New HIPAA Rule Changes a Patient's Rights for Restrictions When Paying Out-of-Pocket
Requires action now: new procedures must be in place by Sept. 22.

This Compliance Alert focuses on the **New Requirements for *Notices of Privacy Practices which Providers MUST give to Patients*** based on the HHS Final Rule issued January 25 of this year[1].

(i) Notices of Privacy Practices (NPPs) for all covered entities now must include the following information:

(1) the sale of protected health information and the use of such information for paid marketing require authorization from the individual;
(2) other uses and disclosures not described in the NPP will be made only with authorization;
(3) covered entities must notify affected individuals of breaches of their PHI; and
(4) individuals can restrict disclosures to their health plan for services for which they pay "out of pocket" and in full.

The rule states that if a patient pays a provider for a healthcare treatment or service "out of pocket," the patient can request and the provider or other HIPAA-covered entity must comply with the request, not to disclose a record of that encounter or service to his/her insurance company, or even a business associate of the health plan, for payment or other healthcare operations.

[1] On January 25, 2013, the Department of Health and Human Services ("HHS") formally published its Omnibus Final Rule ("Final Rule"), which includes modifications to the HIPAA Privacy and Security Rules under the Health Information Technology for Economic and Clinical Health Act ("HITECH"). These changes include, among others:

- Changes to the requirements for *Notices of Privacy Practices;*
- Modification to the standard for reporting breaches of unsecured personal health information (PHI);
- Extension of HHS enforcement authority over business associates;
- Modifications to the requirements for business associate agreements;
- New obligations for business associates to enter into business associate agreements with their own subcontractors

Keeping your practice and AHS Compliant: here is why this new regulation is very important.

When a patient pays for a service out-of-pocket and instructs the provider (through an appropriate 'Restrictions on Uses and Disclosures Form') to not disclose PHI associated with that service for payment or health care operations, AHS is prevented from submitting a claim—since by doing so we would be disclosing PHI. If provider/AHS chooses to bill the service anyway, it would be an unauthorized disclosure constituting a breach. This may subject the provider and/or AHS to a penalty, which could be quite substantial if OCR determines the conduct was reckless (usually due to incomplete or non-compliant HIPAA privacy and security policies). Therefore, when the patient makes such a request, HITECH trumps any perceived contractual duty to file a claim because it can't be done without violating a federal law.

Under the pre-HITECH regulations, you could ignore the patient's request not to file the claim. Under HITECH, you cannot.

Practical Advice for our Clients and AHS

- Have the patient sign a request that information about self-paid services not be disclosed (usually called a Restrictions on Uses and Disclosures Form).
- Flag these records (a written policy and procedure is recommended) so they are not disclosed to the health plan, should the health plan make a request. The easiest way is to keep them in a separate file. If that's not an option, clearly mark the record as "Not for Disclosure for Payment or Health Care Operations."
- If you are sending the records to another provider (which is permissible), make sure the provider knows the records cannot be sent to the health plan due to the patient's written request which is on file.

In the commentary accompanying the Final Rule, HHS provided guidance addressing some of the issues raised during the rulemaking process:

- Medical Records. Providers do not need to create separate medical records or segregate PHI subject to a Required Restriction. However, they will need to use some method to identify portions of the record that contain PHI subject to a Required Restriction to ensure it is not inadvertently sent to or made accessible to the health plan for payment or health care operations purposes.
- Bundled Services. If a patient requests a restriction with respect to one of several items or services provided in a single patient encounter, the provider should counsel the patient on the ability or inability to unbundle the services and the consequences

of doing so (i.e., the health plan may still be able to identify the services performed based on the context). If the provider cannot unbundle the items or services, the provider should give the patient the option to restrict and pay out-of-pocket for the entire bundle of items or services.

- Dishonored Payments. Providers do not need to abide by a restriction if a patient's payment is dishonored. However, HHS expects providers to make reasonable attempts to resolve payment issues with the patient prior to disclosing PHI to the health plan. Providers may require payment in full at the time the restriction is requested to avoid payment issues.
- Downstream Providers. Providers are not required to notify downstream providers of Required Restrictions. This is the responsibility of the patient. Providers should counsel patients that for the restriction to apply to other providers, the patient must pay out-of-pocket and request a restriction when care is rendered by other providers.
- Follow-Up Care. Providers may include previously restricted PHI when billing the health plan for the follow-up treatment if the patient does not request a restriction and pay out-of-pocket for the follow-up treatment and if it is necessary to have the follow-up treatment deemed medically necessary.
- HMOs. Contractual requirements for a provider to submit claims to an HMO do not exempt the provider from obligations regarding Required Restrictions. Provider contracts should be updated to be consistent with these new requirements.
- Mandatory Billing Rules. A provider may submit PHI to a government health plan as required by law (i.e., mandatory claim submission laws). However, there are various mechanisms that allow a provider to avoid such legal mandates (i.e., if the patient refuses to authorize submission of a bill to Medicare). Providers must utilize such mechanisms in order to comply with the request for a Required Restriction.

Although the Final Rule went into effect on March 26, 2013, covered entities have 180 days (i.e. until September 22) to comply with Requests for Required Restrictions.

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