UNIVERSITY PHYSICIANS OF BROOKLYN
POLICY AND PROCEDURE

Subject: **PATIENT REQUESTS FOR ADDITIONAL PRIVACY PROTECTION**

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TJC Standards: RI.01.01.01: The hospital respects, pretests, and promotes patient rights.
LD.04.02.03: Ethical principles guide the hospital's business practices.

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I. PURPOSE

To establish a policy and procedure for allowing a patient to request additional privacy protections to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

University Physicians of Brooklyn will ensure that patient requests for additional privacy protections in terms of restrictions on uses and disclosures of PHI and confidential communications are reviewed in a timely manner and will grant or deny the requests appropriately as required by State and Federal law, professional ethics and accreditation agencies.

III. DEFINITION(s)

None

IV. RESPONSIBILITY

It is the responsibility of all medical staff members and hospital staff members to comply with this policy. Medical staff members include physicians as well as allied health

professionals. Hospital staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the hospital.

V. PROCEDURE/GUIDELINES

A. Restrictions on PHI Paid out of Pocket- University Physicians of Brooklyn is required to agree to a request by a patient to restrict the disclosure of his/ her PHI to the insurer/ health plan in the following circumstances: (1) The disclosure is for the purposes of carrying out payment or health care operations and is not otherwise required by law; and (2) The PHI pertains solely to a health care item or service for which the patient, or another person on behalf of the patient (other than the health plan), paid University Physicians of Brooklyn out of pocket, in full.

1. Obtain Written Request- Requests for restrictions on PHI paid out of pocket should be referred to Hospital Finance. The patient should document the request. See attached Requests for Restriction on PHI Paid out of Pocket form.

2. Evaluate the Request- The Hospital Finance representative should evaluate the request to ensure it could be granted. The following conditions must be in place for University Physicians of Brooklyn to agree to the request:

    a. Payment must be made in full at the time of the request. If the payment is declined, University Physicians of Brooklyn will make reasonable efforts to contact the patient and obtain payment prior to billing the health plan.
    b. Where pre- certification is required for a health plan to pay for services, the patient must settle payments for the care prior to University Physicians of Brooklyn provision of services to the patient.
    c. For items/ services that are bundled together, if University Physicians of Brooklyn is permitted and able to unbundle the items or services and accommodate the patient's request, it will do so. In the event the items/ services cannot be unbundled, University Physicians of Brooklyn will inform the patient and give him/ her opportunity to restrict and pay out of pocket for the entire bundle of items or services.
    d. For follow up treatment where University Physicians of Brooklyn needs to include information that was previously restricted in the bill to the health plan in order to have the service deemed medically necessary or appropriate, University Physicians of Brooklyn will first inform the patient and provide him/ her with the opportunity to request an additional restriction and pay out of pocket for the follow up care. If the patient declines, University Physicians of Brooklyn is permitted to disclose the previously restricted information to the health plan, as long as it is consistent with UPB's policy on "Minimum Necessary Information".
    e. In instances where the restricted information is automatically transmitted to other providers, such as through an e- prescribing tool, University Physicians of Brooklyn will counsel the patient that s/he needs to request a restriction and pay out of pocket with other providers for the restriction to apply to those providers.

3. Notify- If the patient's request meets the conditions noted in Section V.2. above, the Hospital Finance representative must approve the patient's request. The approval/ denial must be documented in the appropriate section of the Requests for Restriction on PHI Paid out of Pocket form.

a. Hospital Finance should notify the applicable areas regarding the patient's restriction, as well as any business associate responsible for the processing and billing of the patient's record.
b. A separate registration record should be created for the item/ service that the patient has paid for out of pocket, with a financial class code of Self Pay. This record should be programmed to prevent routine billing processes.
c. The Requests for Restriction on PHI Paid out of Pocket form should be placed in the front of the patient's chart. HIM should update its systems to ensure that there are no future disclosures of this information to the health plan in the event of health plan audits or other review requests.

4. Documentation: Requests for Restriction on PHI Paid out of Pocket forms must be maintained for six years from the date of creation.

B. Other Restrictions on Uses & Disclosures of PHI- Patients have a right to request other restrictions on the way University Physicians of Brooklyn uses or discloses their PHI for treatment, payment or healthcare operation purposes. These requests should be referred to the Department of Patient Relations.

1. Obtain Written Request- Patient should document the request. See attached Requests for Additional Privacy Protection form.

2. Evaluate the Request- Patient Relations representative, in conjunction with the appropriate department, should evaluate the request to determine whether it should be granted or denied. The following factors should be considered:
    a. Whether the restriction may cause University Physicians of Brooklyn to violate applicable federal or state law. Patient Relations should contact the Privacy Officer and/or legal counsel for assistance.
    b. Whether the restriction may cause University Physicians of Brooklyn to violate professional standards, including medical ethical standards;
    c. Whether University Physicians of Brooklyn information systems make it unfeasible to accommodate the request;
    d. Whether the restriction may unreasonably impede University Physicians of Brooklyn ability to provide treatment to the patient; and
    f. Whether the restriction appears to be in the best interests of the patient.

3. Notify
    a. The patient must be notified of the decision to grant or deny the request. See attached Notice of Additional Privacy Protection Request Review form.
        i. If the patient's request is approved, the notice should specify the restriction University Physicians of Brooklyn has agreed to abide.
        ii. If the patient's request is denied, the notice should specify the reason for the denial.
    b. If the restriction was approved, all hospital and medical staff involved in the patient's care must be notified.
        i. A copy of the Notice of Additional Privacy Protection Request Review form should be attached to the Request for Additional Privacy Protection form and placed in the front of the medical record.
        ii. The Eagle system must be updated to reflect the restriction.
        iii. All staff members must review the record to determine restrictions before using or disclosing the patient's PHI.

c. Patient Relations must notify business associates of restrictions agreed to by University Physicians of Brooklyn.

4. Exceptions- Agreements to all patient restrictions do not apply when the restricted PHI is:
    a. Needed to provide emergency treatment to the patient;
        i. A staff member must instruct individuals to whom PHI was disclosed for emergency treatment not to further use or disclose the information.
    b. Required by the Secretary of the US Department of Health and Human Services to investigate or determine compliance;
    c. Required for uses and disclosures that do not require the patient's authorization (See policy on Uses & Disclosures Not Requiring Patient Authorization);
    d. Needed for uses and disclosures for facility directories (See policy on Facility Directory).

5. Modifying or Terminating Restriction- All modifications or terminations of restrictions must be documented. See attached Modification/ Termination of Restrictions form.
    a. At the patient's request
        i. The patient should document the modification or termination on the form and sign it.
        ii. The Modification/ Termination of Restrictions form should be placed on top of the original Notice of Additional Privacy Protection form in the front of the medical record.
    b. At University Physicians of Brooklyn request
        i. Any hospital or medical staff member who believes there is good reason to modify or terminate a restriction can present the reason to Patient Relations.
        ii. If Patient Relations, in conjunction with the appropriate department, determines that a modification or termination is granted, it should be documented on the Modification/ Termination of Restriction form.
        iii. A Patient Relations representative must attempt to get the patient's signature, agreeing to the modification or termination.
        iv. If only an oral agreement can be obtained, the Patient Relations representative should document the oral agreement on the form.
        v. If the patient does not agree to the modification or termination, the Patient Relations representative should document it on the form. The modification or termination of the restriction will only apply to PHI created or received on or after the date the patient was notified.
        vi. The Modification/ Termination of Restrictions form should be placed on top of the original Notice of Additional Privacy Protection form in the front of the medical record.

6. Documentation. The following documents must be maintained for six years from the date of creation:
    a. Requests for Additional Privacy Protection forms;
    b. Notice of Additional Privacy Protection Request Review forms;
    c. Modification/ Termination of Restriction forms.

C. Confidential Communications- Patients have a right to request that University Physicians of Brooklyn communicate with them about their medical matters in a method or location that is more confidential for them.

1. Obtain Written Request- Patient should document the request. See attached Requests for Additional Privacy Protection form.
    a. An explanation from the patient as to the basis of the request may not be required as a condition of providing the communication on a confidential basis.
    b. The patient must specify how information regarding payment should be handled, where necessary to comply with the request.
    c. The patient must specify an alternate address or other method of contact, where necessary to comply with the request.

2. Evaluate the Request- Patient Relations representative should evaluate the request to determine whether University Physicians of Brooklyn can reasonably comply with the request. The following factors should be considered:
    a. Whether the restriction may cause University Physicians of Brooklyn to violate applicable federal or state law. Patient Relations should contact the Privacy Officer and/or legal counsel for assistance.
    b. Whether the restriction may cause University Physicians of Brooklyn to violate professional standards, including medical ethical standards;
    c. Whether University Physicians of Brooklyn will be able to communicate with the patient promptly and effectively if it complies with the alternative method of communication;
    d. Whether University Physicians of Brooklyn will have the ability to apply the alternative method of communication consistently;
    e. Whether the alternative method of communication would place an unreasonable financial burden on University Physicians of Brooklyn;
    f. Whether the patient has provided adequate assurances of how payment will be handled if University Physicians of Brooklyn agrees to the alternative method of communication.

3. Notify
    a. The patient must be notified of the decision to grant or deny the request. See attached Notice of Additional Privacy Protection Request Review form.
        i. If the patient's request is approved, the notice should specify the alternate method of communication that University Physicians of Brooklyn has agreed to abide.
        ii. If the patient's request is denied, the notice should specify the reason for the denial.
    b. If the alternative method of communication was approved, all hospital and medical staff involved in the patient's care must be notified.
        i. A copy of the Notice of Additional Privacy Protection Request Review form should be attached to the original Request for Additional Privacy Protection and placed in the front of the medical record.
        ii. Eagle system must be updated to reflect the alternative method of communication.
        iii. All staff members must review the record to determine any alternative method of communication.
    c. The appropriate department must notify business associates of alternative method of communication agreed to by University Physicians of Brooklyn.

4. Documentation- The following documents must be maintained for six years from the date of creation:
    a. Requests for Additional Privacy Protection forms;
    b. Notice of Additional Privacy Protection Request Review forms.

VI. ATTACHMENTS

Requests for Restriction on PHI Paid out of Pocket, Requests for Additional Privacy Protection, Notice of Additional Privacy Protection Request Review, Modification/ Termination of Restriction

VII. REFERENCES

Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.522

Date Reviewed	Revision Required (Circle One)		Responsible Staff Name and Title
12/07	(Yes)	No	Adeola O. Dabiri, Director Regulatory Affairs
09/13	(Yes)	No	Shoshana Milstein, AVP Compliance & Audit
09/2016	(Yes)	No	Shoshana Milstein, AVP Compliance & Audit
12/2016	Yes	(No)	Shoshana Milstein, AVP Compliance & Audit

UNIVERSITY PHYSICIANS BROOKLYN, INC.

REQUESTS FOR RESTRICTION ON PHI PAID OUT OF POCKET

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone: _____ (home)

_____ _____ (cell)

_____ DOB: _____

1. Request applies to:

__ Inpatient: Admission date: _____ Floor/ Unit: _____

__ Outpatient: Date of Service _____ Clinic/ Area: _____

2. Description of services(s)/ item(s) being paid out of pocket:

Services: **Items:**

_____ _____

_____ _____

_____ _____

3. Name of health plan restricting disclosure to: _____

4. Payment methodology: ___ Cash ___ Check ___ Credit Card

By signing below, I certify that I am paying for the service(s)/ item(s) listed above out of pocket, in full, and as such, I am requesting that University Physicians of Brooklyn restrict the disclosure of this information to the health plan noted above. I understand that if my payment is declined, University Physicians of Brooklyn will make reasonable efforts to contact me for an alternate payment methodology, but will not be responsible for honoring this request if it does not receive timely payment. I also understand that this request does not apply to disclosures made by University Physicians of Brooklyn to other external health care providers for my treatment and that I am required to request separate restrictions with those providers. Furthermore, I understand that for future follow up visits which require the disclosure of the information restricted above to the health plan in order to determine the medical appropriateness of the follow up visit, I will be given an opportunity at that time to place a new restriction on the entire follow up visit and to pay out of pocket accordingly.

_____ _____
Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____
Description of Personal Representative's Authority Date

FOR UNIVERSITY PHYSICIANS OF BROOKLYN HOSPITAL FINANCE USE ONLY:

___ Approved; Paid in full
___ Denied; Reason for denial:

___ Payment declined, date(s) attempted to contact patient: _____
___ Service/ item cannot be unbundled & patient is unable to pay for entire bundle
___ Patient made request after provision of services or after pre- certification occurred and disclosure was already made to the health plan
___ Follow up visit requires information for medical necessity & patient unable to pay follow up visit
___ Disclosure is required under law

_____ _____ _____
Hospital Finance Representative Name Hospital Finance Representative Signature Date

UNIVERSITY PHYSICIANS BROOKLYN, INC.

REQUESTS FOR ADDITIONAL PRIVACY PROTECTION

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone: _____ (home)

_____ _____ (cell)

_____ DOB: _____

Request for Restriction

As our patient, you have the right to request that we restrict the way we use or disclose your protected health information for treatment, payment or healthcare operations. University Physicians of Brooklyn is not required to agree to your request for a restriction. If we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or to comply with the law.

What information do you want to restrict?

_____

_____

_____

How do you want us to restrict the information and when should the restrictions apply?

_____

_____

_____

Request for Confidential Communication

As our patient, you have the right to request that we communicate with you about your medical matters in a method or location that is more confidential for you. We will not ask you the reason for your request.

What is the alternative method or location of communication that you are requesting?

_____

_____

_____

How will payment, if any, be handled if we agree to communicate with you through this alternative method or location?

_____

_____

_____

By signing below, I certify that I am requesting that University Physicians of Brooklyn University Hospital of Brooklyn afford me with additional privacy protections as stated above.

_____ _____

Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____

Description of Personal Representative's Authority Date

UNIVERSITY PHYSICIANS BROOKLYN, INC.

NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request for Additional Privacy Protection

Dear [Patient Name]:

This letter responds to your request, received from you on _____, that we

- ❑ RESTRICT YOUR INFORMATION
- ❑ CONTACT YOU AT AN ALTERNATIVE METHOD OR LOCATION.

We have reviewed your request and:

❑ Agree to your request for additional privacy protection in the following manner:

_____

_____

_____

❑ Deny your request because of the following reason:

- ❑ The additional privacy protection may cause us to violate a law.
- ❑ The additional privacy protection may cause us to violate professional standards.
- ❑ Our information systems make it unfeasible to accommodate your request.
- ❑ Your request may impede us from treating you appropriately.
- ❑ You have not specified an alternative payment arrangement.
- ❑ We do not feel that your request is in your best interests as our patient.
- ❑ Your request may impede us from communicating with you effectively.
- ❑ We cannot abide by your request consistently.
- ❑ Your request places an unreasonable financial burden upon us.

Please contact the Patient Relations Department at (718) 270-8105 if you have questions or concerns.

A COPY OF THIS NOTICE MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.

UNIVERSITY PHYSICIANS BROOKLYN, INC.

MODIFICATION/ TERMINATION OF RESTRICTION

This is a modification or termination of the patient's request of __/__/__ for a restriction of his/her information.

This modification or termination is a result of a request from:

- ❑ Patient
- ❑ University Physicians of Brooklyn

MODIFICATION: The patient's request for restriction is being modified in the following manner:

_____

_____

_____

TERMINATION: The patient's request for any restriction other than restrictions on PHI paid out of pocket is being terminated. Document reason (if any):

_____

_____

_____

- ❑ Patient agrees to modification/ termination.

  _____ _____
  Signature of Patient or Personal Representative Date

- ❑ Patient orally agrees to modification/ termination.

  _____ _____
  Signature of University Physicians of Brooklyn Member Date

- ❑ Patient does not agree to modification/ termination.
  Modification/ Termination is only applicable after patient notification date of ___/___/___.

THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD ON TOP OF THE NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW FORM.