

Exercising Patient Rights under the HITECH Act

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The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 and signed into law on Feb 17, 2009.¹ Section 13405(a) of the HITECH Act codified in §45 C.F.R 164.522(a)(1) sets forth certain circumstances in which a covered entity must comply with an individual's request for restriction of disclosure of his or her protected health information.² HITECH modified the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, by providing patients with an opportunity to limit sharing of protected health information that would normally occur automatically between covered entities (a physician's office and insurance company) pursuant to the "payment" and "operations" permissible use and disclosure categories.³

Specifically, section 13405(a) of the HITECH Act requires that when an individual requests a restriction on disclosure pursuant to § 164.522, the covered entity must agree to the requested restriction "unless the disclosure is otherwise required by law," if: (1) the request for restriction is on disclosures of protected health information (2) to a health plan (3) for the purpose of carrying out payment or health care operations and (4) if the restriction applies to protected health information that pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.⁴

Patients may now invoke their right to pay for a service out of pocket. By paying for the service without using their health plan, the health plan can no longer rely on the "payment" or "operations" HIPAA information sharing exceptions to obtain access to the patient's medical record. When a patient makes this demand, it must be for privacy purposes, and it needs to be of the patient's own volition. If the check does not clear, or the credit card is declined, then the privacy request need not be honored since the service was no longer paid out of pocket in full. The demand forces the covered entity to offer the patient a cash price. If the patient is a Medicare patient, then this cash price must be the exact same price that would have been charged to Medicare, but for any other patient the cash price that is offered need not reflect the fair market value of the service provided.

There are times when a patient may not be able to invoke this privacy right under HITECH. To the extent that state law regarding Medicaid or health maintenance organizations (HMOs) conflicts with HITECH, then state laws trump this HITECH provision as instances where "the disclosure is otherwise required by law." If a provider is required by state or other law to submit a claim to a health plan for a covered service provided to the individual, and there is no exception or procedure for individuals wishing to pay out of pocket for the service, then the disclosure is required by law and is

an exception to an individual's right to request a restriction to the health plan pursuant to § 154.522(a)(1)(vi)(A) of the Rule.⁵

Remember that state HMO regulations need to create the trumping conflict, not the language of the HMO contract:

... [I]f a provider within an HMO is prohibited by law from accepting payment from an individual above the individual's cost sharing amount then the provider may counsel the individual that he or she will have to use an out-of-network provider for the health care item or service in order to restrict the disclosure... Providers operating within an HMO context and who are able under law to treat the health care services to which the restriction would apply as out-of-network services should do so in order to abide by the requested restriction. We would not consider a contractual requirement to submit a claim or otherwise disclose protected health information to an HMO to exempt the provider from his or her obligations under this provision.^{6, p 5629}

In other words, when working with an HMO you need to abide by any state law that would prohibit you from honoring the patient's privacy request. If such a state law is in place, then your practice might suggest that the patient find an out-of-network physician to obtain private care that is thus not subject to state HMO regulations. If no state law is in place to prohibit you from honoring the patient's HITECH privacy request, then you must honor the patient's request even if there is contractual language in your contract with the HMO that prohibits any form of cash payment for covered services.

Medicare beneficiaries have no right to privacy if a claim is filed. There is a very limited way for them to protect their personal information:

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 that if a physician or supplier charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the physician or supplier must submit a claim to Medicare. However, there is an exception to this rule where a beneficiary (or the beneficiary's legal representative) refuses, of his/her own free will, to authorize the submission of a bill to Medicare. In such cases, 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.^{6, p 5628}

This Medicare flexibility should not be viewed as a broad exception to the need for the physician to opt out of Medicare to privately contract with Medicare patients for covered services. Note that when a Medicare patient invokes a HITECH privacy request, it must truly be of the patient's own volition and that Medicare limiting rates (and thus documenting and coding rules) continue to apply.

Many physicians have logistical concerns about how to parse out a specific part of the medical record in a way that it is not inadvertently shared with other covered entities in the normal course of business. Final Rule commenters noted that "these provisions do not require that covered health care providers create separate medical records or otherwise segregate protected health information subject to a restricted health care item or service. Covered health care providers will, however, need to employ some method to flag or make a notation in the record with respect to the protected health information that has been restricted to ensure that such information is not inadvertently sent to or made accessible to the health plan for payment or health care operations purposes, such as audits by the health plan."^{6, p 5628}

Bundling services can be difficult if a portion of those services was paid for privately under HITECH. Deciding what is protected and what is shared remains difficult. Final rule commenters stated that "we expect providers to counsel patients on the ability of the provider to unbundle the items or services and the impact of doing so... [I]f a provider is not able to unbundle a group of items or services, the provider should inform the individual and give the individual the opportunity to restrict and pay out of pocket for the entire bundle of items or services. Thus we decline to provide as a general rule that an individual may only restrict either all or none of the health care items or services that are part of one treatment encounter."

Downstream providers will need to be notified repeatedly by the patient that HITECH rights are being invoked. Prescriptions will need to be handwritten so that patients may arrive with the prescription in hand at the pharmacy and inform the pharmacist on arrival that the information may not be submitted to the plan. In states like New York where electronic prescribing is required, it appears that there is simply no solution. The final rule commenters admitted that "it would be unworkable at this point, given the lack of automated technologies to support such a requirement, to require health care providers to notify downstream providers of the fact that an individual has requested a restriction to a health plan."

Patients may use their health savings accounts or flexible spending accounts when invoking HITECH privacy rights. The final rule states that "[a]n individual may use an FSA or HSA to pay for health care items or services that the individual wishes to have restricted from another plan; however, in doing so the individual may not restrict a disclosure to the FSA or HSA necessary to effectuate that payment."^{6, p 5630}

In emergency circumstances care will likely be initiated

with implied consent with either no contract at all or an adhesion agreement signed under duress. In these instances, it is difficult to use HITECH, and obviously once the information has been shared there is no way to un-share the information and privately contract for it after care was provided. There are other techniques (discussed below) that can be used in these instances. Patients could use the example HITECH Request Statement included below, or a more detailed four-page form is available from the University of Chicago.⁷

Does HITECH Privacy Protection Apply to Your Patient?

When considering whether a patient can restrict disclosure of medical information, consider the following questions:

1. Do insurance agreements apply to this patient?

If not (such as uninsured or health-sharing-ministry patients), there is no "health plan" and thus no need to formally restrict access in this manner to the medical record. For HMO patients, see #2. For Medicaid patients, see #3. The limited privacy protection available to Medicare beneficiaries is discussed above.

2. Can the HITECH exemption be used for in-network providers?

Look up state HMO law to see whether there is a complete prohibition on private contracting without any privacy exception. If not, see #3. If there is such a prohibition, the patient will need to seek care out-of-network in order to preserve privacy.

3. Is the Medicaid patient allowed to privately contract for "covered services" (not in Kentucky or Colorado)?

In Kentucky⁸ and Colorado⁹ Medicaid patients are not permitted to privately contract for covered services, and this rule applies even when a physician is not enrolled as a Medicaid provider. In the majority of states there is no specific prohibition on private care, and physicians will want to consult the Medicaid Provider Manual about whether the patient may pay privately and use the HITECH exemption. Answers will vary and may be dependent upon whether the physician is a traditionally enrolled provider, an ordering and referring only (or similar category) provider, or not enrolled/credentialed with the state Medicaid program.¹⁰

Actions Patients Can Take in an Emergency

If a patient seeks care at the emergency department or is taken there in an ambulance or on an emergent basis, there are actions available to protect against privacy violations or inflated charges.

Patients should decline to sign the HIPAA Notice of Privacy Practices. A signature is not required by law for treatment, and refusal to sign signals a desire to keep personal information as private as possible.

Patients should ask whether the hospital "accepts Medicare" and when the answer is inevitably "yes," patients should state that they do not have insurance and demand a cash price pursuant to their HITECH privacy rights using the

sample HITECH request statement below.

Patients should ask for the price that would be paid by Medicare. If the hospital does not respond to rapid-fire Medicare pricing requests, then patients should write, next to their signature on patient intake forms: "This is an adhesion agreement signed under duress, and the services delivered under this agreement will be provided at the lower of fair market value or Medicare rates."

Requests for price transparency can help in contesting outrageous bills that show up months later. Patients should take the hospital to court (often small claims court) before it has the opportunity to submit unpaid bills to collections.

Hospital Misstatements

Hospitals may say, "We don't accept health-sharing-ministry patients." This is impossible to enforce (and likely illegal discriminatory behavior—so attempt to get this in writing if an administrator claims it is the hospital's policy). Many hospitals hate health sharing ministries because these organizations help patients get out of adhesion agreements and negotiate fair prices based on experience. It is not advisable for patients to tell the hospital that they are members of a health sharing ministry. From the hospital's perspective, these should be considered uninsured patients.

It is incorrect for hospitals to say, "You must sign all HIPAA forms." In fact, the "MUST" requirements apply to hospitals. (1) The hospital MUST honor HITECH requests (with very limited HMO and Medicaid exceptions in some states). (2) The hospital MUST screen patients for emergency care pursuant to EMTALA regardless of their insurance status

Insurance Company Denials

If a patient is in the unfortunate position of actually using insurance (the goal should be to avoid this if at all possible), then this advice may be helpful if a requested medication or procedure is denied. The patient should: (1) Demand the name of the physician and/or nurse administrator who made the denial decision. (2) Ask for a "peer-to-peer" call regarding the denial between the attending physician and the person making the denial decision. (3) Use the state medical and nursing board websites to determine whether the individual

denying the request is appropriately licensed. If not, report the case of "unlawful practice of medicine" to the board. If the person is licensed, the denial can still be reported, with a complaint that no patient-physician relationship existed, and the opinion used to obstruct care was neither sought nor valued.

Model HITECH Request Statement

I _____ (patient's name) require pursuant to the HITECH Act codified in §45 C.F.R 164.522(a)(1) that my health information related to this set of medical services not be shared with my health plan in exchange for my cash payment in full for the set of medical services. I am making this request of my own volition. I understand that I will need to repeat this request as I approach other covered entities for care related to these same medical services.

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