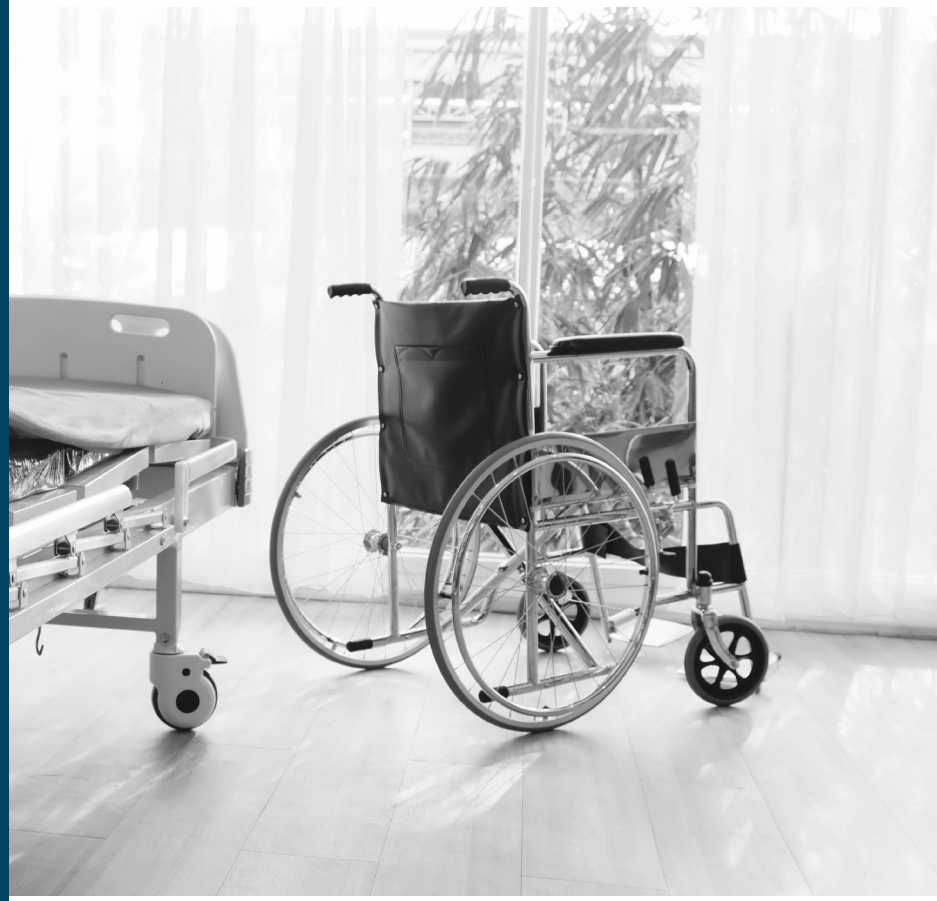
ACHC U®
EDUCATIONAL RESOURCES

DMEPOS

Co-Payment Collection and Patient Assistance

Denise M. Leard, Esq.
Brown & Fortunato

ACHC U®
EDUCATIONAL RESOURCES



Introduction

Introduction

- The law says that a DME supplier must make reasonable efforts: to collect a Medicare beneficiary's co-payment.
- "Reasonable Effort" is not clearly defined. The supplier does not have to bring a collection lawsuit against the beneficiary, nor does the supplier have to turn the beneficiary into a collection agency.

Introduction

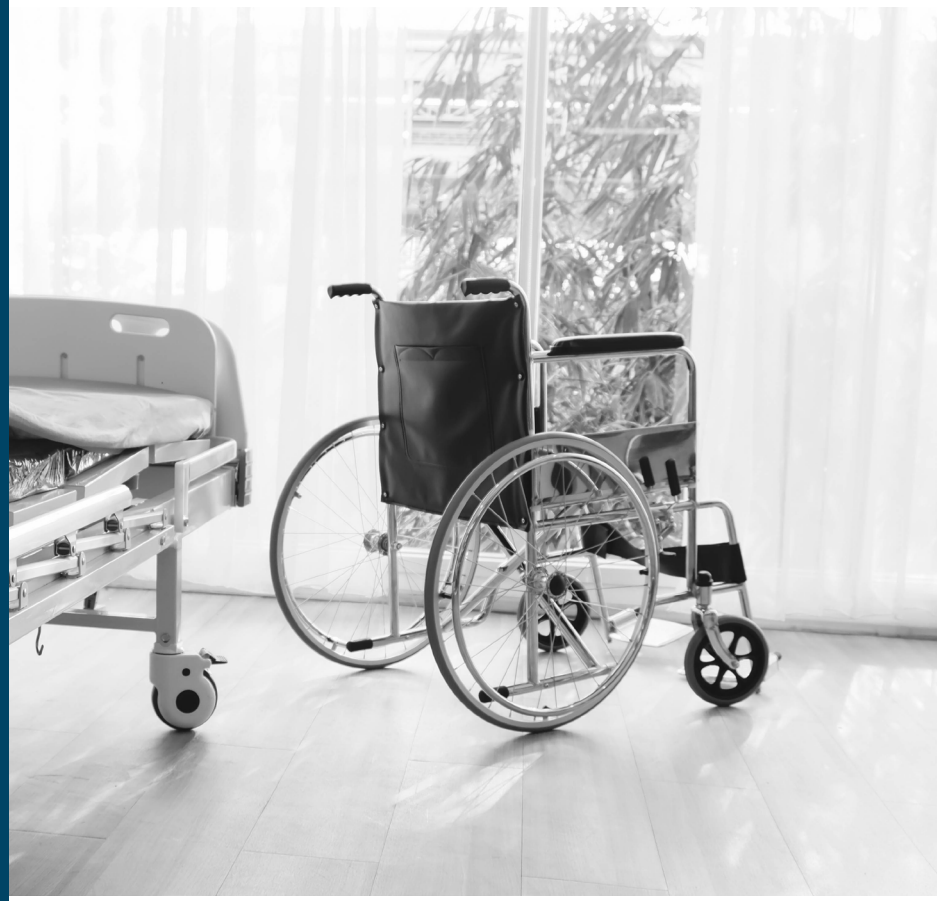
- However, the facts need to be clear that the supplier is attempting to collect the co-payment from the beneficiary.
- Essentially, what this means is this:
  - When the product is delivered to the beneficiary, the supplier will ask the beneficiary to pay the co-payment.
  - If the beneficiary says that he cannot pay the co-payment, the supplier will ask the beneficiary to pay the co-payment over time.
  - If the beneficiary says that he cannot pay the co-payment over time, the supplier will have the beneficiary complete a Financial Hardship Application Form.

Introduction

- In completing the Financial Hardship Application Form, the beneficiary will disclose his financial condition.
- Based on the information provided by the beneficiary, the DME supplier will decide whether to waive all or a portion of the co-payment.
- At the end of the day, if the supplier's co-payment collection efforts are ever scrutinized by a government agency/contractor, the facts need to show that the supplier is colleting the lion's share of the co-payments.

ACHC U
EDUCATIONAL RESOURCES

Federal Law



The Department of Health & Human Services: Office of Inspector General (OIG) Special Fraud Alert

- 1991- the OIG issued a Special Fraud Alert
  - The Alert focused on the healthcare community's routine waiver of co-payments or deductibles under Medicare Part B
  - The OIG stated that routine waiver of Medicare "cost sharing amounts" is unlawful because it results in:
    1. False claims
    2. Violations of the federal anti-kickback statute ("AKS"), and
    3. Excessive utilization of items and services paid for by a federal health care program ("FHCP")

The Department of Health & Human Services: Office of Inspector General (OIG) Special Fraud Alert

- Suspect Marketing Practices
  - Advertisements that stated, “Medicare Accepted As Payment in Full” or “No Out-Of-Pocket Expense.”
  - Routine use of Financial Hardship Forms with no good faith attempt to determine the beneficiary’s actual financial condition.
  - Collection of co-payments and deductibles only from beneficiaries with Medicare supplemental insurance.

The Department of Health & Human Services: Office of Inspector General (OIG) Special Fraud Alert

- The OIG highlighted in its Special Fraud Alert that:
  - "A provider, practitioner or supplier who routinely waives Medicare co-payments or deductibles is misstating its actual charge."
  - Example:
    - Supplier claims a charge for a piece of equipment is $100, but routinely waives the copayment; the actual charge of the equipment becomes $80.
    - Medicare should be paying 80% of $80 rather than 80% of $100.

The Department of Health & Human Services: Office of Inspector General (OIG) Special Fraud Alert

- The OIG is clear in its position that the supplier that routinely waives cost-sharing amounts is being paid more than a reasonable charge.
- Some may argue that routinely waiving cost-sharing amounts helps Medicare beneficiaries, but the OIG disagrees.
  - The OIG's response to this argument is that routine waivers lead to excessive costs and excessive utilization.

The False Claims Act (FCA)

- The most important take away for suppliers:
  - A supplier that routinely waives cost-sharing amounts for Medicare beneficiaries, but bills Medicare for the full allowable amounts, submits false claims.

Anti-Kickback & Beneficiary Inducement Statutes

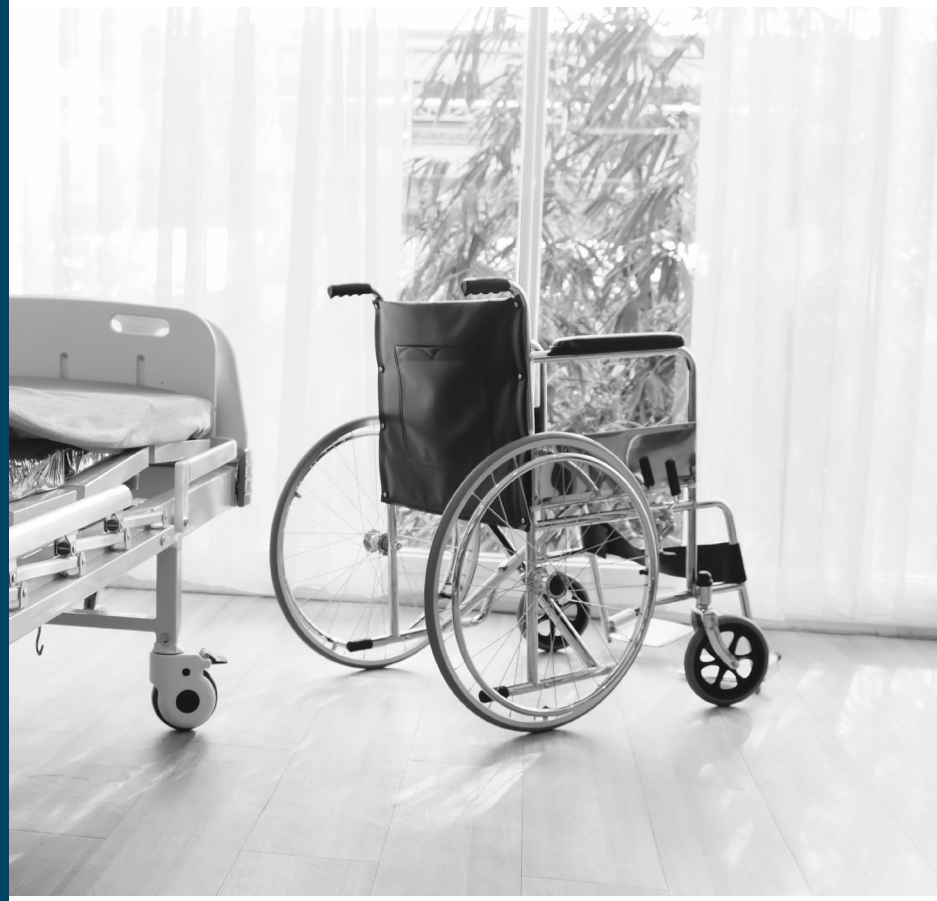
- The AKS prohibits the offering or paying of anything of value to any person as an inducement to purchase, lease, or order an item or service covered by an FHCP.
- An OIG Special Fraud Alert states the following:
  - "When providers, practitioners, or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them."

Anti-Kickback & Beneficiary Inducement Statutes

- The Beneficiary Inducement Statute
  - Prohibits transferring anything of value to a Medicare beneficiary when it is likely to influence the beneficiary to order or receive a Medicare covered item or service from a particular provider, practitioner, or supplier.
  - Nominal Value Exception – A supplier *can* offer a non-cash/non-cash equivalent item to a beneficiary if the item has a retail value of $15 or less. If the supplier offers multiple items to the beneficiary, the value of such items, in the aggregate, cannot exceed $75 over a 12-month period. Reduction or waiver of a co-payment will likely be construed as a “cash equivalent” item.

ACHC U
EDUCATIONAL RESOURCES

State Law



State Law

- State law is not consistent regarding waiver of copayments for non-Medicare and non-Medicaid patients.
- In general, the waiver of co-payments is prohibited by provider contracts.
- However, in the case of non-contracted or out-of-network suppliers, there is less guidance.

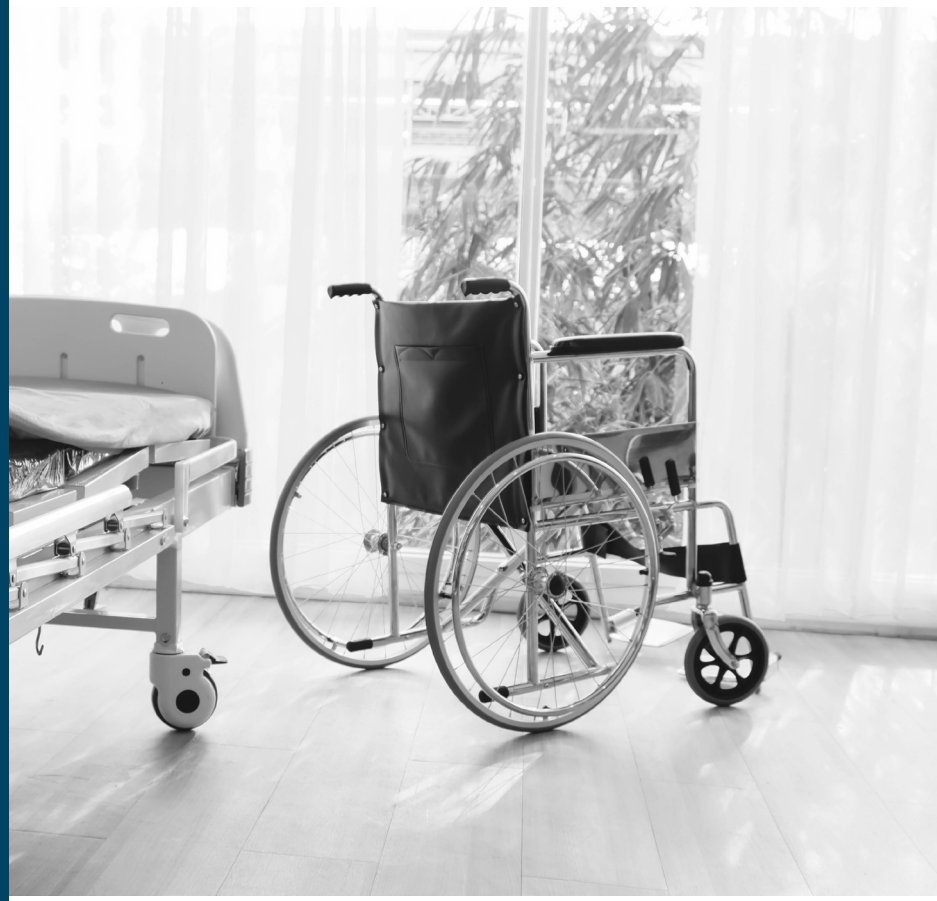
State Law

- State laws regulating insurance fraud and deceptive trade practices have been used by both state regulatory agencies and private parties to act against health care providers and suppliers that routinely waive cost-sharing amounts.
  - Many of the suits allege breach of contract claims and unjust enrichment.
  - Allegations of fraud are also common.
    - Rationale: suppliers submit claims that do not reflect the actual discounted charge, and, therefore, materially misrepresent the transaction.

ACHC U®
EDUCATIONAL RESOURCES

DMEPOS

Supplier Steps



Guidance for a Supplier's Policies & Procedures

- Both CMS and the OIG have identified procedures that will reduce the risk that a supplier will violate a federal statute.
  - Adopt written policies and procedures that prohibit personnel from advertising discounts and waivers of cost-sharing obligations and from advising Medicare beneficiaries that they are not liable for their coinsurance and deductibles.

Good Faith Collection Efforts

- Understand industry guidance on “good faith collection efforts.”
- The OIG recommends:
  - Suppliers adopt written criteria for determining a patient’s financial need.
  - Financial need criteria is not limited to “indigence,” but can include reasonable measures of financial hardships.
  - Examples: cost of living, a patient’s income, assets and expenses, patient’s family size, and the scope and extent of the patient’s medical bills.

Good Faith Collection Efforts

- Suppliers should issue a bill to the party responsible for the cost-sharing amount.
  - If the bill is not paid, the supplier should contact the responsible party, issue subsequent bills, and/or send collection letters.
  - If the bill remains unpaid for 120 days, the supplier may presume that the debt cannot be collected.
    - Save copies of all letters and bills to the patient's file and note all telephone and personal contacts.

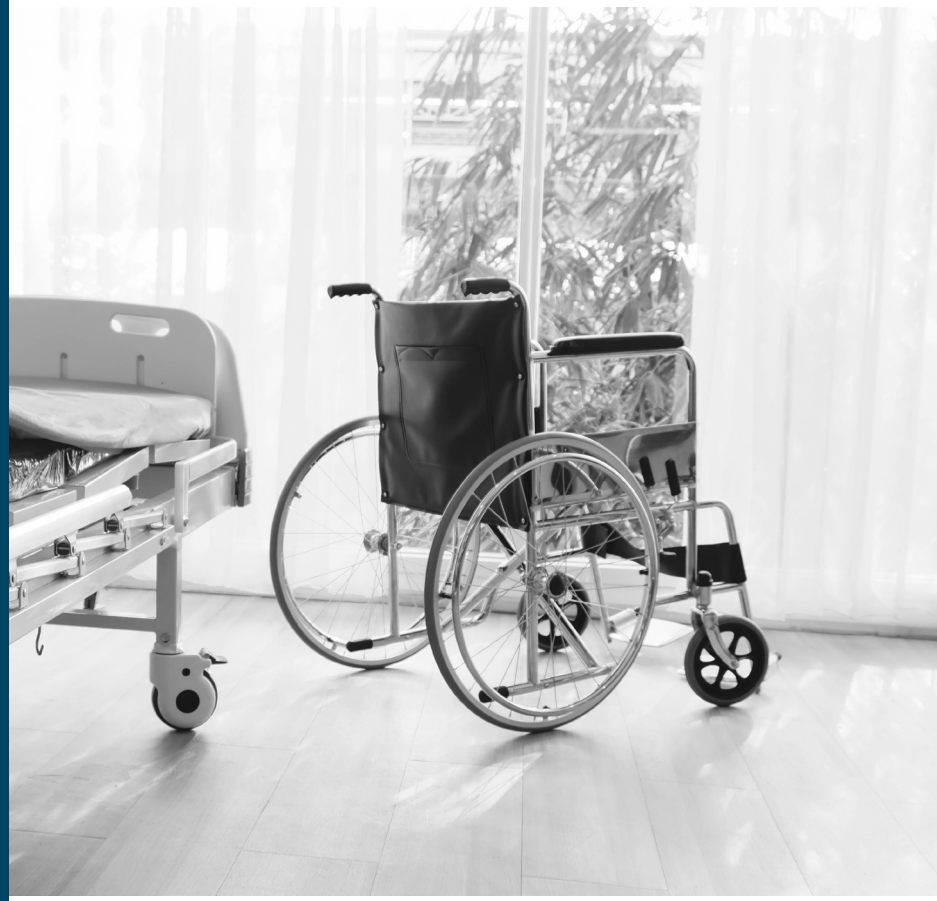
Good Faith Collection Efforts

- Suppliers may waive cost-sharing amounts as long as the following conditions are met:
  - The supplier does not advertise or use waivers to solicit business;
  - The supplier does not routinely waive cost-sharing obligations; and
  - The supplier waives the coinsurance and deductible amounts after
    i. it determines in good faith that the individual is in financial need and
    ii. it fails to collect coinsurance or deductible amounts after making reasonable collection efforts

ACHC U®
EDUCATIONAL RESOURCES

DMEPOS

Safeguards Against Routine Waivers



Safeguards

- Human Nature
  - Need for services and willingness to pay versus services rendered and disinclined to pay.
  - While suppliers should strive to collect copayments and other obligations before services are rendered, it is not always feasible.

Safeguards

- Steps that a supplier can take before rendition of services:
  - Take the customer's credit card/debit card information
  - Take a post-dated check
  - Have the customer pledge collateral (not very realistic)
  - Have the customer sign a short, easy to read statement, in which the customer promises to pay the obligation
  - Have another individual sign a guaranty of the customer's obligation
  - Have the customer disclose names, addresses, and phone numbers of relatives- easier to find the customer if necessary

Safeguards

- After the fact, customer simply does not want to pay
  - Supplier can take reasonable steps to collect the obligation
    - Phone calls, send letters
    - Turn the account over to an attorney-attorney sends letters
      - Collector must always adhere to the Fair Credit Reporting Act, and the amendments thereto under the Fair and Accurate Credit Transaction Act

Safeguards

- The DME supplier should ensure that its written policy reflects the supplier's actual practices.
- The supplier should require patients, who may qualify for a full or partial waiver, to complete and sign the application required under the written policy.
  - Keep the signed applications on file.

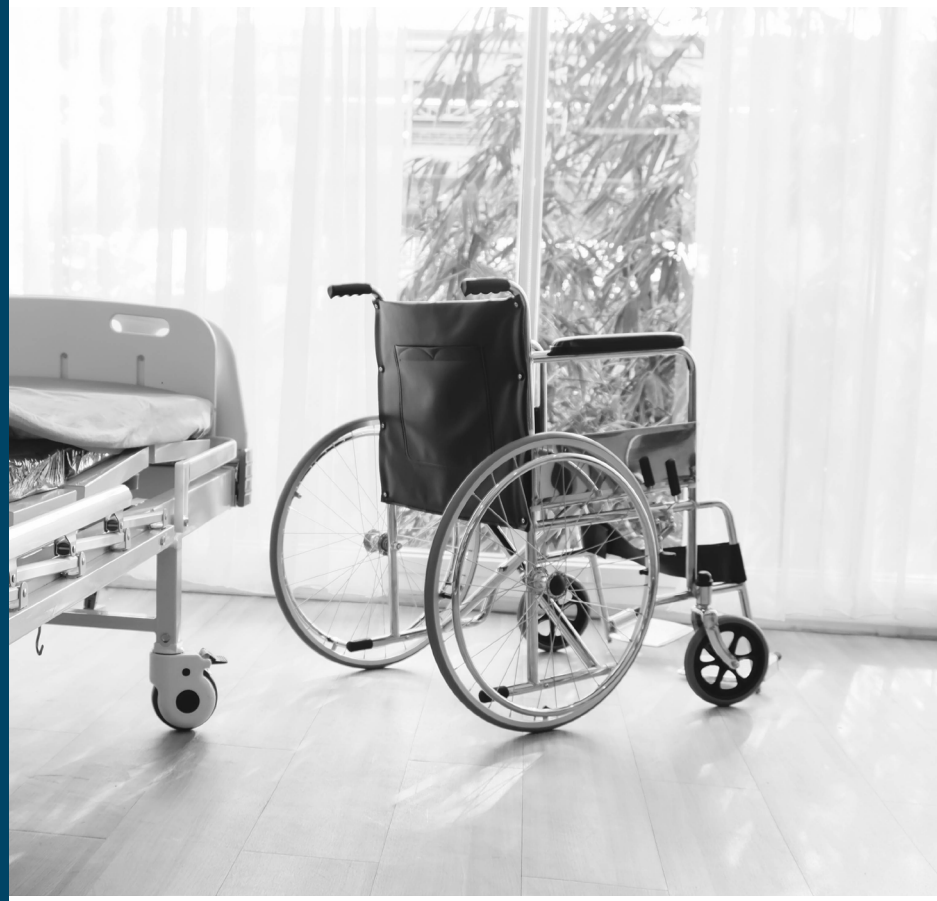
Safeguards

- The supplier should request some form of documentation verifying the application (i.e., a pay stub or W-2) when possible.
- The amounts of copayment reductions should be granted on a sliding scale that is based on the patient's resources.
- The patient's income level should not be the sole factor considered by the supplier-evaluate the totality of the patient's circumstances.
- Assess the percentage of patient population receiving reduced copayments.

ACHC U®
EDUCATIONAL RESOURCES

DMEPOS

Waiving Co-Payments for Out-of-Network Patients



Waiving Co-Payments for Out-of-Network Patients

- DME suppliers are facing a common challenge: Commercial insurers are closing their provider panels, thereby not allowing the suppliers to bill the insurers as in-network suppliers.
- This relegates the out-of-network suppliers to one of two choices.
  - Decline to serve the patient or;
  - To serve the patient and bill the insurer as an out-of-network supplier.

Waiving Co-Payments for Out-of-Network Patients

- The challenge with billing as an out-of-network supplier is that the patient normally has to pay a higher copayment than if the DME supplier was an in-network supplier.
- This has led some out-of-network suppliers to offer to waive the patient's copayment if the patient purchases from the out-of-network supplier.

Waiving Co-Payments for Out-of-Network Patients

- The problem with waiving such copayments is that the out-of-network supplier may be setting itself up for liability.
- Private parties, including insurers and competitors, often file lawsuits against out-of-network health care providers that routinely waive copayments and deductibles.

Waiving Co-Payments for Out-of-Network Patients

- For example, Aetna has pursued an aggressive legal campaign against out-of-network providers that waive copayments and deductibles.
- Aetna has brought suits against providers in California, New Jersey, New York, and Texas.
- Similarly, other insurers have brought suit against out-of-network providers that waive copayments and deductibles.

Waiving Co-Payments for Out-of-Network Patients

- Many of these suits allege breach of contract claims and unjust enrichment.
- Allegations of fraud and deceptive trade practices are also common.
- Claims of statutory and common law fraud allege that providers that waive copayments submit claims that do not reflect the actual discounted charge and, therefore, materially misrepresent the transaction.

Waiving Co-Payments for Out-of-Network Patients

- As an example, such claims have succeeded in the federal and state courts of New Jersey.
- In other states, regulatory authorities have issued guidance indicating that routine waivers of patients' cost-sharing obligations constitute fraud.
- As evidenced by the suits brought by various private parties, a DME supplier will be at risk of having to defend a lawsuit for steering patients to an out-of-network supplier and waiving copayments.

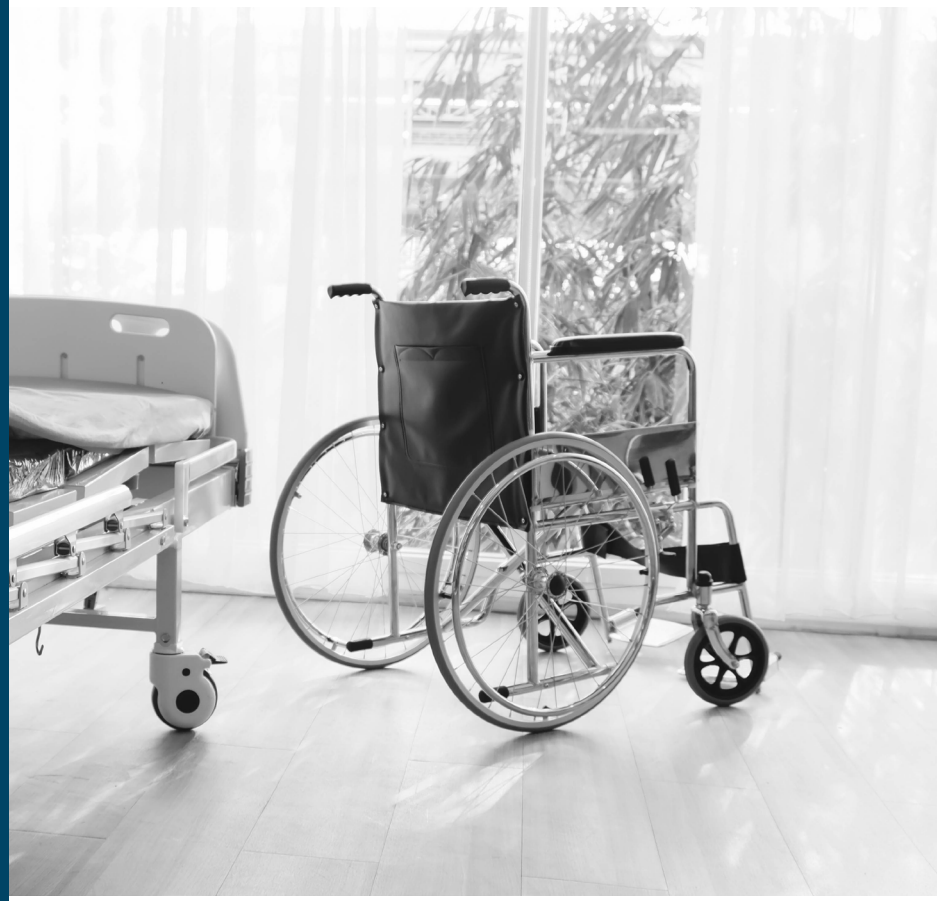
Waiving Co-Payments for Out-of-Network Patients

- A number of state and federal courts have addressed cases involving out-of-network providers that routinely waived copayments and deductibles.
- A common claim in these cases is that the provider submits a false or fraudulent claim and overcharges the insurer when the provider bills the insurer the full amount but does not intend to collect the copayment.

ACHC U®
EDUCATIONAL RESOURCES

DMEPOS

Policy and Procedure for Collections and Patient Assistance



Policy & Procedure for Collections & Patient Assistance

I. POLICY STATEMENT

ABC, Inc. (“ABC”) is committed to complying with federal and state laws concerning accurate billing. At the same time, ABC is committed to providing access to high quality health care to all patients. ABC has encountered situations in which patients are unable to pay cost-sharing obligations because of financial hardships. In some situations, patients fail to pay cost-sharing obligations despite ABC’s good faith collection efforts. To address these situations, ABC will implement this Policy and Procedure for Patient Assistance.

Policy & Procedure for Collections & Patient Assistance

II. PURPOSE

Except under certain circumstances, waivers of deductibles and copayments are unlawful because such waivers misrepresent ABC's actual charge and may result in false claims. Also, the Office of Inspector General has indicated that such waivers may violate the federal Anti-Kickback Statute. Accordingly, this policy sets forth procedures that ABC and all ABC employees will follow before any cost-sharing obligation is waived. Under this policy, ABC may waive a patient's cost-sharing obligation only after the patient demonstrates a financial hardship. Otherwise, ABC will employ good faith efforts to collect copayments and deductibles.

Policy & Procedure for Collections & Patient Assistance

III. DEFINITIONS

3.1 Application - The form entitled, “Economic Assistance Request,” which a patient must complete to request a financial hardship waiver. The application is attached as Attachment A.

3.2 Cost-Sharing Obligations - Payment obligations, including copayments, deductibles, and coinsurance, required under a patient’s arrangement with the patient’s third-party payor.

3.3 Family - All persons residing in a patient’s home who are related to the patient by birth, marriage, or adoption.

3.4 Federal Poverty Guidelines (FPGs) - Often referred to as the “federal poverty level,” FPGs are measures of poverty issued yearly by the Department of Health and Human Services in the Federal Register. The current FPGs are listed in Attachment B.

Policy & Procedure for Collections & Patient Assistance

3.5 Financial Hardship Waiver - Waiver of a cost-sharing obligation provided to a patient because the patient demonstrated a financial need.

3.6 Gross Family Income - Gross family income refers to the total yearly value of the family's income from all sources prior to any tax deduction.

3.7 Manager - Under this policy, the Manager is responsible for reviewing applications and determining whether to grant a financial hardship waiver. _____ will serve as the Manager under this policy. S/he may delegate his/her responsibilities under this Policy to any employee of ABC.

3.8 ABC - In this policy, references to ABC include all employees and representatives authorized to act on behalf of ABC.

Policy & Procedure for Collections & Patient Assistance

IV. PROCEDURE

4.1 Private Insurance Companies.

4.1.1 Contractual Requirements. ABC will comply with all contracts in place with insurance companies. In the event a contract conflicts with this policy, the contract will take precedence over this policy.

4.1.2 Notice of Waivers. When ABC waives the cost-sharing obligation related to the patient's private insurance, ABC will notify the affected insurer.

Policy & Procedure for Collections & Patient Assistance

4.2 Statements Regarding Waivers.

4.2.1 Communications with Clients and Referral Sources. ABC will not advertise or otherwise promote the waiver of deductibles or copayments. No ABC employee may tell the patient or the patient's representative that the patient does not need to pay the cost-sharing obligation unless the patient has submitted an application, and the Manager has authorized a waiver.

4.2.2 Informing the Patient. At the time ABC provides services to a patient, ABC representatives will provide to the patient an estimate of the patient's cost-sharing obligation. If the patient expresses an inability to pay, ABC representatives may inform the patient of the availability of a financial hardship waiver and the application process.

4.2.3 Documentation on Invoice. ABC will document any waiver provided to a patient on the patient's invoice or receipt for service.

Policy & Procedure for Collections & Patient Assistance

4.3 Financial Hardship Waivers.

4.3.1 Application Required. When a patient requests a financial hardship waiver, ABC will require the patient to complete and submit an application entitled, "Economic Assistance Request." If the patient requests an application for patient assistance, ABC representatives may email, fax, mail, or hand deliver the application to the patient. Alternatively, at the patient's request, ABC representatives may receive the information verbally and complete the application on behalf of the patient. Any application completed in this manner will be mailed to the patient for the patient to sign and return. The patient will also be required to supplement an application completed verbally with evidence of financial hardship pursuant to Section 4.3.3.

4.3.2 Up-to-Date Information. Upon receipt of the application, ABC will inform the patient of the patient's responsibility to notify ABC of any changes to the patient's situation. ABC may rely on the documentation submitted by the patient for 12 months, unless the patient notifies ABC of any changes to his or her situation. At the expiration of the 12-month period, ABC will request that the patient completes a new application. ABC's policy to rely on the documentation for 12 months will not be shared with the patient.

Policy & Procedure for Collections & Patient Assistance

4.3.3 Documentation Supplementing the Application. ABC need not request documentation to support the patient's statements on the application in every case. ABC will require supplemental documentation for applications completed verbally. Also, in the event the Manager has any doubts regarding the accuracy and validity of an application, ABC will require the patient to submit documentation evidencing a financial hardship. In such events, ABC will request a copy of the patient's tax return and/or other evidence of the patient's financial need, which may include evidence of:

a. Homelessness;

b. Enrollment in Women, Infants, and Children (WIC) programs;

c. Receipt of food stamps;

d. Participation in a subsidized school lunch program;

e. Participation in an unfunded state or local assistance program;

f. Residence in low income, subsidized housing; or

g. Other evidence of financial need, such as pay stubs or medical bills.

Policy & Procedure for Collections & Patient Assistance

4.3.4 Eligibility Criteria for Financial Hardship Waivers. The Manager will review the submitted documentation and determine whether the patient meets the criteria for a financial hardship waiver. The basis for any determination will be documented and kept in ABC's records. The eligibility criteria for financial hardship waivers are as follows:

a. Full Waiver. The patient is eligible for full waiver of the patient's cost-sharing obligation if the patient's gross family income is less than or equal to the applicable FPG. Under such circumstances, the patient may receive a full waiver. However, the Manager is not required to grant a full waiver; the Manager may determine that a partial waiver is appropriate.

Policy & Procedure for Collections & Patient Assistance

b. Partial Waiver. If the patient's gross family income is greater than the applicable FPB, but less than or equal to two times the applicable FPG, ABC may reduce the patient's cost-sharing obligations. The amount waived will depend upon the particular patient's circumstances. If the patient's gross family income is greater than two times the applicable FPG, ABC will presume that the patient is not eligible for patient assistance unless (i) the patient's family has unreimbursed medical expenses that exceed twenty percent (20%) of its gross family income or (ii) the patient demonstrates the existence of other extraordinary circumstances that justify a financial hardship waiver. Under such circumstances, the Manager may grant a partial waiver of the patient's cost-sharing obligation. The Manager has the authority to grant a full waiver in the event the Manager determines that such a waiver is justified by the patient's financial situation. The basis for any determination shall be thoroughly documented in ABC's records.

Policy & Procedure for Collections & Patient Assistance

4.3.5 Provision of Financial Hardship Waivers. If the patient meets the eligibility criteria, ABC may provide a financial hardship waiver unless the Manager determines that a financial hardship waiver is unnecessary or inappropriate in a particular case. For example, the Manager may decide that a financial hardship waiver is inappropriate because the patient falsified documentation or because the evidence of financial need is unreliable. ABC will promptly notify the patient of the Manager's determination regarding the patient's application.

4.3.6 Documentation. ABC will maintain copies of all applications and supplemental documentation submitted by patients. ABC will document and maintain records concerning (i) the amount of a waiver provided to a patient and (ii) the basis for ABC's decision.

Policy & Procedure for Collections & Patient Assistance

4.3.7 Yearly Review of Financial Hardship Waivers Granted. Each calendar year, the Manager will evaluate the number of patients receiving financial hardship waivers from ABC. If the number of such patients is approximately ten percent (10%) or more of the patient population served by ABC in that year, then the Manager will take steps to ensure that ABC is not unnecessarily waiving cost-sharing obligations. For example, the Manager may retrain staff on this policy and require supplemental documentation for all applications before ABC grants a financial hardship waiver.

Policy & Procedure for Collections & Patient Assistance

4.4 Waivers Following Good Faith Collection Efforts.

ABC may write off the cost-sharing obligation of a patient who does not qualify for a financial hardship waiver only if (i) the patient's cost-sharing obligation remains unpaid after 120 days and (ii) ABC exercised and documented the following collection efforts:

4.4.1 Initial Invoice. After ABC provides services to a patient, ABC will issue to the patient an invoice detailing the amount of the patient's cost-sharing obligation.

4.4.2 Second Invoice. If the patient fails to pay the cost-sharing obligation within 30 days, ABC will send to the patient a subsequent statement detailing the patient's outstanding balance.

Policy & Procedure for Collections & Patient Assistance

4.4.3 Telephone Contact and Third Invoice. If the cost-sharing obligation remains unpaid after 60 days, ABC will send a third billing statement. Within 10 days following the date of the letter, ABC will contact the patient by phone. Phone calls will be made until affirmative contact is established with the patient or the patient's representative. During the phone call, an ABC representative will (i) collect information concerning the reason for non-payment, (ii) solicit an agreement for a specific payment plan, and/or (iii) offer to provide an application for patient assistance. If the patient submits an application, ABC will promptly notify the patient of the Manager's determination. If the application is denied, or the patient does not submit an application, ABC will continue efforts to collect the patient's cost-sharing obligation.

4.4.4 Fourth Invoice. If the patient's obligation remains unpaid after 90 days, ABC will send a fourth billing statement.

Policy & Procedure for Collections & Patient Assistance

All invoices, telephone and in-person contacts regarding the patient's cost-sharing obligation will be documented in the patient's billing file. If a patient's cost-sharing obligation remains unpaid after 120 days, the Manager will review the documentation regarding ABC's collection efforts. The Manager may then direct an ABC representative to continue collection efforts, turn the account over to a collection agency, bring a collection lawsuit, refuse to provide products and services to the client in the future, or write off the obligation. The Manager may write off the obligation as long as the good faith collection efforts listed above are clearly documented in the patient's file.

V. **AUDITS**.

The billing and waiver procedures of ABC will be audited from time to time. Findings from such audits shall be submitted in writing to ABC's officers and directors. ABC's officers and directors may also engage an outside party to conduct an audit of ABC.

ACHC U®
EDUCATIONAL RESOURCES

DMEPOS

Contacting Patient's Family Members for Co-Payment

Contacting Patient's Family Members for Co-Payment

- Federal law requires a DME supplier to make a reasonable effort to collect copayments. Many state laws say the same thing. And most, if not all, commercial insurance contracts contain the same requirement. The intent behind this requirement is that if a patient has "skin in the game," then he will be a more selective consumer of products/services. Even if a 20% copayment is relatively small, if a patient must pay it, he will likely think about the need for the purchase before actually purchasing the product/service.

Contacting Patient's Family Members for Co-Payment

- Failure by a DME supplier to make a reasonable effort to collect copayments can lead to an enforcement action by the Department of Justice and Office of Inspector General under the:
  - federal anti-kickback statute,
  - federal beneficiary inducement statute, and
  - federal False Claims Act. Such failure can also lead to a contract termination and possible recoupment action by a commercial insurer.

Contacting Patient's Family Members for Co-Payment

- A DME supplier can waive or reduce a copayment on a patient-by-patient basis when the patient establishes a financial inability to pay. This type of financial hardship program cannot be advertised or otherwise suggested to the patient before he purchases a product/service. Rather, a financial hardship program can only be presented to the patient after he professes an inability to pay. Notwithstanding how well written and implemented a financial hardship program is, the evidence needs to show that the DME supplier is collecting a reasonable percentage of copayments.

Contacting Patient's Family Members for Co-Payment

- There are instances when the patient does not have the mental and/or physical capacity to respond to a request for payment of a copayment. For example, invoices sent to the patient (whether he is in his home or is in a long-term care facility) may remain unopened. It is logical for the DME supplier to reach out to family members of the patient (e.g., adult children) for payment. But then the question arises of whether sending an invoice to a family member, or otherwise communicating with a family member about a copayment, is permitted by HIPAA. The answer falls into something of a gray area, but if the supplier's steps are conservative, the risk of a HIPAA enforcement action should be low.

Contacting Patient's Family Members for Co-Payment

- Ideally, the patient will provide a list of family members to whom the DME supplier can contact for payment. This will give the supplier the most protection under HIPAA. If the patient does not provide such a list, the risk is probably low under HIPAA if the supplier contacts a family member for payment so long as the information provided to the family member is the minimum necessary for such payment.

Contacting Patient's Family Members for Co-Payment

- The relevant HIPAA section is 45 CFR 164.510(b). It states:
  - B. Standard: Uses and disclosures for involvement in the individual's care and notification purposes -
    1. Permitted uses and disclosures.
       i. A covered entity may, in accordance with paragraphs (b)(2), (b)(3), or (b)(5) of this section, disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information directly relevant to such person's involvement with the individual's health care or payment related to the individual's health care.

The Relevant HIPAA Section is 45 CFR 164.510(B) – It states:

ii. A covered entity may use or disclose protected health information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. Any such use or disclosure of protected health information for such notification purposes must be in accordance with paragraphs (b)(2), (b)(3), (b)(4), or (b)(5) of this section, as applicable.

2. Uses and disclosures with the individual present. If the individual is present for, or otherwise available prior to, a use or disclosure permitted by paragraph (b)(1) of this section and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it:

i. Obtains the individual's agreement;

ii. Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or

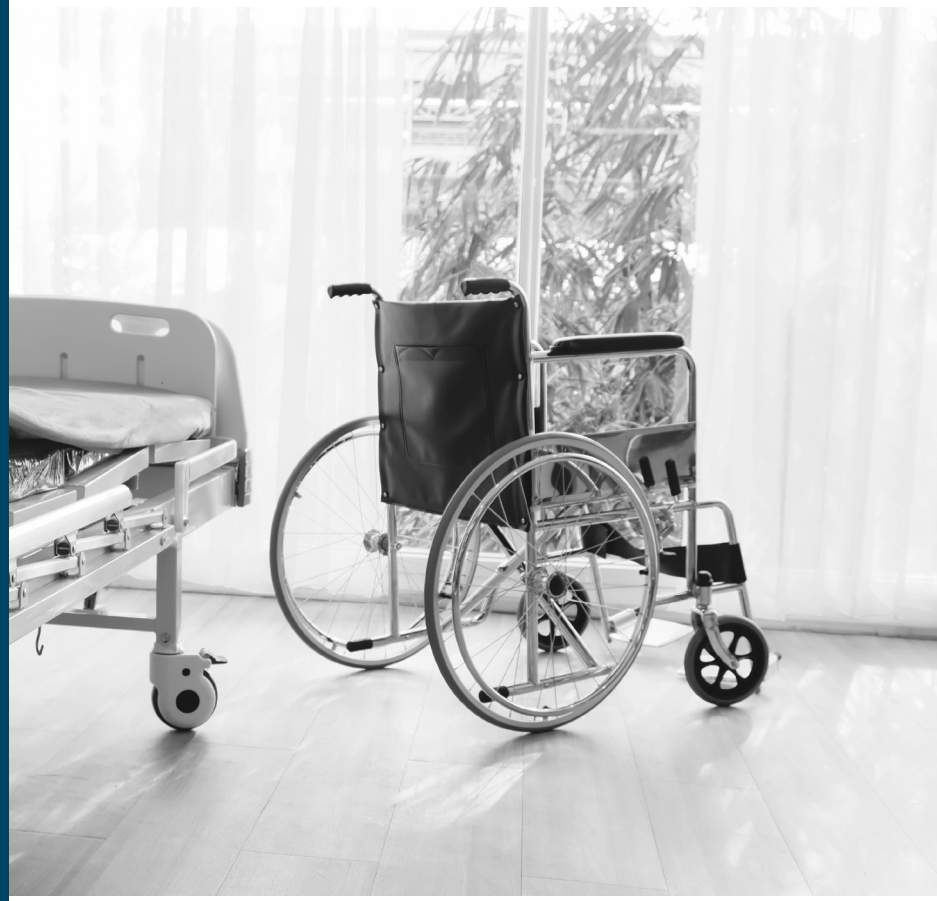
The Relevant HIPAA Section is 45 CFR 164.510(B) – It states:

iii. Reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure.

3. Limited uses and disclosures when the individual is not present. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's care or payment related to the individual's health care or needed for notification purposes. A covered entity may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

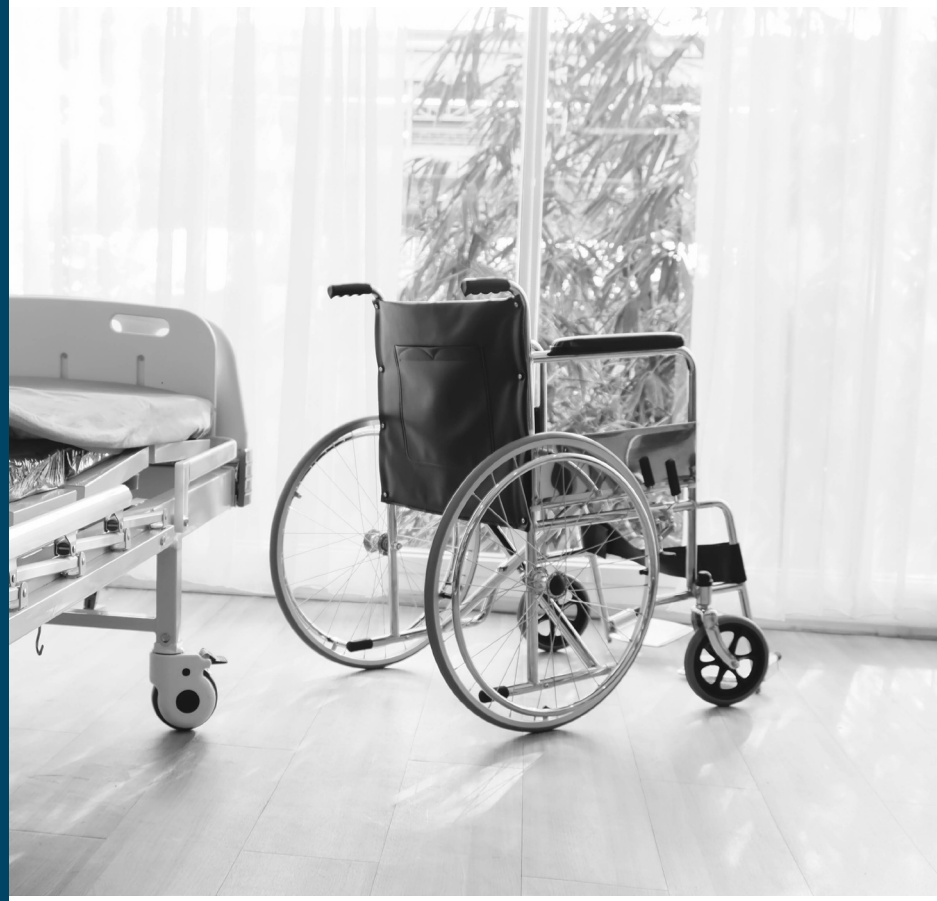
ACHC U®
EDUCATIONAL RESOURCES

Questions?



ACHC U®
EDUCATIONAL RESOURCES

DMEPOS



Thank you

Denise M. Leard, Esq.
dleard@bf-law.com | 806-345-6318

Brown & Fortunato
Amarillo · Dallas