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CASE OF THE MONTH

When Good Intentions Violate HIPAA Rules

by Rikki Valade, RN, BSN, PHN

As a physician or person involved in the healthcare workforce, you likely encounter ongoing challenges complying with Federal Health Insurance Portability and Accountability Act (HIPAA) regulations in all areas of your practice.

This "Case of the Month" involves a HIPAA breach by a physician who attended a weekly "stats conference" in an academic acute hospital setting.

The Case:

In the case, *Koos v. Medical Staff of Ronald Reagan UCLA Medical Center*, analyzed by Christopher J. Allman JD, CPHRM, DFASHRM, in the *Journal of Healthcare Risk Management*'s Case Law Update, Dr. C, a resident, presented a de-identified case involving an infant with 0/0/0 Apgar scores.[1] Dr. K, an attending obstetrician, was in attendance. Following the presentation, Dr. K asked Dr. C for both the mother and infant's medical record numbers. Dr. C declined this request since Dr. K was not part of the patients' treatment team. Dr. K persisted to obtain the medical record numbers over the next several days. Eventually, Dr. C relented and provided the numbers. Dr. K obtained the fetal heart tracings and reviewed these in a resident room with an unauthorized non-UCLA physician. When another attending physician questioned Dr. K's actions, Dr. K responded that he, Dr. K, "sanctioned" the review. The matter was reported to the obstetrics (OB) department chair and ultimately to UCLA's medical staff executive committee. This committee determined Dr. K's action did not meet regulatory or UCLA policy and recommended a 90-day suspension, education, and $25,000 fine.[1]

A three-day hearing was held where Dr. K stated his review of the records was for "patient safety" and "quality improvement" which fell under the HIPAA healthcare operations privacy rule. Both the hearing panel and subsequent administrative panel disagreed and upheld the medical staff's decision. When Dr. K filed an action in the California Superior Court to set aside this decision, the court denied his request. Dr. K subsequently appealed the decision to the California Court of Appeals. The appellate court upheld the decision, finding that the administrative panel's decision was supported and justified by the evidence presented at Dr. K's hearing.[1]

Analysis:

HIPAA allows use of protected health information (PHI) for healthcare operations which include certain administrative, financial, legal, and quality

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improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment.[2] These operations and activities are defined by the covered entity, in this case, the hospital. Although Dr. K purported that his review of the records was for "quality improvement," he failed to invoke (hospital) policy supporting his position that he was authorized to review the records prior to the hearing.[1,3] Additionally, UCLA policy provided that Workforce members "should only access and use PHI as necessary for their job functions."[1]

The U.S. Department of Health and Human Services (HHS) indicates six allowances under HIPAA for the *Permitted Uses and Disclosures of PHI*. One allowance is related to Treatment/Payment/Healthcare Operations:[4]

■ Treatment Purposes

Treatment is the provision, coordination, or management of healthcare and related services for an individual by one or more healthcare providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.

■ Payment Purposes

Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for healthcare delivered to an individual and activities of a healthcare provider to obtain payment or be reimbursed for the provision of healthcare to an individual.

■ Healthcare Operations

Healthcare operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity

Dr. K additionally argued that the event was a sentinel event for which a root cause analysis was needed to further support his review of the records. However, the appeal board found this testimony not credible due to his failure to invoke the policy prior to the hearing, or report the alleged sentinel event to anyone at the university.[3]

Risk Management Considerations:[1]

1. When rules are not followed, both the physician and the institution are subject to potential liability from the involved patients, and, possibly, other patients along with the Office of Civil Rights and other state and federal authorities.
2. When proper protocols are not followed, any quality review or peer review protection that may be afforded to the information obtained in a review may be lost. This may mean that the information obtained may become evidence in a professional liability or other court action.

As a provider, you should understand your role in protecting a patient's PHI and know when it is allowed and when it is NOT allowed to review a medical record. Unauthorized access can put you at risk of professional disciplinary action and a monetary fine.

Reduce your risk of a violation:

- Only access PHI for quality reviews or patient safety reasons if you are authorized by the healthcare organization.
- Complete yearly HIPAA training: 1) refresh your knowledge; 2) be aware of any changes.
- Complete a HIPAA Risk Assessment of your practice.

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- Only use a HIPAA-compliant patient portal, email, or text platform.
- Do not share PHI with other providers who are not part of the treatment team.
- Know the 6 Most Common HIPAA Violations:[4]
  1. Improper Use and Disclosure of PHI
  2. Publicly Disclosing PHI
  3. Failing to Maintain Mandated HIPAA Documentation and Conduct Risk Assessments
  4. Exposing Yourself to Hackers/Cyber Risk
  5. Compromising Data by No or Poor Encryption Technology
  6. Improperly Disposing of PHI

Contact CAP for information on Federal HIPAA guidelines. You can also find a full explanation of the HIPAA Privacy Rule at **HHS.gov**

Rikki Valade, RN, BSN, PHN is a Senior Risk Management and Patient Safety Specialist at Cooperative of American Physicians, Inc.. Questions or comments related to this article should be directed to RValade@CAPphysicians.com.

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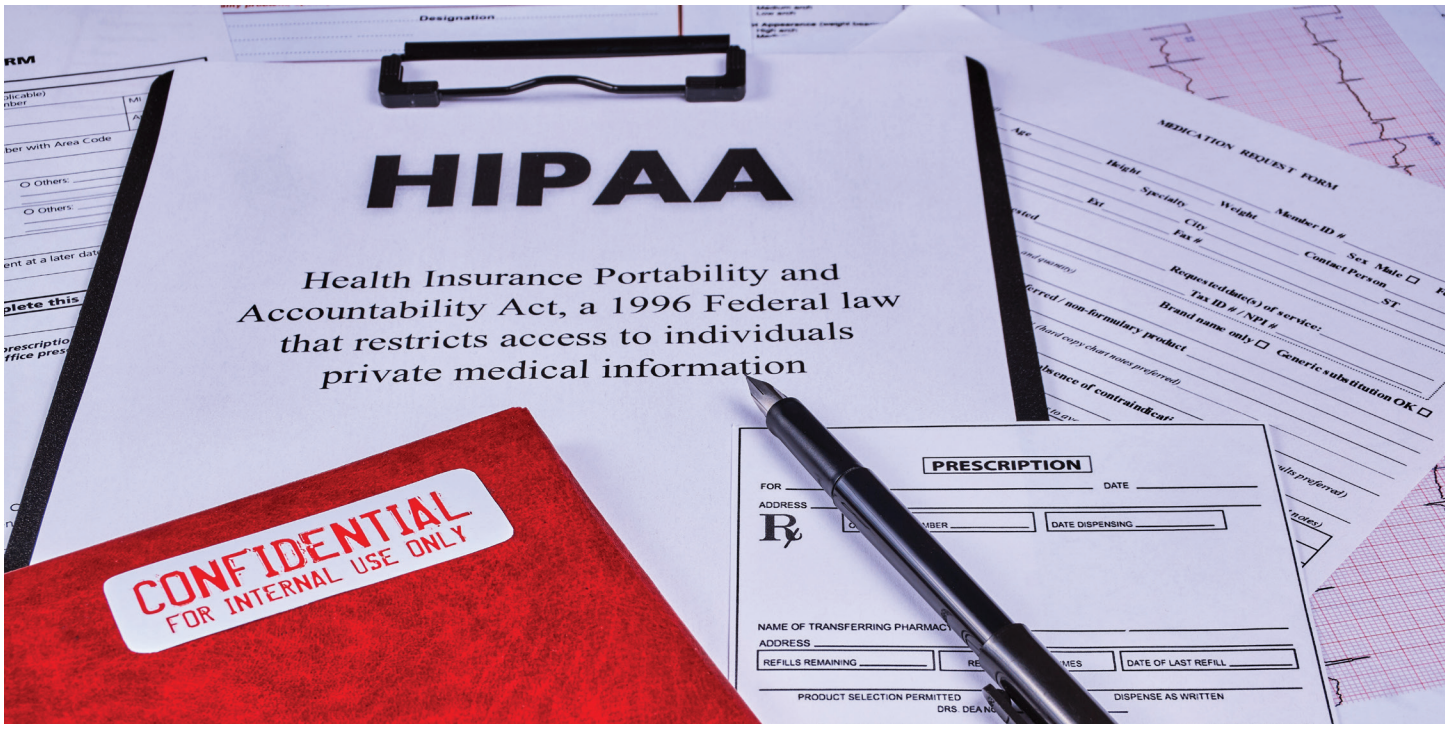

Law Enforcement and a Search Warrant . . . In Your Office

by Maryland Nua

Like a scene out of Law & Order, imagine you have detectives in your office waving around their badges, telling you and your staff they are investigating "something" and need information on one or more of your patients.

First, don't panic. Time is critical, and this article is designed to outline the steps you and your staff need to take if faced with this challenging scenario.

Under certain and limited circumstances, law enforcement and other agencies may access protected health information (PHI) without express patient authorization. For example, medical records may be obtained in a criminal investigation pursuant to a valid search warrant (Civil Code §56.10(b)(6)).

The requestor has a duty to provide appropriate credentials and indicate what authority they have to obtain information. Once the requestor's credentials and authority are confirmed as legitimate, it is your office's responsibility to release your patient's health information in compliance with what is specifically requested, nothing more or less.[1] Your office personnel must understand that they are required to follow patient confidentiality rules and regulations when law enforcement personnel or a government representative requests your patient's protected health information (PHI). In this instance it is crucial to adhere to the "minimum necessary" rules established by HIPAA.[2]

Depending on the urgency of the situation, when the requestor is from an investigative branch of government (Social Services, school district, health Inspector), your office may request a fax, on official letterhead, from the investigating department to include 1) the information requested is relevant, specific, and limited in scope and, 2) under what code or regulation you may release your patient's information to the individual(s) on site in your office.[3]

If the representative is requesting information beyond the scope of the authorization provided, your office must inform the requestor that a search warrant or court order is necessary for the information they are seeking.[4] Certain laws require additional specific authorization to protect the medical record of the diagnosis and/or treatment of the following patient conditions: minors, HIV, psychiatric/mental health conditions, and alcohol/substance abuse.[5]

Search Warrants

When a search warrant is served, this indicates that two conditions were met for a judge to sign off on approving the search warrant:

- A misdemeanor or felony has been committed.
- Evidence related to a criminal case is likely to be found in the location described in the search warrant.[1]

Search warrants may have two different paths:[4]

- **The physician is not a suspect.** In this instance, medical records may be released only to a "special master" rather than to a police officer. A special master is an attorney who is a member in good standing of the State Bar of California and who has

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been selected by the court from a list maintained by the State Bar. ("California Penal Code § 1524 (2021) - Justia Law")

The special master must accompany the person serving the warrant and must inform the physician, upon whom the warrant is being served, of the specific items being sought and that the physician being served will have an opportunity to produce the items requested. If the physician being served states that certain items should not be disclosed, those items must be sealed by the special master and taken to court for a hearing. ("California Penal Code § 1524 (2022) - Justia Law"). The physician must be informed of the date, time, and place of the hearing, which ordinarily must be held within three days.

- **The physician is a suspect** - Law enforcement officers may, pursuant to a valid search warrant, conduct a search of the office. (Penal Code §1524). The office should ask law enforcement to produce the warrant for inspection. When your office is presented with a valid search warrant, let the officers know you are contacting your personal attorney and ask if they can wait until your attorney is present to start the investigative process.

Having your attorney in your office as the search takes place is ideal but if that is not possible, contact your personal attorney for direction and stay on the phone with them telling them in detail what is being searched and seized and document everything.[4]

Key steps to execute in the event of an investigation on the premises:

- Do not interfere with the investigation
- Inform staff that they are not required to make statements to investigators
- Close the office and send non-essential employees home

It is in your office and patients' best interest that a seizure log is created as patients' original records and the office electronic health record system may be seized during the processing of the search warrant. Request that medical records are segregated and sealed and document that you made that request in the seizure log.[1]

Request the prosecuting attorney's business card as seized patient records may be needed to treat active patients, which will require your office to contact the prosecutor's office to make arrangements to copy records so that you may continue to practice. Bear in mind that the prosecutor's office may charge your office to copy requested records.[4]

In summary, when law enforcement comes to a physician's office requesting records, it is important to handle the situation professionally and in accordance with the law. Here are the steps to consider:

- ☐ **Confirm identity and authority of inquiring party:** Request to see valid authorization and identification from requestor. Review warrant or subpoena for validity and scope of patient information requested.
- ☐ **Call your attorney:** Immediately contact your attorney for direction and guidance in responding to search warrant.
- ☐ **Protect patient's health information:** Prevent tampering or unauthorized access to your patient's health information. As you comply with legal obligations maintain the integrity of your patient's health information.
- ☐ **Log request into disclosure log:** Log search into disclosure log. Keep a detailed record of the law enforcement agency, the officers' names, badge numbers, and the purpose of their request. Note the date, time, and any other relevant information about the interaction.
- ☐ **Disclose patient information that is minimally necessary:** Release records that are specified in warrant or subpoena. Do not share any more information than what is stated is subpoena. HIPAA regulations still apply as privacy and confidentiality must be protected.
- ☐ **Patient notification (if required):** Consult with an attorney whether patient notification is required.

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- ☐ **Accommodate law enforcement request:** Compliance with an authorized request from a law enforcement agency should be done in collaboration with your attorney to ensure patient privacy and confidentiality is held within the confines of the law and HIPAA.

Remember, each situation may vary, and it is essential to consult legal counsel to navigate through the process appropriately.

Once the urgency of the search is over, contact CAP at 800-252-0555 and request to speak with the Risk Management Department to report the incident.

Maryland Nua is a Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to MNua@CAPphysicians.com.

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MARCH 2024

Ask My Practice

By Andie Tena and Leilani Ligans

Enhancing Employee Satisfaction in Healthcare

Senate Bill 525 (SB 525), scheduled to go into effect in June of 2024, establishes a minimum wage schedule for covered entities, which includes hospitals, skilled nursing facilities, home health agencies, and physician groups that have 25 or more physicians and will require these entities to increase the minimum wage for many categories of workers to up to $25 per hour. Groups and independent practices that have fewer than 25 physicians are excluded with a few exceptions based on contracts with covered facilities.[1] ***If you are concerned about whether the law applies to you, we recommend consulting an attorney***.

While SB 525's effective date may be postponed, it will not affect all physicians in relation to employment costs. It will, however, affect how staff are recruited and retained.

In an industry where human capital is the cornerstone of quality care, the well-being and contentment of healthcare workers are not just peripheral concerns but fundamental components of operational success and patient outcomes.

The Significance of Employee Satisfaction

Healthcare is inherently demanding, characterized by high-stress environments, long hours, and emotionally taxing situations. Amidst these challenges, fostering a culture of employee satisfaction is a strategic imperative with profound implications.

1. **Enhanced Productivity:** Satisfied employees are more engaged, motivated, and productive. They exhibit higher levels of commitment to their roles and are willing to go above and beyond to deliver exceptional care. Consequently, patient satisfaction and outcomes improve, bolstering the organization's reputation and financial performance.

2. **Reduced Turnover and Recruitment Costs:** High turnover rates not only disrupt continuity of care but also exact a heavy financial toll on healthcare organizations. By investing in employee satisfaction initiatives, such as professional development opportunities, recognition programs, and supportive work environments, healthcare providers can mitigate turnover rates and minimize recruitment expenses.

3. **Elevated Quality of Care:** Employee satisfaction is intrinsically linked to the quality of care delivered. Satisfied healthcare workers are more likely to collaborate effectively, communicate transparently, and adhere to best practices, resulting in superior patient experiences and clinical outcomes.

4. **Positive Organizational Culture:** A culture that prioritizes and demonstrates a commitment to employee well-being fosters loyalty, trust, and camaraderie within the workforce. This, in turn, cultivates a positive organizational climate where innovation thrives, teamwork flourishes, and resilience in the face of adversity is strengthened.

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Value-Adding Strategies

To optimize employee satisfaction and harness its transformative power, healthcare organizations must implement strategies that address the multifaceted dimensions of employee well-being:

1. **Invest in Training and Development:** Continuous learning opportunities not only enhance employee skills and competencies but also demonstrate organizational commitment to professional growth. Whether through mentorship programs, skills workshops, or tuition reimbursement initiatives, investing in employee development nurtures a culture of lifelong learning and empowers staff to reach their full potential.

2. **Prioritize Work-Life Balance:** Balancing the demands of work and personal life is essential for preventing burnout and sustaining employee satisfaction. Offering flexible scheduling options, telecommuting arrangements, and wellness programs promotes well-being and ensures that employees feel valued and supported both inside and outside of the workplace.

3. **Promote Transparent Communication:** Open and transparent communication channels are foundational to fostering trust, accountability, and engagement among employees. Regular feedback, daily "huddles," and one-on-one check-ins provide avenues for dialogue, enabling healthcare workers to voice concerns, share ideas, and contribute to organizational improvement initiatives.

4. **Recognize and Reward Excellence:** Acknowledging and celebrating employee contributions instills a sense of pride, motivation, and loyalty. Whether through formal recognition programs, peer-to-peer commendations, or performance bonuses, recognizing excellence reinforces desired behaviors and incentivizes continuous improvement.

5. **Cultivate a Culture of Empowerment:** Empowering employees to take ownership of their roles fosters a sense of autonomy, purpose, and fulfillment. Encouraging shared decision-making, delegating authority, and soliciting input on process improvements empowers healthcare workers to innovate, problem-solve, and drive positive change within their respective domains.

6. **Create a Benefits Package That Allows for "Add-In" Benefits:** Be creative with your employee's benefits package by creating additional options for gym membership reimbursement, additional paid holidays or floating holiday, or childcare assistance,

In the dynamic landscape of healthcare delivery, employee satisfaction is a strategic imperative with far-reaching implications for organizational success and patient care. By prioritizing initiatives that enhance employee well-being, healthcare organizations can cultivate a culture of excellence, innovation, and compassion that not only attracts top talent but also elevates the quality of care delivered to those who need it most. In this symbiotic relationship between employee satisfaction and organizational value, the dividends are not just measured in financial terms but in the immeasurable impact on the health and well-being of individuals and communities alike.

Andie Tena is CAP's Assistant Vice President of Practice Management Services. Leilani Ligans is CAP's Vice President of Human Resources.

Questions or comments related to this column should be directed to ATena@CAPphysicians.com or LLigans@CAPphysicians.com.

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Personal Umbrella Insurance Is a Must-Have for Physicians

SYMPHONY RISK

From having excellent malpractice coverage to remaining compliant with regulations, CAP members are well versed in protecting themselves from the potential liabilities associated with practicing medicine.

Even outside of the clinical setting, physicians are vulnerable to personal liability lawsuits, which may generate exposures that can easily exceed homeowners and automobile insurance limits and cause significant financial loss.

Physicians should consider purchasing a personal umbrella insurance policy, an often overlooked yet very important and inexpensive piece of coverage that supplements the basic liability coverages provided by your home and auto insurance.

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Here are several important exposures that warrant serious consideration for an extra layer of coverage over basic home and auto insurance:

- Owning a home, having a swimming pool, or employing a housekeeper, nanny, or other domestic staff
- Having children who are away at school
- Owning a dog
- Blogging and/or posting comments or photos online
- Serving on a board of a non-profit and/or a for profit organization

You may think that your current homeowners, automobile, and other property policies already offer enough protection. However, without a personal umbrella liability policy, any claim that is greater than your current coverage limits could wreak havoc on your financial assets, or negatively impact your future earnings if you do not have enough to pay the balance of any damages awarded against you.

While significant assets do require more coverage, a personal umbrella policy can protect both physicians with amassed wealth and those who are building their portfolio.

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To learn more, and to speak to a licensed insurance professional, contact Symphony Health via email at healthcareservices@symphonyrisk.com or call 800-819-0061. Symphony Health is CAP's preferred partner for your business and personal insurance needs, supplementing your medical malpractice coverage from CAP.

To learn more, email healthcareservices@symphonyrisk.com or call 800-819-0061.

CMS Finalizes Prior Authorization & Interoperability Rule

by Gabriela Villanueva

In mid-January the Centers for Medicare and Medicaid Services (CMS) issued the Prior Authorization Final Rule, and with it a very significant interoperability component to increase availability of electronic health information (EHI) across multiple platforms.

The CMS final rule will initially establish these new requirements for Medicare Advantage (MA) organizations, Medicaid (Medi-Cal in California) and state Children's Health Insurance Program (CHIP), Fee-for-Service (FFS) programs, Medi-Cal managed care plans, CHIP managed care entities, and issuers of Qualified Health Plans (QHPs).

The success of a more streamlined prior authorization (PA) process will require the implementation of application programming interfaces (APIs) to increase the exchange of electronic health information (EHI) for medical items and services—excluding drugs. Notably, CMS excluded all drugs, including Part B drugs paid through a medical benefit. Unexpectedly, CMS notes in the final rule that it did not anticipate an overwhelming response it received in favor of including medications, prompting them to evaluate potential options to include them in the future.

In a CMS press release, Secretary of the Department of Health and Human Services (HHS), Xavier Becerra, stated, "When a doctor says a patient needs a procedure, it is essential that it happens in a timely manner. Too many Americans are left in limbo, waiting approval from their insurance company."[1] Those likely to benefit the soonest by these new requirements will be Medicare Advantage enrollees due to a prior MA and Part D finalized rule in calendar year 2024 that complement the prior authorization final rule to add continuity of care requirements and reduce disruptions in treatment plans for beneficiaries. Starting mostly in 2026, most impacted payers will be required to send PA decisions within 72 hours for urgent requests and seven calendar days for non-urgent (standard) requests for medical items and services. Starting in 2026, these payers will also be required to provide a specific reason for a denied PA decision, regardless of the method used to send the PA request to help facilitate resubmission of the request or an appeal when needed.

Responding to heavy feedback, HHS will continue to evaluate the HIPAA prior authorization transaction standards, including the use of enforcement discretion of covered entities that have already implemented the necessary prior authorization API for future rulemaking. Fortunately, the rule will not be implemented until January 2027. This ensures sufficient time to train staff, giving payers the ability to build and update APIs and operational procedures.

The January 17th final rule is estimated to achieve approximately $15 billion dollars in savings over ten years, but more importantly, reduce the instances of denying care and services to patients already covered for those benefits and the unnecessary time burden placed on valuable administrative and clinical time.

CMS Final Rule Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

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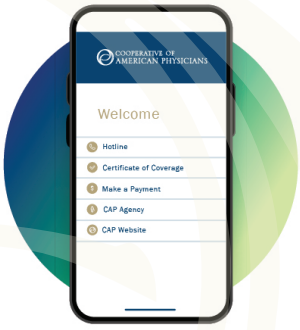
333 S. Hope St., 12th Floor
Los Angeles, CA 90071



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