New Medicare Law Changes Key Part of Reassignment Rules

The Medicare Prescription Drug Modernization and Reform Act (MMA) was signed and became effective on Dec. 8, 2003. We told you about the impact the MMA would have on physician reimbursement, in the January issue of the Insider. And no doubt you’ve read a lot about a major focus of the MMA, the new prescription drug benefit for Medicare beneficiaries. But some aspects of the MMA that will have a big impact on physician practices haven’t been getting as much attention. One such aspect is a change the MMA makes to the reassignment rules. We’ll explain what the change is and what it may mean to radiology practices.

What Are Reassignment Rules?
It’s generally illegal to bill Medicare for services performed by others, explains Virginia health care attorney Thomas W. Greeson. But it’s often impractical for every Medicare provider to bill on his or her own behalf, so the Medicare reassignment rules contain exceptions that permit physicians to reassign their right to bill Medicare to someone else, in certain circumstances.

For example, the physicians in a practice commonly reassign their right to bill Medicare to their group practice. That way the practice’s coding, billing, and collection staff can handle billing for all the physicians in the practice, and revenues can be distributed in accordance with an agreement among the physicians. Likewise, radiologists employed by a hospital may reassign their right to bill Medicare to the hospital. Or a radiology group may have a contract with another provider—say a cardiology practice—to provide professional interpretations to the cardiologists for a fee. If structured properly, the radiologists in the group could reassign their right to bill Medicare for those professional interpretations to the cardiologists.

But radiologists working as independent contractors—that is, not employed by a hospital or group practice as a “W-2 employee”—weren’t covered by this exception to the reassignment rules. So independent contractors often had difficulty reassigning their Medicare benefits to another practice.

Requirement for Clinic Work ‘On the Premises’

The old reassignment rules required that reassigned work done for a clinic or other facility be done “on the premises” of the clinic or facility. This was a significant provision because the definition of “clinic” includes just about everything except a hospital or an independent diagnostic testing facility (IDTF), Greeson explains. “Clinic” is defined as “a freestanding entity (e.g., a physician, medical group, outpatient dialysis facility, ambulatory surgery center, or imaging center) which provides diagnostic and/or therapeutic health services on an
outpatient basis in quarters which it owns or leases.” So under the old reassig

ment rules, if a radiologist had an agreement to interpret images for a family practice and had reassigned his right to bill Medicare to the family practice, then he had to interpret the images at the family practice’s offices.

But this requirement was often violated. It’s typical for the films to be physically delivered or transmitted electronically to the radiologist for reading and interpreting at the radiologist’s office. That’s because radiology offices are likely to have much better facilities for reading films than the family practice office, or other “clinic,” does. Plus, it’s impractical for the radiologist to go to another location just to read one or two films, Greeson points out. So, many arrangements in which radiologists provided interpretations for entities defined as “clinics” were in violation of the reassignment rules because the radiologists didn’t read the films on the premises of the provider to whom the radiologist was reassigning his right to bill Medicare, Greeson explains. His clients have billed Medicare separately when performing services “off the premises.”

MMA Revises Reassignment Rules

The MMA contains an amendment to the reassignment rules that’s likely to affect radiology in some significant ways, Greeson says. The amendment permits a physician to reassign Medicare payments to any entity with which the physician has a “contractual arrangement” for the provision of professional services. So now a physician can reassign his Medicare payments to someone other than a W-2 employer. And there’s no longer a requirement that the professional services that are the subject of the reassign be provided on the premises. This will affect radiology practices in the following ways:

More freedom to contract with other physicians. Once CMS releases instructions to the carriers implementing the change—which Greeson expects to happen as early as February—radiology practices will no longer be required to interpret films on the premises of clinics they reassign to. So offering off-site professional services to clinics becomes easier and less risky, and that may spur an increase in the opportunities for radiologists to offer their services to clinics for a fee and let the clinic bill globally. And it may encourage the use of teleradiology in these circumstances, Greeson suggests.

Insider Says: The new MMA doesn’t change teleradiology billing rules at all, notes Greeson. So while the change in the reassignment rules may open up opportunities for local teleradiology arrangements, it won’t open the door to interstate teleradiology because the place of service rules remain the same.

Easier to hire independent contractors. The MMA’s new reassignment rule will make it easier for practices to hire radiologists on a contract basis to fill in for absent radiologists or to provide coverage on a regular basis, Greeson points out. Under the MMA the independent contractor radiologist can reassign her right to bill Medicare to the practice, and the practice can then bill the services using the independent contractor’s provider number.
This should be a big help to many radiology practices that found themselves short staffed and used *locum tenens* to cover duties that would normally be performed by employees or members of a practice, Greeson says. The services of a *locum tenens* are billed under the absent physician’s provider number with the appropriate modifier indicating that the service was provided by a *locum tenens*. But Medicare has strict limits on how a practice may use and bill for services provided by a *locum tenens*, so using them to substitute for full-time staff on a semipermanent basis is an administrative nightmare and a compliance catastrophe waiting to happen, Greeson says. Plus, *locum tenens* can be very expensive. Using an independent contractor is much simpler and less risky from a compliance point of view, and it’s likely to cost a lot less than using *locum tenens* for the same purpose, Greeson remarks.

**Increased competition from practice management companies.** The change in the reassignment rules may open the market to increased competition for hospital contracts from radiology practice management companies. The law makes it easier for these companies to hire physicians as independent contractors—rather than as W-2 employees—and bill Medicare for their services. So Greeson believes that management companies may begin offering to staff and manage the radiology departments at hospitals, much as they do emergency departments. This may lead to competition for hospital contracts.

**Billing for PET/CT**

**Q** We have a PET/CT scanner in our independent imaging facility. My radiologists have asked us to order CT with every PET scan—something the radiologists say that we do the CT, anyway, but need an order to get paid for it. One of our referral sources contacted us and said that this demand for a CT order with every PET order is tantamount to fraud. My radiologists insist that their request is legitimate. What’s the answer?

**A** Your radiologists may find themselves in hot water if they demand CT orders with every PET scan, says radiology administrator Michael Bohl. They’re likely to lose referral sources who are offended by the request, like the physician you mention in your question. Plus it’s appropriate to bill separately for the CT only if the CT is itself medically necessary. So it’s just a matter of time before you get demands for repayment—or worse—from your payors, he cautions.

Many radiology practices with PET/CT scanners are perplexed by this issue. That’s because all PET scans are composed of two phases—an emission phase and a transmission phase, Bohl says. A typical PET scanner has radioactive source rods within the scanner that “transmit” the radiation through the patient at certain points during the scan. But with a PET/CT scanner, the CT acts as the radioactive source that transmits the radiation through the patient, he explains. So while your radiologists are correct that they must do the CT to do the PET, that’s exactly the problem—they couldn’t complete the PET without the CT. Because the CT scan merely replaces the transmission phase of the PET scan, it is a component of the PET scan—so it’s included in the reimbursement for the PET scan, Bohl notes.

In certain rare instances the PET scan and the CT scan may be separately billable and reimbursable. But to be separately billable, the CT scan must be medically necessary, ordered by the referring physician, and performed according to protocols appropriate to the patient’s condition (for example, slice thickness, use of contrast), Bohl says. As a general rule, practices with PET/CT scanners aren’t going to be able to bill the CT component separately.

**Insider Says:** CMS will be issuing instructions to the carriers on implementing the new reassignment rules shortly. The MMA requires that these instructions contain program integrity provisions, which we’ll explore in future issues if warranted. In the meantime, keep in mind that a practice or an individual physician who plans to reassign Medicare payments still must have a “contractual arrangement” with the clinic or entity regarding the provision of professional services to the clinic or entity. And the radiologist still must complete a CMS 855R assigning his right to bill Medicare.

---

**The INSIDER welcomes questions from subscribers. You can 1) send your questions to Brownstone Publishers, Inc., “Ask the Insider,” 149 Fifth Ave., 16th Fl., New York, NY 10010-6801; 2) fax (845) 889-8044; 3) call (845) 889-4058, and speak with the editor; or 4) e-mail jgormley@brownstone.com**

---

© 2004 by Brownstone Publishers, Inc. Any reproduction is strictly prohibited. For more information call 1-800-643-8095 or visit www.brownstone.com
What to Put in Your Standards of Conduct on Billing and Coding

It’s essential for your practice to have a document laying out your standards of conduct. It should spell out your practice’s commitment to ethical conduct and compliance, and guide your employees in their ethical and legal behavior—such as providing gifts to referral sources and making political contributions. “If you’re ever investigated, the government will view your failure to have standards of conduct as evidence that you’re not fully committed to compliance,” says Washington, D.C., health care attorney Ronald L. Wisor Jr.

But while the OIG suggests that practices have a standards of conduct, it doesn’t tell them what the document should say. So, in a series of articles, the Insider will help you draft or revise your standards of conduct, section by section. We’ll start with the section on billing and coding because that’s one of the biggest trouble spots faced by medical practices. “This is typically a problem area for practices, and the target of government enforcement efforts,” notes Washington, D.C., health care attorney William A. Sarraille. With Wisor’s and Sarraille’s help, we’ve also drafted a Model Clause that you can use as the starting point for the billing and coding section in your standards of conduct (see p. 5).

What Standards on Billing and Coding Should Say

The type of standards of conduct you write will depend on the extent of your resources and the size of your practice. The bigger your practice and the more resources it has, the more general your document is likely to be, Sarraille says. The smaller the practice or the less extensive the resources, the more detailed your document will be because you’re not as likely to have a separate, detailed policies and procedures manual (see box, below).

But whether your standards of conduct section on billing and coding is general or detailed, it should address the following points. Note that our Model Clause addresses these points generally and can be used as a starting point for a more detailed document.

**State commitment to correct billing and coding.** First, say that you’re committed to submitting legal, accurate claims and that you’ll comply with all applicable laws, rules, and regulations [Clause, par. a]. “This is your basic statement of commitment to compliance,” Sarraille says.

Spelling out that this compliance is a top priority should help you get employees to take it more seriously.

**Bar submission of false claims.** Next, bar the submission of any claims that are false or fraudulent. Also, say that you’ll submit claims only for tests and services that are medically necessary unless the tests can be billed as a screening service or the patient signs an ABN [Clause, par. b]. This reinforces your most important compliance message.

**Require employees to follow all applicable laws and regulations.** Next, tell employees that they must follow all applicable federal and state laws, rules, and regulations [Clause, par. c].

**Should You Write General or Detailed Standards?**

Standards of conduct documents can vary greatly. Some are simple, brief statements of the practice’s policy, while others are more complex and detailed. “The type of standards of conduct you draft for your practice will generally depend on the amount of resources you have available to develop your compliance program,” says Washington, D.C., health care attorney William A. Sarraille.

**General standards of conduct.** If you’re a large practice or have sufficient resources, you’ll probably be able to spend the money on developing a comprehensive set of separate policies and procedures for your employees to follow. “If that’s the case, then your standards of conduct will serve as a statement of overriding principles sketched out in broad terms,” says Washington, D.C., health care attorney Ronald L. Wisor Jr.

For example, your section on billing and coding won’t tell employees how they should code specific tests or procedures. “Since the purpose of the standards of conduct is to alert the whole practice to your general compliance principles, the statements won’t be as technical or specific and will just say that employees are required to comply with all applicable laws,” Wisor says.

**Detailed standards of conduct.** If you have a smaller practice or you’re short on resources, your standards of conduct may have to do much more, says Sarraille. If this is the only statement your practice will make about compliance and you won’t have separate, detailed policies and procedures, the standards of conduct should be a much more detailed and specific document, Sarraille explains.

For example, instead of just saying that your employees must follow all applicable laws, rules, and regulations when coding, your standards might spell out the answers to specific coding issues.

If you develop a more detailed standards of conduct, you should start with those areas where you now have problems or expect to have problems in the future, Sarraille says. “If you’re short on resources, you have to target your compliance efforts to those areas where you’re most likely to get into trouble,” he says.
laws, rules, and regulations [Clause, par. c].

Require employees to follow all private payor policies. Since submissions of false claims to private payors can result in compliance trouble, instruct your employees to follow all private payor payment policies [Clause, par. d].

Require proper coding. Require all your employees to conform to your practice’s policies and procedures for billing and coding. Also require them to know and follow all applicable carrier and intermediary coding instructions [Clause, par. e].

Require proper claim documentation. Having complete documentation available will help you if you’re ever audited or investigated. So tell employees they must provide all required information on each claim form and make sure that each claim is properly documented [Clause, par. f].

Set auditing programs. Next, tell employees that you’ll set up auditing and monitoring programs to ensure that only valid, legal claims are submitted to government or private payors [Clause, par. g]. This signals to employees that you’re serious about ensuring accurate coding. It should

(continued on p. 6)
Seven Tips to Get Your Radiology Charts Audit-Ready

Audit notices strike fear in the hearts of physicians, office managers, and administrators alike. But if the services you bill for are properly documented and your charts are complete and well maintained, you really shouldn’t have much to fear from an audit, says radiology coding and compliance expert Jackie Miller. Except in cases of billing fraud, most audits don’t result in large repayments to a payor, unless the charts are inadequate, she remarks.

If poor documentation by a physician is a problem in your practice, there’s not much you can do; an audit that finds inadequate documentation to support payment may be just what that physician needs to change her ways. But often, practices run into trouble at audits not because the documentation is inadequate, but because the physicians and/or the transcriptionists are careless and charts are so poorly maintained that it’s difficult for the auditor to find what he needs.

Maintaining charts properly is the key to surviving an audit—and to providing excellent patient care. We’ll run down several common problems auditors find in patient charts, and give you seven tips to help you ensure that your charts don’t fall short.

**Seven Tips to Avoid Common Mistakes**

Trying to pull records together in the days or weeks before an audit is a recipe for disaster, Miller says. So she suggests that you perform a mini-audit—that is, pull a few random charts every month to discover and correct any problems. This practice will alert you to any ongoing problems you may have with your office staff, so you can implement better procedures to ensure that records are properly maintained. And it will also reveal any documentation issues that may exist with physicians—forewarned is armed.

Here are seven tips you should remember when you conduct your mini-audit:

1) **Ensure chart contents pertain to single patient.** Miller says she has often encountered patient charts that contain notes, correspondence, or test results that belong to a different patient. This is evidence of very sloppy record keeping and makes a terrible impression. It puts patients at risk, as well, she says. So check every film and piece of paper in the chart to make sure it belongs there, she says.

2) **Properly secure all chart contents.** Miller says that you can avoid the problem of mislaid documents by properly securing everything that goes into a patient chart. For example, radiology charts should have a sleeve for films if the films are kept with the rest of the record; otherwise, the film number and location should be clearly noted within the chart. And physician orders should be stapled or otherwise permanently secured to the chart, as should any other loose paper, such as telephone message notes, or correspondence.

Sometimes film jackets become so bulky that practices may keep other documents, like correspondence and patient questionnaires, in a separate place. There’s nothing wrong with this practice, but if you keep information somewhere other than within the chart, make sure that the...
film jacket references this other documentation. That way, you can retrieve it easily when you need it, such as during an audit.

3) Make sure chart is chronological. This is crucial for proper patient care, yet Miller says she sometimes encounters patient charts that aren’t arranged chronologically. To auditors and others, this is a red flag indicating poor record-keeping practices, if not poor clinical practices, she says. Again, this is more likely to happen when a patient has a large chart that contains several film jackets, she notes.

4) Maintain legible, complete, properly identified, dated entries. It’s important that any notes made by physicians, nurses, technologists, or others are legible and that each entry is appropriately signed and dated. Since most radiology charts are type-written transcriptions, legibility is less of an issue for radiologists than for many other specialists. But radiology charts have another common problem, Miller notes. Often, if a transcriptionist can’t understand the dictation, she’ll leave a space for the radiologist to fill in before signing the report. But too often that doesn’t happen, Miller says, and holes in the transcription create a terrible impression on an auditor.

Insider Says: Many practices still allow radiologists to sign off on each other’s reports. Miller explains that signing another radiologist’s report is a violation of the Medicare conditions of participation. And if a patient ever sues you for malpractice—even if he isn’t a Medicare patient—it’s difficult to defend the suit when the radiologist who interpreted the film isn’t the same radiologist who signed the report.

5) Proofread all entries. Miller says that she has reviewed charts that contain signed radiological interpretations with such obvious errors, that the radiologist clearly never read the report before signing. For example, one mammogram report she read referred to a tibia. This makes a terrible impression on an auditor—and a poor impression on the referring physician who reads the report. Miller notes that with the use of voice recognition technology, this type of problem may become more frequent.

So when you conduct your mini-audit, be sure to read through all reports in the chart to confirm that your radiologists read their transcribed reports before signing them. If you find signed reports with obvious errors, you should point them out to the radiologist and counsel him on the importance of reading reports before signing, she says.

6) Verify that errors are corrected appropriately. It’s never proper to erase, white-out, or remove a medical record entry, Miller emphasizes. Instead, draw a single line through the error, add the corrected information, and initial and date the corrected entry. Anyone who corrects an error any other way should immediately be instructed in the proper method for correcting chart errors. Miller points out that erasures, white-outs, and lost entries lead to speculation of a cover-up of bad decision-making, she notes.

7) Make sure deficiencies are corrected and not repeated. Any serious problems that appear frequently in your mini-audits should spur you to rethink the way you compile and maintain your charts. Perhaps you may even need to approach the practice owners with your concerns, Miller suggests—especially if inadequate physician documentation is a concern.

Insider Source

---

Adopt Film Release Policy that Complies with Applicable Laws

Since the HIPAA privacy regulations went into effect, most practices and facilities have adapted their record release policies—including their film release policies—to ensure that they’re HIPAA compliant. But sometimes in their anxiety to comply with HIPAA, practices and facilities have neglected to ensure that their policies comply with other applicable laws—such as the Mammography Quality Standards Act (MQSA) and state laws, says New York health care attorney Matthew Kupferberg.

We’ll tell you about the laws that govern the release of medical records—including radiological films and images. And we’ll go over some special concerns you should have regarding the release of radiological films and images. We’ll also give you some tips on what to include in your film release policy, and give you a Model Policy on p. 9 that you can adapt and use.

Laws Governing Medical Records Release

There are several laws that govern when you may and may not release medical records, including radiological films and images, Kupferberg says. For example, in addition to
FILM RELEASE POLICY
(continued from p. 7)

HIPAA and the MQSA, your state laws may require you to provide access to medical records, including films and images, under certain circumstances—even without patient authorization. Here’s a rundown on the laws that your film release policy must comply with.

HIPAA privacy regulations. The HIPAA privacy regulations require you to maintain the confidentiality of a patient’s protected health information (PHI), meaning any personally identifiable health information. So films or images of a patient’s body that are identifiable as that person—because they’re labeled with the patient’s name, for example—can’t be released or disclosed without the patient’s authorization, except to carry out treatment, get paid for services, or conduct health care operations. HIPAA permits patients access to their own PHI and requires you to provide patients with copies of it at a reasonable fee that’s based on your cost of reproducing the PHI. In other words, you may charge a patient the costs of reproducing film or images, but may not add a “service fee” unless it approximates the cost of your staff time to reproduce the film or image, Kupferberg explains.

MQSA. If you perform mammograms, you must make sure that your film release policy is MQSA-compliant, Kupferberg emphasizes. The MQSA requires providers to give a patient original mammograms at her request, he notes. This differs from most other laws governing medical records in general, which permit providers to keep originals and provide the patient and others with copies, Kupferberg points out. And if for some reason the patient has provided you with original mammograms taken by another provider, you must return those to her at her request, he adds.

State laws on reporting of information to law enforcement or public authorities. Most states require the reporting of medical information to law enforcement or public health authorities under certain limited circumstances, Kupferberg explains. For example, many states require health care workers to report to state child welfare agencies or law enforcement when they come across suspected child abuse cases. Or physicians may be required to report a diagnosis of certain infectious or sexually transmitted diseases to the state health agency. And many states and localities require health care workers to notify law enforcement when treating a gunshot wound.

State laws on release of records to patients. Many states have laws governing the release of medical records to patients, too. These laws typically require a health care provider to furnish a patient with a copy of her records on request, permit the patient to designate a third party to receive records, permit the provider to charge the patient a certain amount for copying the records, and require a provider to respond to the patient’s request within a set time frame, Kupferberg explains.

If the law in your state offers patients easier or more complete access to their records than HIPAA does, state law will control, Kupferberg cautions. For example, although HIPAA says you must provide a patient with copies of her records within 30 days of her request, if your state law says you must do so within 10 business days, you may charge the records within 10 business days.

Check State Laws Before Drafting Film Release Policy
Figuring out how all these laws work together in the real world can be challenging, but it’s worth the effort to establish a film release policy that ensures compliance with all the applicable laws. Before you can begin to put together your policy, you must get a handle on what your state law requires. To do this, check your state’s medical society and specialty society. These societies often can provide you with comprehensive information about your state’s medical record release requirements. Many of these societies have also done an analysis that compares your state law’s requirements with HIPAA’s requirements and will provide that analysis free or at a small charge.

If the information isn’t available from your state medical or specialty society, ask your attorney to look into it for you. You need good information about what your state requires and whether your state permits more or easier patient access than HIPAA does in order to create a compliant policy.

How to Develop Film Release Policy
Once you’ve gotten information on state laws, you can begin developing your film release policy. Like our Model Policy, your policy should do the following:

- **Explain when releasing films and images without specific authorization is appropriate.** Your policy should state that, pursuant to the HIPAA privacy regulations, you may release films and images to other health care providers for the purpose of treating the patient, to payors for the purpose of being paid for services, and to others for the purpose of “health care operations” [Pol., par. 1].

- **Discuss when patient authorization is needed for release to third parties.** In general, your policy should require your staff to get authorization from the patient for any other release, Kupferberg says—but here’s where state law comes into play. If your state requires you to
report suspected child abuse, for example, you may be required to release films or images to law enforcement that show the reason for your suspicion—like a child’s X-ray that shows multiple old fractures. Kupferberg advises his clients to ask for a subpoena in those cases, but some states may force you to give up a copy of the film or image in those circumstances without one. Your policy should reflect whatever your state law requires [Pol., par. 2].

Describe procedure for releasing films and images to patients. Your policy should make it clear how staff should respond when patients ask for copies of films or images. That is, staff should require a written (continued on p. 10)

---

**Model Policy**

Establish Film Release Policy to Protect Your Practice and Patients

Here’s a Model Policy, developed with the help of New York health care attorney Matthew Kupferberg, on the release of radiographic films and images. We’ve used HIPAA requirements to construct this policy and have indicated where state law may differ. You’ll need to find out your state law requirements in order to develop a film release policy that’s appropriate for your practice. Get this Model Policy online: enter KEY # RACRI0005

---

**Film Release Policy**

From time to time, we receive requests to release films and other radiographic images. It is the policy of XYZ Radiology to respond to these requests in full compliance with all applicable laws. Accordingly, the staff of XYZ Radiology is instructed to adhere to the following policy when responding to requests to release films or other radiographic images.

1. **Access permitted without authorization.** Copies of films, images, and other information may be released without patient authorization only to:
   a. Other health care providers for patient treatment;
   b. Third-party payors to secure payment for services; and
   c. Other departments of this facility for the purpose of health care operations.

2. **Authorization required.** In all other circumstances, originals or copies of films or other images may not be released to any third party without a signed authorization from the patient, with the following exceptions: [Insert your own state’s requirements, if any, here, e.g., as required to comply with laws requiring us to report suspected child abuse and gunshot wounds.]

3. **Patients’ access to their own films.** Patients are entitled to obtain their films and radiographic images upon presentation of a written release request. Patients are to receive copies of any films or images they request, except in the case of mammograms, of which they must be given the originals. Patients may be denied access to their films or images in the following circumstances:
   a. The patient is an inmate of a correctional facility, and XYZ Radiology provided the service to the patient under contract to the correctional facility, and the correctional facility objects to the release of the information to the inmate on the grounds that release may harm the inmate or others.
   b. A licensed health care professional has determined that the release of the information to the patient is likely to endanger the patient or others.
   c. The request was made by a patient’s personal representative, and a licensed health care professional has determined that release to the personal representative may endanger the patient.

4. **Response time and charges.** Staff will fulfill all compliant requests for release of films and other images within [insert either 30 days or your state’s required response time if it is less than 30 days]. XYZ Radiology charges patients $[insert amount—check your state law for guidance on what you may charge for copies, e.g., $.25 per page for paper records and $1.00 per film].

5. **Subpoenas.** XYZ Radiology will respond only to subpoenas accompanied by a patient authorization that specifies the films requested and the person to whom the records should be sent. In the event that a subpoena has no patient authorization, the subpoena should be turned over to [insert name or title of designated person], who will contact the patient and the issuer of the subpoena to obtain either a valid patient authorization or a court order for release of the records. Employees should not respond to such a subpoena without the prior approval of [insert name or title of designated person].
release request from the patient [Pol., par. 3].

Note that HIPAA and some state laws allow providers to refuse patients access to their own records (including films and images) only in very limited circumstances—for example, when the provider reasonably believes that having access to the information in the record will cause harm to the patient or others. Typically, this is an issue only with psychiatric or psychotherapy notes, but if a patient may be unreasonably harmed by seeing an image of his tumor, for example, you can refuse to release the film. Also, prison inmates can be denied access to records in certain circumstances. Although this situation doesn’t come up often in radiology, Kupferberg says it’s a good idea for your film release policy to explain that patients may be denied access to films or images in certain, unusual circumstances and that the radiologist will make that determination.

Your policy should also state that, in compliance with MQSA, patients requesting their mammograms must get originals, with the practice retaining the copies.

Establish time frame and charges. Your film release policy should clearly state how quickly the staff must comply with the request and how much you may charge for the films or images—again, you must check your state law to make sure it’s not stricter than HIPAA, and then craft your policy accordingly [Pol., par. 4].

Educate staff about subpoenas. Films and images frequently are subpoenaed, so your staff must know how to respond to subpoenas under HIPAA and state law. For example, your film release policy should instruct your staff to respond to a subpoena only if accompanied by a HIPAA-compliant authorization from the patient. If the subpoena isn’t accompanied by a HIPAA-compliant patient authorization, Kupferberg suggests that the office manager or compliance officer contact the issuer of the subpoena and ask the issuer to obtain either this authorization or a “so-ordered” subpoena—in essence, a court order signed by a judge. Because HIPAA permits a provider to release PHI as required by law, a court order will protect you from a wrongful disclosure claim. Once you’ve got the so-ordered subpoena, be certain to release only the information specified in the subpoena.

Insider Says: Kupferberg thinks it’s a good idea to contact the patient to let her know what’s going on. That way, if she doesn’t want the information released she can try to prevent it.

Insider Source
Matthew Kupferberg, Esq.: Arent Fox Kintner Plotkin & Kahn, PLLC, 1675 Broadway, New York, NY 10019.