better.

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Chapter 1

What Is Release of Information?

Release of information (ROI) is the process of providing access to protected health information (PHI) to an individual or entity authorized to receive or review it. *PHI* is a term derived from a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that refers to health information about a specific patient. Authorization to release this information typically is provided by the patient to whom it pertains or that patient's legal representative. However, the staff working in a healthcare organization's ROI area may be responsible for monitoring and controlling access to PHI by others within the organization as well as by those who have a right to access PHI without patient authorization.

The ROI function previously was known as the correspondence or copy desk because staff members received letters requesting copies of patient records. However, today, patients and other authorized individuals obtain copies of medical information in a variety of ways, including directly through a patient portal, electronically stored on a USB drive, and electronically written to a DVD.

Fifty years ago, what has come to be known as the health information management (HIM) department was called the medical records department, and the only mail it received was requests from insurers, attorneys, patients, and physicians for copies of medical records or professional journals and books. Fax machines were a rarity in both the medical records department and administration in those days. Today, the HIM department still receives conventional mail that includes requests for patient information along with glossy advertisements and the occasional professional journal that hasn't converted to an online format. But today's requests for information also come via fax, email, and for some organizations, through a secured portal for information other than what the patient can access directly on

the organization's health information portal. The requestors now include an array of third-party payers, researchers, quality improvement organizations, governmental and other external auditors, and, of course, attorneys, patients, and physicians.

More than 50 years ago, requests for copies of patient records were sent directly to physicians, who copied and sent their records or instructed the medical record librarian to copy designated documents and mail the copies to requesting parties. In those days, a written authorization might or might not have existed. Today, if physicians are participating in the same health information exchange (HIE), no information needs to be "sent"; rather, physicians access the HIE, search for the patient who has been referred to them or whom they referred, and access the clinical findings—all through secure computer access. Times definitely have changed.

With the advent of patient portals and HIEs, one would think the volume of requests being placed with the HIM department would be diminishing. They are not. In fact, additional requestors are surfacing. For example, in one state, hospitals are responsible for validating that individuals who register for a gun have not had behavioral health treatment. With the recent GermanWings crash¹ and a study on physician addiction,² there likely will be additional policies related to reporting patient care documentation to various governmental authorities. Today, ROI occurs in a variety of settings—hospital HIM, radiology, human resources departments, home health agencies, physician offices, payers, specialty screening centers, urgent care, and skilled nursing facilities, to name just a few. Health information-credentialed staff members manage the function in some, but not all, of these venues.

This decentralization of ROI has both advantages and disadvantages. One advantage is that many departments share the work, so it might not be necessary to add employees strictly for ROI. Another advantage is that each department becomes "expert" with respect to the components of its records and can address the contents of its records to comply with a request.

However, the disadvantages are several:

- If a request for copies of patient records asks for "any and all documents" pertaining to the patient, then first the request must be validated for reasonable purpose for "any and all documents." If confirmed, then someone must copy the request and distribute it to all departments that may have records on the patient or one department must serve as the clearinghouse that gathers the records necessary to respond to the request. Organizations using one or more electronic health records (EHR) are finding it easier to centralize the ROI because a single department may be given the access rights to electronic documentation generated by many staff members residing in many departments and available on several EHRs.
- When ROI remains decentralized, staff in each department/location must be fully educated with respect to federal and state laws and regulations that apply to ROI and to any ROI policies implemented by the facility. Maintaining a thorough and current understanding of regulations and their nuances can be challenging, but this ensures that all departments involved in ROI remain up to date and have the technology available to provide requestors the necessary

information in the necessary format.

- Later chapters address an aspect of HIPAA known as “accounting of disclosures.” This process results in a list of all disclosures of PHI to third parties that were not specifically authorized by the patient. Collecting this information can be difficult when multiple departments or individuals throughout the organization disclose information. It is further complicated by the use of HIEs.

These are just some of the reasons why centralizing ROI may be beneficial. Later chapters discuss other effects of centralization and how to address them when necessary.

New Formats for a New Age

Historically, releasing PHI meant providing paper copies of various documents, and this practice still continues today. For example, the HR department still might provide paper copies of health insurance applications and employment health testing results. Providers that have not transitioned completely to an EHR may have portions of their records in paper form. If requested, these portions of the record will need to be copied or scanned.

But today, releasing PHI doesn't always involve paper copies of a patient's records. For example, the constant chase to have films returned and the high cost of preparing duplicate films encouraged radiology departments to implement electronic radiology imaging systems. Many radiology departments have started using picture archiving and communication systems (PACS) to eliminate the need to create radiologic films and the inherent storage requirements associated with them. PACS-equipped radiology departments often provide CDs containing requested images. Requestors are finding that asking for paper copies only means that they will now need to store the paper. So now they are requesting the copies be written to CDs, DVDs, or similar media that can easily be copied to their document repositories and eliminate the bulk of paper.

Release of PHI isn't limited to paper copies and high-density media. A variety of other media environments serve this function, as well. For example, the cardiology imaging department might create and release copies of videos, and the pathology department might release slides containing treated slices of specimen. Some PHI is contained in tracing and monitoring systems such as fetal monitors, pulmonary monitoring devices, anesthesia systems, and cardiology tests.

With the intense focus on patient privacy and patients' access to their health information, managing ROI has never been more challenging than it is today.

Who Requests Access to Health Information?

Health information demands are numerous. The variety of requestors includes but is not limited to:

- Other caregivers who serve the patient in the same or alternate settings
- Payers
- Payer agents who audit charges against documentation, review claims for excess payment recovery, or assess the necessity of services
- Governmental agencies such as the U.S. Department of Health and Human Services, the Occupational Safety and Health Administration, the U.S. Food and Drug Administration, quality improvement organizations, state departments of health, and others that use the information to further their purposes
- Researchers who collect data to obtain more information about established disease conditions such as cancer or to treat conditions more effectively
- Operational teams that gauge the performance of healthcare providers and organizations by identifying pathways to provide more efficient care
- Insurers that want to evaluate the health of applicants
- Attorneys who want to determine the extent of injuries
- Patients who want to monitor their health or take information to a specialist or other physician
- Family members who need the information to obtain additional care or reimbursement for the care provided to a relative

Throughout this book we will be discussing disclosure of patient information. Often this term is confused with use of patient information. Briefly, *disclosure* means releasing patient information outside of the organization, while *use* means using the patient's data within the organization generally for patient treatment, payment, or healthcare operational activities. Figure 1.1 presents a sample policy on the uses of PHI for treatment, payment, and healthcare operations.

Figure 1.1 | Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations

Title: Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations

Policy: PHI for which this organization is responsible may be used and disclosed for treatment, payment, and healthcare operations (TPO) only in accordance with HIPAA and other laws and regulations, and with our privacy notice.

Purpose: To protect patient privacy and ensure regulatory compliance, this policy outlines the requirements that must be followed when using or disclosing PHI for purposes of TPO.

Scope: This policy applies to PHI in any form that is being used or disclosed for the purposes of TPO. It applies to our workforce, affiliates, agents, and business associates.

GENERAL RULES:

1. Except where prohibited by state or federal laws, we may use and disclose PHI for treatment, payment, and our own healthcare operations without permission from an individual who is the subject of the PHI.
2. We may disclose PHI for the healthcare operations of another covered entity (CE) provided that the receiving CE has or had a relationship with the patient who is the subject of the PHI, the PHI pertains to that relationship, and the disclosure is for a purpose listed below:
 - Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing healthcare costs; protocol development; case management and care coordination; contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment
 - Reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; reviewing health plan performance; conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers; training of nonhealthcare professionals; and accreditation, certification, licensing, or credentialing activities
 - For the purpose of healthcare fraud and abuse detection or compliance
3. Uses and disclosures of PHI must be consistent with our privacy notice.
4. The minimum necessary standard applies to uses and disclosures of PHI except for treatment purposes.

Figure 1.1 | Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations (cont.)

5. State and/or federal laws define specially protected categories of information that require more stringent protection than afforded by HIPAA. A valid authorization form, signed by the individual or legal representative, is required prior to any disclosures of the following:
 - a. HIV test results
 - b. Alcohol and drug abuse records (42 *CFR* Part 2)
 - c. Genetic screening test results
 - d. Confidential communications of psychotherapy notes contained in medical records of treatment by a psychiatrist, social worker, psychologist (or graduate of or student enrolled in a doctoral degree program and working under the supervision of a licensed psychologist), or licensed mental health nurse clinical specialist
 - e. Other professional services of a licensed psychologist
 - f. Social work counseling/therapy
 - g. Domestic violence victims counseling
 - h. Sexual assault counseling
 - i. Psychotherapy notes documenting therapy sessions and kept by a mental health professional outside of a patient's medical record

Because this book discusses ROI throughout, distinguishing between patient consent and patient authorization is also important and necessary. These terms often are used interchangeably, but there is a distinction under HIPAA. Patient *consent* may be obtained but is not necessary to use the PHI for treatment, payment, or healthcare operations. Patient *authorization* is necessary to disclose PHI to a third party for reasons other than treatment, payment, and healthcare operations. However, this distinction has become blurred with the development of HIEs where providers from inside and outside of the source organization may access the information for patient care purposes.

When an organization establishes an HIE, it often will incorporate language in its Notice of Privacy Practices (NPP). The NPP also may include language to address the sharing of PHI among clinicians for treatment, the disclosure to payers, and the use of data for operational initiatives such as quality reviews. However, when it comes to the NPP's language for HIEs, often organizations will indicate that

the organization participates in an HIE and then makes available a separate document for the patient to “opt out” of allowing their data to be included in the HIE data repository. (See Figure 1.2.)

Figure 1.2 | ABC Provider Health Information Exchange

ABC Provider Health Information Exchange (HIE) Opt-Out

Name: _____

Date of Birth: ____ / ____ / ____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

I hereby acknowledge and agree as follows:

1. I WISH to **OPT-OUT of the ABC Provider HIE**. I understand that by making this selection, **NONE** of my healthcare providers will be able to access my health information maintained anywhere on the ABC Provider HIE, even in cases of a medical emergency;
2. I UNDERSTAND that my providers who originally generated information about me **will continue to have access** to my information, but only in the medical record that they created for me or by obtaining it via previously established methods;
3. I UNDERSTAND that this **HIE Opt-Out** will NOT allow ABC Provider to make my health information available to other connected HIEs with whom ABC Provider participates, even in cases of a medical emergency;
4. I UNDERSTAND that this **HIE Opt-Out** does NOT cover or effect my opting out of any other HIE. I UNDERSTAND that if I wish to opt out of another HIE, I am responsible for approaching my provider participating in such other HIE(s) about how I can do that;
5. My **HIE Opt-Out** selection will remain in effect unless I change it in writing;
6. I UNDERSTAND that once this **HIE Opt-Out** goes into effect, I can change my mind **only by** submitting a **Cancellation of Prior ABC Provider HIE Opt-Out** form;
7. I have had an opportunity to have all my questions about this **HIE Opt-Out** and any others answered;
8. Any information that is disclosed before I submit this **HIE Opt-Out** cannot be taken back and will remain with my provider, who may have accessed such information before this **HIE Opt-Out** went into effect; and
9. This request can take up to two business days to take effect.

Figure 1.2 | ABC Provider Health Information Exchange (cont.)

For your protection, ABC Provider HIE requires that you verify your identity in order to process this request. Upon receipt, our HIE Opt-Out Liaison will contact you at the telephone number you provided.

Signature: _____ Date: _____

If Legal Rep, State Authority: _____

Completed and signed ABC Provider Opt-Out form can be returned to Registration/Reception Desk; faxed to (555)555-5555; or mailed to:

**ABC Provider Health Information Exchange
123 Main Street
Anytown, US 12345**

Easing the Effort

HIE, system interoperability, and the expansion of EHRs have helped ease the process of providing information to requestors. As more documents become available online, staff members working in the ROI function will be able to accommodate requests on a timelier basis and with less effort than searching for paper documents. Few healthcare organizations have a fully electronic health record, but even those that do not now often scan their remaining paper at the time of discharge, thus allowing the ROI staff to print, save, and access those documents on alternative media without leaving their desks. A discussion of the typical steps involved in the ROI process follows.

Typical steps in the ROI process

1. Receive request to access or obtain copies of a patient's record
2. Confirm that the organization treated this patient and that records are available
3. Log the request
4. Validate that the appropriate party (typically the patient or patient's representative) authorized the request
5. Validate that the request contains all necessary elements
6. Reject an invalid request and log the invalid request out
7. Determine the location(s) of or applications storing the requested components of the record
8. Search for and retrieve the components

9. Review the record for the specific documents requested
10. Review the record for specific documentation that is to be excluded
11. Prepare the copies in the mode requested or make arrangements for review of the record by the requestor
12. Count the pages copied and calculate fees, if any
13. Invoice or prebill the requestor for copies or review time
14. Collect payment and mail/provide copies
15. Log the completed request

Who Should Manage ROI?

With the exception of New Hampshire,³ the healthcare provider is the legal owner of patient records that it creates. With this single exception, the record is the property of the provider—not the patient. Patients, however, do have the right to the information contained in the record. As the owner, the provider is responsible for deciding who may use the information, for what purpose, when and how the information in the record may be released, and what should be released. A myriad of laws and policies govern the provider's decision matrix for these items. However, the onus of the proper management of the disclosure is that of the legal owner of the patient record and/or the business associate that the owner engaged to perform the disclosure function for the owner.

Rapidly emerging automation of PHI capture and storage to ensure longitudinal access to PHI for patient care is a hallmark of today's healthcare environment. Electronic medical and health records are replacing paper records in physician offices and ambulatory settings to facilitate PHI collection and access, as well as to gain the economies and legibility these systems offer. The latter goal was the premise of the Institute of Medicine's (IOM) recommendations.⁴ Since the IOM's time, there have been federal mandates to expand the use of EHRs. The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act of 2009, was one. It offered incentives for certain providers to adopt and implement EHRs. Additionally, HITECH also expanded the protections of PHI, defined criteria that providers must achieve and demonstrate that they are using EHRs in a meaningful way, imposed additional sanctions on those business associates using and/or processing PHI, expanded the exchange of health information, and detailed the actions required when an unauthorized disclosure occurs. While not all providers have adopted EHRs, as of December 2014, 94% of all eligible short-term hospitals and 77% of all eligible office-based healthcare professionals have been paid for participation in the Centers for Medicare & Medicaid Services EHR Incentive Programs.⁵

In the acute care setting, health records and PHI are contained in a variety of media in a hybrid environment that includes patient information in both electronic and paper forms. The HIM professional understands the source, creation, and flow of patient information and where the documentation

that complies with the Business Record Act⁶ is stored. The integration of various systems—including but not limited to radiology, cardiology, and therapies—allows HIM departments to access, monitor, and release appropriate information from the myriad of systems that exist throughout healthcare organizations. Finally, the health information professional has the knowledge and training necessary to apply the vast number of regulations that restrict or address PHI release. To facilitate access by clinicians and staff, the various systems deposit their data and reports into an electronic document management system (EDMS), thus creating a single place to find a patient’s information. The EDMS may be designated as the organization’s source for the legal health record.⁷ Alternatively, the various ancillary electronic systems and the scanned portion of the record may be attached to the EHR, and then the EHR may be designated as the organization’s source for the legal health record. There are pros and cons to each option, but a discussion of those are beyond the scope of this book. Regardless, it is the duty of the organization to assign one or more individuals the responsibility for accessing the PHI sources to respond to requests for patient information accurately and in a timely fashion.

Which Regulations Govern ROI?

Numerous regulations govern ROI from the patient record. The American Hospital Association has stated that, in addition to documenting patient care and serving as a communication vehicle between caregivers, the purpose of the medical record is “to (1) meet the legal requirements imposed on the [provider] and (2) provide clinical data of interest to the researchers and clinical data research systems.”⁸

The purpose of the medical record is tied directly to the use of records as evidence. Business records are defined as records made in the regular course of business at the time that, or within a reasonable time after, the recorded event occurred and under circumstances that reasonably might be assumed to accurately reflect the actual event.⁹ The Business Records Act provides a foundation for the use of health records by others as evidence because the documents can be relied on with respect to the treatment of and decisions about the person to whom they pertain.

Restrictions surrounding ROI are rooted in the common law concept of “doctor-patient confidentiality.” This concept prohibits a physician from disclosing information obtained from a patient or known about the patient’s condition. Discussions between physicians and their patients are privileged and protected from disclosure. The attorney-client and clergy-penitent privileges provide similar protections. Other landmark laws that address ROI are:

- The Freedom of Information Act (5 U.S.C. §552) enacted in 1966 applies to access to most records maintained by the executive branch of the federal government, and some independent federal agencies (U.S. Postal Service, Federal Communications Commission, Federal Trade Commission, Consumer Product Safety Commission, U.S. Environmental Protection Agency, Centers for Disease Control and Prevention, etc.). The Freedom of Information Act, as amended,

is tied to the original Privacy Act of 1974 (5 U.S.C. §552a), which applies to those records maintained by government-owned healthcare facilities. The Privacy Act also requires each federal agency that maintains personal records, such as medical records, to implement a system that allows the subjects of their records to review those records and to receive a copy of all or any portion thereof in a form comprehensible to him or her and to permit that individual to request amendment of a record pertaining to him or her. HIM professionals working in veterans administration facilities must comply with disclosure rules under the Privacy Act.

The U.S. Constitution protects the privacy of citizens with the Fifth and Fourteenth Amendments by prohibiting unwarranted invasions of privacy by federal and state entities.

- The *Code of Federal Regulations (CFR)* addresses the confidentiality of patient records pertaining to alcohol and drug abuse and establishes additional restrictions with respect to the disclosure of information from records of patients treated or diagnosed with these conditions in a federally assisted drug or alcohol abuse program. (Visit <http://archive.hhs.gov/ohrp/documents/19750701.pdf>.) HIM professionals working in substance abuse rehabilitation environments must be aware of these regulations. However, most acute care facilities that provide treatment for these conditions comply with confidentiality requirements pertaining to alcohol and drug abuse patient records by including a clause in their authorization forms that allows patients to explicitly permit the release of health information that may include reference to these conditions.
- HIPAA (45 *CFR* §§160 and 164) took effect in 2003 (and as amended through March 2013) and provided greater and nationwide privacy and security protections for PHI maintained by healthcare providers and health insurance plans. HIPAA consists of a sweeping set of regulations that also address electronic transmission of health data, funding for fraud investigations, and the portability of insurance coverage. HIPAA regulations have created opportunities for many HIM professionals to serve as their organizations' privacy officers. These regulations also spawned the need for organizational procedures that address a variety of subjects, including notice of privacy practices, amendments to PHI, directory preferences, alternative methods of notification, authorization form content, timeliness of provision of copies, charges for copies of PHI, minimum necessary uses and disclosures, business associates, and uses for treatment, payment, and healthcare operations. The complete HIPAA Privacy and Security Rule is available at www.hhs.gov/ocr/privacy/hipaa/administrative/combined/hipaa-simplification-201303.pdf.
- E-discovery amendments to the Federal Rules of Civil Procedure (FRCP) address access to patient information maintained in electronic form in devices and systems not traditionally considered part of the patient record. Because FRCP governs the way civil lawsuits are conducted, the amendments significantly modify the discovery portion of litigation. The e-discovery rules will broaden the policies and procedures that HIPAA necessitated to include creation and retention of patient information in such devices as PDAs, email, and various monitoring systems. They also will increase the involvement of the chief technology officer and HIM director with the pre-discovery activities of their organization's legal counsel.
- All HIM managers must have access to and knowledge of the state laws that govern access and

disclosure of patient information or PHI in their location. State laws may be more stringent than HIPAA regulations and will preempt HIPAA provisions in these situations. States often have more stringent requirements with respect to authorizations, sensitive conditions, charges for copies, and the time allowed for providing copies to requestors.

- The HITECH Act applies certain HIPAA provisions directly for business associates. Business associates are now directly “on the compliance hook” since they are required to comply with the safeguards contained in the HIPAA Security Rule. Additionally, the act requires that patients be notified of any unsecured breach. If a breach impacts 500 patients or more, then HHS must also be notified.

Another must-have resource is a complete set of the organization’s policies pertaining to access and disclosure of patient information. These policies often incorporate processes that apply to medical staff access to records of their own and other members’ patients, the extent of law enforcement access to patient records, the manner in which requests from health or licensing authorities are processed, and other local jurisdictional issues.

Unfortunately, state and federal regulations are not always consistent with respect to ROI and patient confidentiality rights. For example, Arkansas permits physicians to deny patients or their attorneys or guardians certain medical records upon a showing of “detrimentality” (Ark. Code 16-46-106).¹⁰ Other states, such as California and Colorado have shorter time frames, 15 and 10 days respectively,¹¹ for fulfilling requests for copies of records. Many states, including Delaware, Kansas, and Missouri, have specific regulations governing the disclosure of sensitive conditions such as HIV status. Regulations in some states, including New Jersey, Pennsylvania, and Virginia, address mental health conditions. This lack of uniformity and consistency makes it necessary for every HIM department to research the regulations that govern its activities.

Where to Find Regulations

Various sources provide information about pertinent state and federal regulations. Most states publish their laws on the Internet. They often appear on the official state website within the health department or health and human services department section. Other Internet listings include:

- Health Information and the Law, a project of the George Washington University’s Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation: www.healthinfolaw.org
- Health IT Project: www.healthit.gov/sites/default/files/appa7-1.pdf
- Lamb Law Office (includes the copying fees for each state): www.lamblawoffice.com/medical-records-copying-charges.html
- State laws for all 50 states: www.alllaw.com/state_resources

The American Health Information Management Association (AHIMA) has an extensive library of articles, practice briefs, a Release of Information Toolkit, and guidance available through its website

and Body of Knowledge. AHIMA members have unrestricted access to the organization's website, but much information on the site is also accessible to nonmembers as a public service.

The state hospital association maintains a comprehensive library of regulations and keeps a pulse on what is happening in the legislature. Ask your state hospital association to add your facility to its mailing list for legislative and regulatory information.

Ask your facility's attorney to provide copies of pertinent laws governing confidentiality, ROI, content of authorizations, and the order of consent.

Finally, every state has an HIM association. Many state associations (component state associations) publish state-specific legal manuals that address ROI and other practice-related guidance. To find your state association, visit www.ahima.org/about/governance?tabid=csa.

Summary

ROI is an ideal career option for anyone who enjoys knowing about the legal side of medicine. This aspect of HIM requires understanding the medical record, its creation, and the manner in which documentation flows to fulfill the different information needs of a variety of requestors. ROI affords extensive interaction with the public, a rare experience for HIM staff members who often specialize in and work in areas such as coding and transcription.

Resources

American Health Information Management Association. "Release of Information Toolkit: A Practical Guide to the Access, Use, and Disclosure of Protected Health Information" (Chicago: 2013).

American Health Information Management Association. "Laws and Regulations Governing the Disclosure of Health Information (Updated)" (Chicago: 2013).

American Health Information Management Association. "E-Discovery: Preparing for the Coming Rise in Electronic Discovery Requests" (Chicago: 2007).

References

1. The GermanWings crash was a deliberate airplane crash by a copilot who was found to have been seen by a physician who deemed him "unfit to return to work." The copilot discarded the physician's note. The physician's findings were not reported to the airline.
2. NBC News. "Is your doctor stoned? Physicians with substance abuse problems continue to work." Retrieved from <http://www.wrcbtv.com/story/28642330/is-your-doctor-stoned-physicians-with-substance-abuse-problems-continue-to-work> (3/29/15).

3. Health Information and the Law (a project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation). "Who Owns the Medical Record." Retrieved February 29, 2015, from <http://www.healthinfolaw.org/comparative-analysis/who-owns-medical-records-50-state-comparison>.
4. Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press; 2001), 166.
5. Office of the National Coordinator for Health Information Technology. Retrieved from February 29, 2015, from <http://dashboard.healthit.gov/quickstats/quickstats.php>.
6. 28 USC §1732(a).
7. The legal health record (LHR) is that compilation of data and findings about a patient that describes the reason for the encounter, care rendered, results of testing and procedures performed, outside information used for the physician's evaluation and management of the patient, and information about the patient and his or her treatment collected during the episode or encounter. It does not contain information related to billing such as claims for services or requests for copies of records or other correspondence unrelated to the treatment during the given encounter. The LHR is the organization's business record and is made available to authorized requestors.
8. American Hospital Association. "Hospital Medical Records—guidelines for their use and release of medical information," (Chicago: 1972).
9. Roach, W. H., *Medical Records and the Law* (Boston: Jones & Bartlett, 2003.), 384.
10. Select State Disclosure Laws. US Legal, Inc. Retrieved October 7, 2015, from <http://healthcare.uslegal.com/doctor-patient-confidentiality/select-state-disclosure-laws/>.
11. Health Information and the Law. Retrieved February 29, 2015, from <http://www.healthinfolaw.org/comparative-analysis/individual-access-medical-records-50-state-comparison>.

SECOND EDITION

The Practical Guide to
**RELEASE OF
INFORMATION**

ROI in a HITECH World

ROSE T. DUNN, MBA, RHIA, CPA, CHPS, FACHE
with **BEN BURTON, JD, MBA, RHIA, CHP, CHC**

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- Breakdown of state regulations regarding ROI

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