# VNS HEALTH CORPORATE
# POLICY & PROCEDURE

**TITLE**: Patient Request Not to Disclose PHI to a Health Plan

**APPLIES TO**: VNS Health Home Care, including the Home Care, and Care Management Organization (CMO) divisions;
VNS Health Behavioral Health, Inc.;
VNS Health Personal Care;
VNS Health Health Plans;
VNS Health Hospice Care; and
Medical Care at Home, P.C. (collectively, "VNS Health")

**POLICY OWNER**: Corporate Compliance Department

**FIRST ISSUED**: September 23, 2013

**NUMBER**: HIPAA.2

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## PURPOSE

This Policy and Procedure establishes the rules that VNS Health will follow when a patient requests that VNS Health not disclose their protected health information ("PHI") or submit a claim for services rendered to their health plan.

## POLICY

A patient has the right to request restrictions on how VNS Health uses or discloses their PHI to carry out treatment, payment and health care operations. VNS Health must agree to a patient request to restrict disclosure of PHI to a health plan if: (a) the PHI pertains solely to health care items or services for which the patient has paid VNS Health in full at time of service; and (b) the disclosure is not otherwise required by law (e.g., responding to a Medicare or Medicaid audit).

The restriction on disclosure of PHI to a health plan will not apply to follow-up treatment if disclosure of the original treatment information is necessary to receive payment for the follow-up treatment, unless the patient requests the follow-up (and original) treatment information not be disclosed to the health plan and the patient pays for the follow-up treatment in full as described herein.

**PROCEDURE**

1. If a patient requests that VNS Health not submit their PHI to their health plan for services rendered, the VNS Health staff that was notified must proceed under the coordination of benefit process. Such staff needs to indicate that the patient is self-pay in the patient record system with a note indicating the patient does not want their health plan billed and that patient will be/has submitted their request in writing to the Revenue Cycle Department.

2. The patient must make the request to the Vice President of Revenue Cycle Department, with a copy to the Chief Compliance and Privacy Officer, or designee, in writing on the Patient Restriction on PHI Disclosure form in Appendix A. The request will only be honored if the patient pays VNS Health, in full, for the care. For elective services, an initial payment of estimated charges will be required to be made up front prior to receipt of services and any outstanding amounts due will need to be paid within thirty (30) days of the receipt of an invoice from VNS Health. In the case of an emergency, payment for emergency services will need to be made within thirty (30) days of receipt of an invoice from VNS Health.

Note: Where the restriction requested by the patient applies only to one of several services provided during a single patient encounter, the patient must agree to pay for all the services provided if the services cannot be unbundled.

3. The Vice President of Revenue Cycle Department or designee will document the request for restriction in the insurance comments section of the patient's account record.

4. If payment is not received within thirty (30) days of patient's discharge, one written reminder will be sent to the patient and if the patient does not submit or make arrangements for payment within three (3) business days, VNS Health may change the patient's status in the system from Self-Pay and submit a claim to the health plan for payment. Furthermore, if the patient pays and the patient's payment is subsequently dishonored (e.g., a check is returned for insufficient funds), VNS Health will notify the patient in writing that payment was not obtained and that the patient has three (3) business days to remit payment. If payment is not received within three (3) business days, VNS Health may submit a claim to the health plan for payment.

5. VNS Health does not need to maintain a separate medical record for services where the patient has requested their health plan not be billed, but VNS Health will flag the record to indicate that a restriction has been placed on disclosure.

6. All requests for restrictions will be referred to the Vice President of Revenue Cycle Department.

**REFERENCES**: **45 CFR § 164.522**

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| **Reviewed**: | 9/2013 | 1/2015 | 11/2016 | 4/2018 | 11/2019 | 10/2020 | 3/2022 |
| **Revised & Approved**: | 9/2013 | | 11/2016 | 1/2019 | 1/2020 | 3/2021 | 6/2022 |
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| **Reviewed**: | 6/2023 | | | | | | |
| **Revised & Approved**: | 9/2023 | | | | | | |

VNS Health

**Appendix A.**

**Patient Restriction on PHI Disclosure**

| Patient Name | Date of Birth |
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I request that health information regarding my (the patient's) care and treatment received on _____ ("Services") NOT be released by _____ [insert provider entity] ("VNS Health") to my health plan: _____ ("Health Plan"). As a result of this restriction, I understand that VNS Health will not submit any claim for payment for the Services to the Health Plan, and I agree to be financially responsible for cost of and to reimburse VNS Health in full for the Services. I understand that I must make an initial payment of $_____
Any subsequent amounts due must be paid within thirty (30) days of request.

I understand that if VNS Health is not paid in full within thirty (30) days of request, VNS Health is permitted to submit a claim to my health plan for the Services.

I further understand that this restriction on disclosure of my health information does not apply to any follow-up care I receive, unless I specifically request that information about the follow-up care also not be provided to the health plan. I understand that such request must be made at the time I receive the follow-up care, and if I make such request, I will also be responsible for payment, in full, for the follow-up care.

I acknowledge that this request does not apply to related services that are not provided by VNS Health (e.g., pharmacy, durable medical equipment), and I will need to make separate requests to such providers if I do not want them to release my information to my health plan.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

| _____<br>Signature of patient or personal representative | Date _____ |
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