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South Carolina Health Information Management Association
An Affiliate of the American Health Information Management Association

POSITION STATEMENT/TALKING POINTS

H.3350 Physicians Transmitting Patient Records

IDENTITY STATEMENT:

The South Carolina Health Information Management Association (SCHiMA) is a dynamic professional association representing more than 1300 health information management (HIM) professionals working throughout South Carolina and neighboring states in various roles in the health care industry. The mission of SCHiMA is to lead and educate the community in health informatics and information management to promote the quality and integrity of health information.

Our members are a collective of professionals intimately involved in directing and managing health information development, collection, quality, integrity, confidentiality, and accessibility. Our roles include positions at all levels of operational and administrative services and management, privacy and security administration, strategic planning, revenue cycle management, information systems/technology implementation and management, consulting, compliance and regulatory activities, and education in all types of hospitals & health systems, nursing facilities, behavioral health and addiction medicine services, ambulatory care centers, surgery centers, physician practices, hospice and home care services, outpatient therapy & support, regulatory agencies, insurance companies, and vendor settings.

The unique areas of knowledge that our members possess are critical for managing, analyzing, classifying and utilizing data vital for patient care; operational, legal and financial viability; leading the transition from paper to computer-based records; and enhancing the quality and value of health information.

BILL VERBIAGE (as of 01/19/2011):

A BILL

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION [44-115-35](#) SO AS TO REQUIRE A PHYSICIAN, UPON REQUEST OF A PATIENT, TO TRANSMIT THE PATIENT'S MEDICAL RECORD TO THE HOSPITAL AT WHICH THE PATIENT HAS BEEN OR IS SCHEDULED TO BY HOSPITALIZED WHEN THE PHYSICIAN IS NOT THE PATIENT'S ATTENDING PHYSICIAN AT THE HOSPITAL; TO REQUIRE THE PHYSICIAN TO ALSO TRANSMIT A SUMMARY OF THE MEDICAL RECORD ON A FORM DEVELOPED AND PUBLISHED BY THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL; AND TO REQUIRE TRANSMISSION OF THE RECORD TO BE CONDUCTED SO AS TO MAINTAIN CONFIDENTIALITY.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 115, Title 44 of the 1976 Code is amended by adding:

"Section [44-115-35](#). A physician, upon the written request of a patient or a patient's representative, must transmit the patient's medical record to a hospital where the patient has been, or is scheduled to be, hospitalized and the physician is not or will not be the patient's attending physician while the patient is hospitalized. The physician also must transmit with the medical record a summary of the treatment the physician rendered. This summary must be on a form developed and published by the Department of Health and Environmental Control. The physician shall transmit the medical record and summary in a manner so as to maintain confidentiality."

SECTION 2. This act takes effect July 1, 2011.

SCHIMA RESPONSE TO PROPOSED AMENDMENT:

SCHIMA has reviewed the proposed bill language related to H.3350, and has significant questions regarding the origination and intention of the bill. Without any history as to the reason behind the proposed amendment, we are quite unsure why such "specifically vague" legislation would be introduced that will likely only serve to frustrate providers on both the requesting and receiving ends of the transaction.

The following items are points of general concern identified by our organization, and while not all-inclusive, represent the continuum of issues presented by the bill in its current form. From SCHIMA's perspective, we are unclear as to the necessity of the amendment as written, but would certainly welcome additional background to understand the intention.

Redundancy of current obligations provided for under federal law.

Under HIPAA, physicians are not able to restrict access of a patient record save in the rare event that access to the record would be of significant harm to the patient themselves (which invokes a secondary set of obligatory actions by the provider to review the content of the record with the patient in a manner that reduces the risk of harm). Once a patient has provided written authorization to release the records, the provider, under federal law, is required to respond.

In a provider-to-provider release of information transaction (i.e., the patient is scheduled for surgery by a specialist, and the surgeon or pre-admission testing department of the delivering hospital requests a copy of records for pre-surgical clearance), there is no reason that a physician could provide that would excuse him/her from releasing records to the requesting provider who has transmitted a properly executed authorization for release of information from a patient or their legal representative.

Requirement for Medical Summary Form

SCHIMA has significant question and concern for the new requirement for a separate, unique Summary of Medical Treatment, written on a new DHEC-approved paper form (or typed into a template), to be created and/or subsequently updated for release with a patient's physician office medical records to a hospital provider. There are myriad questions that arise from the health information management practitioner's standpoint, which include but are not limited to:

- Who is determining what goes on that form? Will there be hospital provider input to ensure we get what WE need from the medical records and documentation perspective?
- Will providers be permitted to create their own forms with minimum criteria designated by DHEC, or will the only acceptable form be an indexed and approved DHEC form?
- Is there any concern that the creation of another paper form does not support the move toward electronic health records and data transmission?
- What will hospital providers going to need to do with it once it has been received? Will there be an expectation that the summary of medical treatment become part of the hospital's legal health record?
- Will there be a requirement for the hospital provider to pursue the form if the physician transmits records, but NOT the DHEC medical summary form?
- What if a physician sends a medical treatment summary form that is incomplete, illegible, doesn't have a date/signature/some other patient identification, etc.? Are the hospital providers going to have any responsibility for managing the proper completion of that document?
- What are the consequences of physicians failing/refusing to comply with the regulations?
- Will hospital providers be required to track and report statistics or other compliance data related to physician submission of the form for licensure, Medicaid provider eligibility, etc.?
- How can a hospital be assured that the summary of medical treatment form was completed by the treating physician? Will there be provisions that will allow for a mid-level provider to complete the summary (which is quite possible, based on current physician workloads and obligations)? If so, how will this mesh with individual hospital's medical staff rules and regulations for providers permitted to document in the record?
- Will there be an expectation for hospitals to ensure that the "new" attending physician document in the new care record receipt and review of the summary of medical treatment form and/or co-signs the summary of medical treatment form?

In a time of already stressed healthcare systems (people and plant), as well as initiatives to combat redundant data collection and administrative requirements, we are unclear of the value of a standard summary of medical treatment for every release of records request where a physician is sending records to a hospital and they are not the attending physician.

Vague delineation of requirements for request processing.

Based on common operational experience, SCHIMA's professionals have concern in regard to general silence in the amendment language related to response, transmission and record reproduction cost recoupment attempts. While we would anticipate that the vast majority of physicians would continue in their current practice to release records for continuing patient care to other providers in a timely manner and without restriction or reckless transmission practices, we do have concern that there will be a percentage who may not meet the standard of practice and act in accordance with the requests as received.

Response Timeframes

In the current language of the bill, there are no timeframes for response given for these specific requests. Because it is a continuing care instance, SCHIMA believes that the

standard language of HIPAA permitting 30 days to respond to a request could be invoked in situations where an uncooperative provider may not release records in a timely fashion, which would be perceived as a retaliatory act against a patient who is having services under the direction of another physician or at a hospital where the uncooperative provider may no longer practice.

Should the bill continue and receive amendment, SCHIMA would recommend that a timeframe to produce records to the receiving provider be included to provide stricter guidance for expected response. Most hospitals release of information service sections in practice release records to requesting providers for patient care in several hours, not weeks, as a course of business. Practices do not accept waiting days or weeks for patient records for continuing care or professional billing services, so a reasonable reciprocal response for continuing care would be expected.

Prohibition of Charges for Records for Continuing Care

There is potential, based on current language, for a physician practice to attempt to circumvent the language in the existing bill that prohibits charging for copies of records. The specific concern is that the medical treatment summary technically is NOT a copy of the medical record, but another document created by the physician upon request.

Through our practical collective experience in the field, we can see where a situation may arise that a practice may attempt to invoke a charge policy on that specific document by misinterpreting 44-115-90 (relating to permission of reasonable charges for the cost of creating new documentation for a patient request, which is typically meant to cover requests for medical summaries for attorneys, disability services claims, workers compensation cases, etc.).

In a time when providers are identifying and pursuing administrative fees for services as standard as a Saturday appointment during normal posted hours, it is NOT unreasonable to believe that increase of patient-based fees for non-direct-care services may increase as well.

Focus on specific scenario for release of one type of record to one type of provider.

SCHIMA has questions in regard to why only hospitals were designated as the one specific provider to whom the physician would be required to release records and the summary of medical treatment. There may be instances where other types of providers - both inpatient and outpatient, but not necessarily only acute care – may need the same information from a physician. Would they not be provided with the same legal rights to medical information for patient care? Home health, nursing homes, rehabilitation services (OT/PT/SLP), other specialty physician practices, other physicians of the same specialty/practice area, cancer centers, and the like may have need for the same information as the hospital.

Again based on observed situations in the field, we believe that the more likely scenario would be a patient leaving one practice and going to another practice of the same specialty who would have difficulty in transferring records to the new practice. This amendment does not address that situation, but only those providers who fit into the definition of “hospital” under South Carolina law.