The List: Five HIPAA Myths Debunked

by Abigail Beckel and Shirley Grace

The Health Insurance Portability and Accountability Act, or HIPAA, was enacted 12 years ago by Congress, partly to address the security and privacy of health data. Since then, myths have abounded. We've debunked some common ones for you:

1. MYTH: Sign-in sheets in medical offices are a no-no.

REALITY: The law does not prohibit the use of sign-in sheets. The goal is to ensure that physicians take appropriate measures to protect their patients’ privacy. For sign-in sheets and other incidental disclosure of patient names, the law states that it “is not intended to impede these customary and essential communications and practices.” However, you are expected to exercise reasonable safeguards, such as requiring as little personal information on the sign-in sheet as necessary.

2. Myth: You may no longer say a patient’s name aloud in the waiting room.

REALITY: Well, that would make it awfully hard to call anyone back for their exam: “Hey you, the doctor will see you now” doesn’t really cut it, does it? As with the sign-in sheet issue, this is an exaggeration of what would normally be considered a reasonable safeguard. Calling patients back for an exam by name is fine.

3. MYTH: Your patients can sue you for not complying with HIPAA.

REALITY: Even if a patient is the victim of a major violation of the HIPAA Privacy Rule, he still can’t sue you for it. He can file a written complaint with the Office for Civil Rights at the Department of Health and Human Services. That office may choose to investigate complaints and impose fines. However, HHS does expect you to voluntarily bring yourself into compliance in the event of a complaint.

4. MYTH: If a patient refuses to sign an acknowledgement form, you can’t treat that patient.

REALITY: Refusing to sign your Acknowledgement of Privacy Practices form won’t preclude that person from being your patient. You are only required to make a “good faith effort” to secure her signature; otherwise, it’s business as usual.

5. MYTH: Patients can get free copies of their medical records from you.

REALITY: Not true. A patient certainly has the right to request a copy of his medical record from you, but the enactment of HIPAA did not make him the owner of the record. You have 30 days to comply with such a request and you can also require that the patient cover the cost of copying and mailing the records.

March 30th is Doctors Day, the one time each year we recognize the remarkable job our doctors do for so many patients, in so many specialties. We take this opportunity to express our appreciation for their time, their dedication, and their commitment to the health of our community.

Origins

The first Doctors’ Day observance was held on March 30, 1933, by the Barrow County Alliance in Winder, Georgia. The idea of setting aside a day to honor physicians was conceived by Eudora Brown Almond, wife of Dr. Charles B. Almond, and the recognition occurred on the anniversary of the first administration of anesthesia by Dr. Crawford W. Long in Barrow County, Georgia, in 1842. The resolution was introduced to the Women’s Alliance of the Southern Medical Association at its 29th annual meeting held in St. Louis, Missouri, November 19-22, 1935, by the Alliance president, Mrs. J. Bonar White. On October 30, 1990, President George Bush signed S.J. RES. #366 (which became Public Law 101-473) designating March 30th as "National Doctors’ Day."
**Quiz: Acronyms**

Test your coding knowledge by taking this quiz.

- What does the acronym PBSC stand for?
  a. Peripheral body surface cell
  b. Positive blood stem cell
c. Protein-bound sensory cell
d. Peripheral blood stem cell

- What ICD-9-CM code should you report for multifocal atrial tachycardia (MAT)?
  a. 427.42
  b. 427.61
c. 427.89
d. 428.22

- What acronym best describes posterior ischemic optic neuropathy?
  a. PION
  b. PIN
c. ONP
d. PONT

- What does the acronym VLAT stand for?
  a. Very low ablation testing
  b. Visual laser ablation of trigone
c. 427.89
d. PIOL

- What ICD-CM code should you report for branch retinal artery occlusion (BRAD)?
  a. 362.24
  b. 362.31
c. 362.32
d. 362.37

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**TrendSpotter: E-Prescribing Gathers Momentum**

The Government wants you to toss your Rx pad - or else by Ken Terry

If you’re like the majority of physicians, you don’t prescribe electronically and you don’t see why you should. After all, what’s wrong with the old prescription pad that has served you well over the years? But citing safety, quality, and efficiency, the government, private insurers, and some medical societies want you to change your mind.

A CMS initiative will start adding 2% to your Medicare payments if you prescribe electronically. The incentive drops to 1% in 2011 and 2012 and to 0.5% in 2013. Starting in 2012, CMS will pay you 1% less than its fee schedule if you don’t e-prescribe; that penalty will rise to 1.5% in 2013 and to 2% in 2014 and every year thereafter.

But with standalone e-prescribing systems priced at around $3,000, plus monthly maintenance fees, observers are divided on whether the CMS incentive alone will be sufficient to get doctors to adopt e-prescribing. Bruce Merlin Fried, a Washington, D.C., healthcare attorney and health IT policy expert, is one of those who think that it will. “The incentive will have an enormous impact on doctors moving toward e-prescribing.” The penalty on the back end, he adds, will convince many other physicians to do the same.

Representatives of primary-care medical societies, however, are less optimistic. Steven Walden, director of the American Academy of Family Physicians Center for Health Information Technology, which has been promoting e-prescribing for years, says, “I don’t think the 2% incentive will be enough for most family physicians. It will accelerate the thinking of people who are close to making the decision for their practice; but for those physicians who don’t think they should be e-prescribing or aren’t ready, this 2% — which, for a family physician, is about $1,400 a year — is not enough to change their decision.”

The incentive is prompting some physicians “to take a harder look” at e-prescribing, says Michael Barr, vice president of practice advocacy and improvement for the American College of Physicians. “It’s not something people are taking lightly. Some doctors are wondering, ‘If I’m going to invest in technology, is now the right time for me to go the EMR route, or should I go to e-prescribing?’”

Both the investment and the work flow changes are much greater with an EMR, he admits.

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**New Approach for a Bad Economy**

Nowadays, your patients are in no mood to cough up copays, or even fill that script you just wrote. by Pamela Moore

You’ve probably already seen the signs. A few months back, Benjamin Glover wrote a much-quoted piece for The Wall Street Journal about how “tough times” were prompting patients to skip care: “A 59-year-old woman decided not to have a mammogram this year. At her age, she should be screened for colon cancer, too, but she is holding off until she becomes eligible for Medicare at 65. …She is pinching pennies by scribbling on preventive care,” he wrote.

That’s risky behavior for patients, but what about you? Legal, moral, and economic hazards abound. What if a patient doesn’t fill her prescription, gets sicker, and blames you? As the economy worsens, more patients will eschew visits and instead call in or e-mail for scripts and treatment plans. Are you confident about when to require patients to show up in the office as a condition of treatment?

Here are a few suggestions to protect yourself and your patients.

- **Talk money.** Don’t be afraid explain to a patient why your prescription or recommendation is important. Ask patients to let you know if they don’t follow through for financial or other reasons. A 2008 study by the Center for Studying Health System Change revealed that only 48% of physicians feel ready to discuss medical budgeting with patients. But if your patient is already sitting there in your exam room planning to cut those pills you just prescribed in half to save money, you had better know now, so you can suggest alternatives. You may refer to insurance patients that paying for treatment is worth working short elsewhere. This is marketing that benefits you and your patients. Brace yourself for the conversation.
- **Tighten up recall and reminder processes.** You can’t realistically expect all patients to show up for regular follow-ups, now more than ever. Set policies to document when you’ve asked patients to come in for a checkup, annual exam or other service. Use the myriad of automated reminder systems to encourage patients to make appointments for those services and to show up for them. You want to stress the importance of the visit.

Likewise, when you ask patients to make an appointment for a mammogram, colonoscopy, or other diagnostic or specialty service, follow up to see if they made and kept the appointment. You can’t force them, but you can document that you encouraged their compliance.

Take a look at how you communicate results of lab work, too. You might not see this patient again for quite some time, so you are confident that your patients heard every abnormal finding? Don’t depend on flipping through the chart just before a patient visit to alert you to whatever news the patient needs to hear. Set plans to communicate outside patient visits.

- **Set restrictions on virtual care.** Expect more calls or e-mails from existing patients, and be prepared with a standard policy that covers the reasons folks will need to make an appointment to see you.

David Troxel, medical director for The Doctors Company, a malpractice carrier, helped write national guidelines for managing “e-risk,” the malpractice risk associated with virtual treatment. He advises, certainly, limiting phone or Web-based advice to patients you’ve already seen in your office. New symptoms for diagnosed problems or referrals may be easily handled virtually, but entirely new problems or serious complications need to be seen. “Physicians are trained to get a good deal of information by reading the nuances of body language,” Troxel points out. Pain, for example, is hard to judge without a physical exam. If you wish you could see a patient, then by all means advise them to come in, cost aside. You have a moral obligation to provide your best care.

It would be nice, sure, if patients’ personal finances didn’t affect your care and your business. But it’s not an ideal world and the times call for pragmatic solutions.

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**Quiz: Medical Terminology**

- What term describes a scalp hair and that is often accompanied by keratodema of the palms and soles?
  a. Epidermolysis bullosa
  b. Clouston’s syndrome
c. Clubnail
d. Milroy’s disease

- What term describes the accumulation of senile fluid that resembles a cyst?
  a. Hygroma
  b. Hyaluron
c. Hydroxyapatite
d. Hydroxyapatite

- What term describes a flap of tissue over a tooth that is either undermined or partially erupted?
  a. Onychauxis
  b. Open-bite deformity
c. Osteopenia
  d. Onlay

- What term describes the triangular, smooth area of mucous membrane at the base of the bladder, located between the ureteric openings in the back and the urethral opening in front?
  a. Trigonocypha
  b. Trigone
  c. Trigntus
  d. Tubercle