ATTORNEYS REQUEST FOR PATIENT BILLING RECORDS

Radiology Waukesha SC adheres to Wisconsin Statute 146.83

1) **Person requesting records must be authorized by the patient.**
2) **Written authorization is required to get copies of a patient's billing records**
3) **Radiology Waukesha SC will provide paper copies of patient billing records per statute.**
4) **Copies of patient billing records will require payment per statute.**

Mail Request to: Radiology Waukesha SC
Request for Billing Records
P O Box 44370
Madison, WI 53744-4370

Fax Request to: Radiology Waukesha SC
Request for Billing Records
866-769-8052

Radiology Waukesha SC provides only billing records and does not have access to actual medical records.

Wisconsin Statutes 146.83 – Access to patient health care records

Current as of: 2015 | *Check for updates* | *Other versions*

(1b) Notwithstanding s. 146.81 (5), in this section, a "person authorized by the patient" includes an attorney appointed to represent the patient under s. 977.08 if that attorney has written informed consent from the patient to view and obtain copies of the records.

(1c) Except as provided in s. 51.30 or 146.82 (2), any patient or person authorized by the patient may, upon submitting a statement of informed consent, inspect the health care records of a health care provider pertaining to that patient at any time during regular business hours, upon reasonable notice.

(1f)

(am) If a patient or person authorized by the patient requests copies of the patient's health care records under this section for use in appealing a denial of social security disability insurance, under 42 USC 401 to 433, or supplemental security income, under 42 USC 1381 to 1385, the health care provider may charge the patient or person authorized

by the patient no more than the amount that the federal social security administration reimburses the department for copies of patient health care records.

(bm) If the department requests copies of a patient's health care records for use in determining eligibility for social security disability insurance, under 42 USC 401 to 433, or supplemental security income, under 42 USC 1381 to 1385, the health care provider may charge no more than the amount that the federal social security administration reimburses the department for copies of patient health care records.

(cm) Except as provided in sub. (1g), a health care provider may not charge a patient or a person authorized by the patient more than 25 percent of the applicable fee under sub. (3f) for providing one set of copies of a patient's health care records under this section if the patient is eligible for medical assistance, as defined in s. 49.43 (8). A health care provider may require that a patient or person authorized by the patient provide proof that the patient is eligible for medical assistance before providing copies under this paragraph at a reduced charge. A health care provider may charge 100 percent of the applicable fee under sub. (3f) for providing a 2nd or additional set of copies of patient health care records for a patient who is eligible for medical assistance.

(1g) The requirement under sub. (1f) (cm) to provide one set of copies of records at a reduced charge if the patient is eligible for medical assistance does not apply if the health care provider is the department or the department of corrections.

(1m)

(a) A patient's health care records shall be provided to the patient's health care provider upon request and, except as provided in s. 146.82 (2), with a statement of informed consent.

(b) The health care provider under par. (a) may be charged reasonable costs for the provision of the patient's health care records.

(2) The health care provider shall provide each patient with a statement paraphrasing the provisions of this section either upon admission to an inpatient health care facility, as defined in s. 50.135 (1), or upon the first provision of services by the health care provider.

(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

(3f)

(a) Except as provided in sub. (1f) or s. 51.30 or 146.82 (2), if a person requests copies of a patient's health care records, provides informed consent, and pays the applicable fees under par. (b), the health care provider shall provide the person making the request copies of the requested records.

(b) Except as provided in sub. (1f), a health care provider may charge no more than the total of all of the following that apply for providing the copies requested under par. (a):

1. For paper copies: $1 per page for the first 25 pages; 75 cents per page for pages 26 to 50; 50 cents per page for pages 51 to 100; and 30 cents per page for pages 101 and above.

2. For microfiche or microfilm copies, $1.50 per page.

3. For a print of an X-ray, $10 per image.

4. If the requester is not the patient or a person authorized by the patient, for certification of copies, a single $8 charge.

5. If the requester is not the patient or a person authorized by the patient, a single retrieval fee of $20 for all copies requested.

6. Actual shipping costs and any applicable taxes.

(c)

1. In this paragraph, "consumer price index" means the average of the consumer price index for all urban consumers, U.S. city average, as determined by the bureau of labor statistics of the U.S. department of labor.

2. On each July 1, beginning on July 1, 2012, the department shall adjust the dollar amounts specified under par. (b) by the percentage difference between the consumer price index for the 12-month period ending on December 31 of the preceding year and the consumer price index for the 12-month period ending on December 31 of the year before the preceding year. The department shall notify the legislative reference bureau of the adjusted amounts and the legislative reference bureau shall publish the adjusted amounts in the Wisconsin Administrative Register.

(4) No person may do any of the following:

(a) Intentionally falsify a patient health care record.

(b) Conceal or withhold a patient health care record with intent to prevent or

obstruct an investigation or prosecution or with intent to prevent its release to the patient, to his or her guardian, to his or her health care provider with a statement of informed consent, or under the conditions specified in s. 146.82 (2), or to a person with a statement of informed consent.

(c) Intentionally destroy or damage records in order to prevent or obstruct an investigation or prosecution.

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SVA Healthcare Services, LLC

☐Compliance/OIG ☒HIPAA Privacy ☒HIPAA Security ☒Other Regulatory/Law ☐SVA - Organizational

Policy Name:	Disclosure of PHI	Date Established:	3/3/2006
Policy Number:		Date Reviewed:	6/22/2015
Reviewed and Approved By:	Compliance Committee	Next Review Date:	3/16/2016

Objective: All workforce members will disclose and release patient information in accordance with federal and state regulations to prevent non-compliance and client dissatisfaction.

Narrative: Disclosure is the external release, transfer, provision of, access to, or sharing in any other manner, of information outside of the organization. This is also called "release". As a third party medical billing service, it is SVA's policy to only disclose ***financial*** information to a requestor according to state and federal guidelines. Where PHI or personally identifiable health information is part of the financial information needing release, all disclosures or releases should be handled in accordance with this policy. PHI may generally be released for treatment, payment, and operations activities. This policy is oriented towards patients who are residents of Wisconsin and Illinois. For residents of other states or where "State law" is referenced, contact the Compliance Manager for additional clarification.

Definitions:

Personally Identifiable Health Information – includes any information that can be used to reasonably identify a person including PHI.

Protected Health Information (PHI) - is any information in the medical, financial, or research record that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service. There are 18 identifiers as follows:

Names – including first initial, last name combinations	Phone numbers
All elements of dates (except year) for dates directly related to an individual, including birth, admission, discharge, date of death; and all ages over 89 and dates (including year) indicating age	Zip codes for all geographical subdivisions smaller than a State and less than 20,000 people
Electronic mail addresses	Fax numbers
Medical record numbers	Social Security numbers
Health plan beneficiary numbers	Account numbers (except SVA account numbers
Biometric identifiers, finger and voice prints	Vehicle identifiers, plate, and serial numbers
Device identifiers and serial numbers	Web Universal Resource Locators (URLs);
Internet Protocol (IP) address numbers	Certificate/license numbers
Full face photographic images and any comparable images	Any other unique identifying number, characteristic, or code

SVA has determined client acronyms and account numbers (ABC 12345) to be PHI. This information should be handled as follows in addition to other requirements of this policy:

- It may not be included in external emails without encryption
- It may be used as a confirming identifier to verify patients and callers
- It may be used in patient notes for compliance issues or transaction corrections

Procedure:

An Authorization for Disclosure is not needed:

When a patient is requesting information for payment regarding his own account or record **by phone** the minimum necessary standard would not apply. It is SVA's policy to document all phone calls in patient notes of the patient account. Three of six elements below must be used to verify the identity of the patient to disclose information verbally. At least three of these elements must be requested from any caller to determine that caller is involved in the patient's care:

- Full name
- Date of birth
- Account number
- Social security number
- Home address
- Telephone number

Only financial information (balance due, insurance determinations) can be released to another individual verbally when there is no authorization on file but consent is implied.

- For example, after verifying the identity of a patient, the patient asks if the financial information (copay, coinsurance, etc) could be relayed to his spouse as the spouse has a better understanding of insurance. Financial information could be disclosed verbally in this case to the spouse.
- Other verbal authorizations are to be handled as stated further in this policy.

For further information on releasing PHI to individuals other than the patient, consult the Release of Information Grid. Release to non-patients should be based on the employee's professional judgment.

- Where callers are sharing knowledge about the patient's care, insurance, and identity in the process of resolving accounts, release of the minimum information necessary may be more acceptable without patient authorization.
- Where callers are requesting details about the patient's care, insurance or identity, it is reasonable to request additional authorization from the patient.
- Release should conform to the minimum necessary standard and is restricted to billing information.

Routine disclosures do not need patient authorization and includes such exchanges as communication with payors about claim status and benefits, calls to hospitals about patient demographics, data transmission to business associates, and follow up with physicians and clinic staff on charges.

A patient may request a copy of billing records **in writing** by identifying his or her name along with other patient identifiers and his or her signature to reasonably confirm the patient account. An Authorization for Disclosure Form is not needed – this is for a request from someone other than the patient. Any request for billing PHI must be provided within 30 days of the request with an additional 30 day extension permitted with notification to the patient.

For further information on releasing an electronic copy of PHI, consult the Electronic Records Request Policy.

Operational Uses

These are internal uses of PHI for purposes related to the following types of activities

- Quality improvement and quality control activities
- Financial analysis
- Training
- Credentialing
- Evaluating employee performance
- Fraud and abuse detection
- Investigations
- Business planning and management activities
- Customer service

Fax and Mail

- When a statement is sent in error to a patient or another address, a disclosure has occurred and should be reported through the on-line Compliance Incident Report (See the processes on Patient Complaints – Statement Sent in Error or Statement Sent to Incorrect Address)
  - Patient notes should be documented and the incident reported using SVA Compliance Hotline (x62699) or the on-line Compliance Incident Report
- All internal and external information sent by mail will meet the minimum necessary standards. Only trained and authorized staff will handle mail.
  - All types of media containing this PHI will be placed in secure, confidential envelopes or containers and marked "Confidential". (Internal and external)
- Fax cover sheets with confidentiality statement will be used. Fax numbers should be verified prior to sending the fax and dialed correctly. PHI should not be on fax cover sheet.
- Trained staff routinely check fax machine and distribute to appropriate personnel.
- When information is faxed in error, the incorrect party is contacted and advised to destroy fax. Fax confirmation sheet should be attached to original.
- If faxes are received in error, the sender must be informed immediately and the information placed in the locked shredding bins.
- Numbers should not be pre-programmed in fax unless routinely checked for accuracy

Sensitive PHI – This is conditioned by State law. This applies to accounts with information such as HIV testing, drug and alcohol or drug abuse (AODA) related treatment, sexually transmitted diseases (STDs), some emergency services, or mental health service codes. When handling Sensitive PHI, adhere to the following procedures.

- A separate signed authorization by the patient or their representative for releasing this specific information to any third party must be obtained prior to the disclosure.
    - In Wisconsin, mental health information may be released to other HIPAA entities like insurance payers without authorization. If this information includes AODA diagnosis information, it may not be released.
- This type of PHI should never be faxed or emailed.
- This type of information should never be disclosed to parents of adult children or spouses without written authorization from the patient. If no authorization is available from a minor child who is a patient, it may not be advisable to provide this information to parents or guardians as well. Please seek guidance from the Compliance Manager.

Written Authorization For Disclosure of PHI on Financial Statements

Written authorization may be made by the following individuals:

- The patient if they are an adult and competent
- Parent, guardian or legal custodian of a minor patient
    - This applies to non-sensitive services or sensitive services of which the parent, guardian or legal custodian has knowledge.
    - It does not apply to services, including sensitive services, where a parent, guardian or legal custodian has been excluded from the care process
- Legal guardian of an incompetent patient
- Person authorized in writing by the patient
- Health care agent as designated by the patient
- Court-ordered temporary guardian of the patient
- An emancipated minor
- A minor child who has obtained sensitive healthcare services

Requirements of a Written Authorization/Release:

SVA will not honor an invalid authorization. The patient may directly request his or her own information without a valid authorization form. When disclosing to a third party, a written authorization is required in accordance to state regulations and should be written in plain language containing the elements of a valid authorization. Verify any request for authorization through the Checklist for Valid Authorization.

- It may be emailed where directed by the patient in accordance with the Electronic Records Request Policy.
- Information may not be faxed
- Authorization for Workers Compensation service follows separate requirements and does not require a patient's signature. Questions on validity should be escalated to a Supervisor or the Compliance Manager.
    - Release of reports or supporting documentation for workers compensation, liability, or other non-health insurance payers should be reviewed to determine if there is any information such as a diagnosis or nature of service (ie screening) that conflicts with payer type.

Written authorizations are scanned to the patient account as correspondence and noted with the expectation that other employees releasing information for the patient are reviewing the authorization to ensure it is applicable and not expired.

Answering Machine Messages:

- All information left on an answering machine should be concise and general.
  - Only the SVA client name, patient's first name and contact phone number should be included in the message.
- Appointment reminders can include the date and time of the appointment and a phone number to call with questions.
- No information regarding care or condition should be in the message itself.
  - Example: "I'm calling from National Radiology Specialists for Mary Smith. We recently received a denial for services provided and I would like to confirm the insurance information that we have on file". Please return my call @ --- --- ---- between the hours of _____ to _____ Monday through Friday"
- Where the Client name suggests a sensitive physician specialty or diagnosis, the message should not mention the client and only reference a call from a billing office regarding a medical service

Additional Permitted Releases

- For the purpose of treating a patient (discussion among health care providers, referrals), seeking reimbursement for health care services (phone calls to insurance) and for health care operations (appointment scheduling between providers, credentialing).
- For a disclosure to a personal representative or spouse of a deceased patient or an adult member of the decedent's immediate family if the spouse is no longer living. This is conditioned by State law.
- For information regarding appointment scheduling or appointment reminders.
- To an attorney requesting information regarding a Workers' Compensation case. This is conditioned by State law.
  - Wisconsin - State Statute 102.13(2)
  - Illinois - 820 ILCS 305
  - Other states available from Compliance Manager
- To public health or health oversight activities.
- Use for victims of abuse, neglect or domestic violence or other persons at risk.
- Worker's Compensation proceedings, judicial and administrative proceedings. This is conditioned by State law.
- Use by coroners, medical examiners and funeral directors in the case of deceased persons
- To a patient or their guardian if the patient 1) is under 18, 2) has not had an independently obtained or sensitive service related to drugs, alcohol, mental health, HIV and STDs, and 3) is not emancipated. This is conditioned by State law.

Emancipated Minors

An emancipated minor is one who has gained independent control through courts and is not in any way reliant upon parental support and control and can manage financial affairs before reaching age 18. It may also include a person who marries between the ages of 16-18 years of age, or an individual who has served in the armed forces. Once emancipated, the minor obtains the legal capacity of an adult. The burden is placed on the minor to demonstrate emancipation

Limitations on Disclosure/Release

- As a third party medical billing service, the patient's chart is the property of SVA's clients. Any request for medical records or medical reports from a third party should be referred back to the client/facility where services were rendered unless the request is from a payer for reports for claim adjudication.
- Any information regarding insurance benefits or eligibility should be referred back to the patient so he or she may contact the insurance company. Three-way calling with the patient on the phone is permissible.
- Parents may be limited from obtaining or providing financially-related healthcare information about their children
    - If the child has received sensitive services described below,
    - If the child is older than 18 but is covered under the parent's health insurance, or
    - If the child is an emancipated minor.
    - Please consult the Release of Information Grid.
    - If a parent provides information to update an account on an adult child, this information should not be accepted without authorization from the adult child.
- Discussion of PHI should be limited during cell phone use.
- Speakerphones should not be used for the discussion of PHI or the retrieval of voice mail unless in a private, closed office.
- Release for subpoenas, court requests, and non-government charity programs must have written patient authorization for release of information unless the party is providing direct payment for patient care. Subpoenas indicating that patient has received notice are permissible for releasing patient information.
    - Subpoenas should be reviewed by the Compliance Manager unless these are discovery subpoenas that only require an itemized statement.
- Explanations of benefits that are sent to payers as proof of primary payment must have all information of unrelated patients removed or hidden.
- Use of alternative sources for demographic references must be current and verified to match the patient's identity. Use of demographic information from other SVA multi-search accounts or external legal or public use resources must match patient full name, middle initial, and date of birth or other demographic identifiers and actively updated or verified as current within one year from the update. For partially complete sources, two or more sources must be used to confirm addresses. Examples of alternative sources include payer portals, Wisconsin CCAP, and White Pages where names and other information are available to verify patient identity and location.
- Where a patient has requested his or her service not to be billed to insurance and the patient has paid for the service in full, SVA may not forward this charge to insurance regardless of the contractual relationship between the payer and client.
    - This restriction may be rescinded if the patient's obligations under the client's financial policy are not met.
- Marketing to patients and fundraising from patients are not activities in which SVA engages. Therefore restrictions and patient communication requirements on these activities are not applicable.

Amendments to PHI

- Any request to amend a patient's billing record should be forwarded to the Compliance Manager for review. As most information recorded by SVA comes from other sources such as correspondence, explanation of benefits and related transactions, it is likely that SVA will have limited information to amend.
- Any request to amend a patient's medical record should be forwarded to the client or client's facility. SVA will not amend a medical record.
- An individual's request may be denied if:
    - The information was not created by SVA;
    - The information is not part of the designated record set maintained by SVA and its business associates;
    - Federal and state law does not permit
    - Records are deemed accurate by SVA upon review
    - The Compliance Manager will respond to the amendment request and forward it to the individual within 60 days of receipt of the request form. If needed, SVA may take one 30-day extension by notifying the individual in writing within the 60-day response period of the reason for the extension and the date on which the plan will provide its response.
- If an amendment to PHI is made, the Compliance Manager will notify any appropriate business associates of the amendment. Additionally, the Compliance Manager will:
    - Insert the amendment or provide a link to the amendment at the site of the information that is the subject of the request for amendment.
    - Inform the individual that the amendment is accepted.
    - Obtain the individual's agreement to have the covered entity notify the relevant persons with whom the amendment needs to be shared.
    - Within a reasonable time frame, make reasonable efforts to provide the amendment to persons identified by the individual and persons, including business associates, that the covered entity knows also hold the PHI that is the subject of the amendment and that may have relied on or could possibly rely on the information to the detriment of the individual.
- If the request for amendment is denied, the Compliance Manager will communicate to the patient in plain language to explain:
    - The basis for the denial.
    - The individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement. The covered entity may reasonably limit the length of the statement of disagreement.
    - A statement that if the individual does not submit a statement of disagreement, the individual may request that the covered entity provides the individual's request for amendment and the denial with any future disclosures of PHI.
    - A description of how the individual may complain to the covered entity or the secretary of Health and Human Services.
    - The name (or title) and telephone number of the designated contact person who handles complaints for the covered entity.
    - If the request is denied, and the individual submits a statement of disagreement, the Compliance Manager will link or append the statement of disagreement to the disputed PHI and include the statement of disagreement, the request for amendment, and the

denial of the request (or, in the alternative, a summary of the situation) in future disclosures of the disputed PHI. The Compliance Manager may also prepare a rebuttal to the individual's statement of disagreement and send it to the individual. In this case, the Compliance Manager will link or append the rebuttal to the disputed PHI, and will include the rebuttal in future disclosures of the disputed PHI.

- Where SVA is informed by another covered entity of an amendment to an individual's PHI within the designated record set, SVA must amend the protected health information in written or electronic form.
- Where the individual requests that the request for amendment and the plan's denial be included in future disclosures of the PHI, SVA will link or append the request for amendment and the plan's denial of the request to the disputed PHI (or, in the alternative, a summary of the situation) in future disclosures of the disputed PHI.

Mitigation

Where employees can interrupt or prevent the further release of PHI, general actions should be taken, documented on the account, and included with the compliance report. This may include but is not limited to the following:

- Requesting any recipients of PHI that was sent in error to return the PHI.
- Requesting any recipients of PHI that was sent in error to shred the PHI.
- Invalidating incorrect addresses to prevent further statement disclosures.
- Holding statements.
- Changing insurance to prevent claims submission to incorrect payers.
- Remapping insurances.
- Obtaining missing patient demographic information.

Prohibitions on Releasing PHI

Under no circumstances, may staff engage in the following activities related to PHI

- **Selling or otherwise using PHI for personal gain or activities.**
- **Using, accessing, or disclosing PHI in violation of the Minimum Necessary Policy or other SVA policies and standards on handling PHI.**
- **Using, accessing, or disclosing PHI in a deliberate or reckless manner that could incur civil or other financial or criminal penalties under HIPAA regulations.**
- **Using, accessing or disclosing PHI by social media, portable devices, pictures, or other media not otherwise approved by SVA or permitted by HIPAA regulations.**

Monitoring: The Compliance Manager will review questionable authorizations and unauthorized disclosures of patient information and will test knowledge of staff on knowledge of disclosure at least annually.

Enforcement and Response: Employees who do not follow the policy or do not report policy non-compliance will be subject to SVA's general disciplinary protocol. Compliance Manager will immediately communicate issues that are significant to area Supervisor or Manager for consult. The Compliance Manager will report continued non-compliance through the Compliance Report. Changes to audit process will be communicated by Compliance Manager to Quality Assurance Team.

Policy Distribution and Results List: This policy will be provided to all employees. Employees will be educated at least once annually on importance and duty of following this policy. The Compliance Auditor will present any results, deficiencies, discrepancies, or trends from audits to Compliance Manager to address. Results of audits will be made available to Supervisor and/or Manager, Managing Director and Compliance Committee.

Related Documents:
SVA Valid Authorization Form
Checklist for Valid Authorization
Release of Information Grid
Patient Complaints – Statements Sent in Error
Statements Sent To Incorrect Address

Resources: Ministry Health Care Disclosure of Patient Protected Health Information 11/9/05
HIPAA COW Communication of Protected Health Information 12/8/04