

MEDICAL RECORDS, LIENS, & INSURANCE

PRESENTED BY CANDACE GLEED & SASHA CUNO



MEDICAL RECORDS

- Request Forms
- HIPPA Authorizations
- 78B-5-619 Patient Access to Medical Records—Third Party Access
- Hitech Act Requests



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RECORDS REQUEST FORM

TO:	Medical Records Custodian	FROM:	
OF:		DATE:	
FAX:			
PHONE		PAGES:	2
RE:			

Dear Records Custodian:

This office represents the above-named individual. Enclosed please find a release form executed by our client which authorizes you to release any and all information that you may have regarding the above.

****MEDICAL RECORDS****

At this time, we are requesting a complete copy of any and **all medical records** that you have, or may have access to including, but not limited to, **opinion reports, records, images, correspondence, x-rays, hospital reports, physicians' reports, nurses' notes, laboratory results, in and out-patient clinic records, etc. beginning *****.**

****FILMS & IMAGES ****

At this time, we are requesting a complete copy of any and all **x-ray and imaging reports**, including but not limited to, **films, images, x-rays, imaging reports, studies, scans, MRIs, CTs, nuclear imaging, photos, ultrasounds, videos, etc. beginning *****.**

**** BILLING RECORDS ****

We are also requesting a complete copy of any and **all medical billing information including itemized billing statements and itemized UB-04 claim forms, detailing the total charges and balance due** that you have for services provided for the above as soon as possible **beginning *****.**

Please **fax** your invoice for copying services along with the requested documents to *****. We appreciate your cooperation and immediate attention to this matter. Should you have any questions or concerns, call *****|

Thank you,
***FIRM NAME**
***REQUESTER NAME**

BILLING REQUEST FORM

TO:	Records Clerk	FROM:	
OF:		DATE:	
EMAIL:			
PHONE		PAGES:	2
RE:			

Dear Records Custodian:

This office represents the above-named individual. Enclosed please find a HIPAA release form executed by our client which authorizes you to release any and all information that you may have regarding the above.

**** BILLING RECORDS ****

We are also requesting a complete copy of any and **all medical billing information including itemized billing statements and itemized UB-04 claim forms, detailing the total charges and balance due** that you have for services provided for the above as soon as possible **beginning ***** to *******.

Please **fax** your invoice for copying services along with the requested documents as soon as possible to *********, **or email to *******. We appreciate your cooperation and immediate attention to this matter. Should you have any questions or concerns, call *********.

Thank you,

Firm Name

HIPPA RELEASES

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA



Patient Name: _____ Health Record Number: _____

Date of Birth: _____ Social Security Number: _____

I, or my authorized representative, authorize the use or disclosure of personal health information (PHI) regarding my care and treatment as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. The PHI requested may include information relating to sexually transmitted disease, alcohol and drug abuse, mental health treatment, confidential HIV/AIDS related information, and genetic testing. **I hereby consent to the release of this information.**
2. I have the right to revoke this authorization at any time by writing to the health care provider listed on this authorization. The revocation will not apply to PHI which has already been released in response to this authorization. The revocation will not apply to my insurance company when law provides my insurer the right to contest a claim under my policy.
3. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
4. I may inspect or copy the PHI to be used or disclosed, as provided in 45 CFR 164.524. If I have questions about the disclosure of my PHI, I can contact the Health Information Manager at the office or facility named on this authorization.
5. Any PHI disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

6. Name and address of health provider or entity to release this information: _____
7. Name and address of person(s) or category of person to whom this information will be sent: Firm Name _____
8.a. Specific information to be released: <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records (HCFA forms & accounting ledgers), insurance records, records sent to you by other providers, and correspondence from other providers. <input type="checkbox"/> Other: _____
8.b. Authorization to Discuss Health Information I authorize the health provider or entity listed in 6 to discuss my PHI with the person(s) or category of person listed in 7.
9. Reason for release of information: Evaluation or adjudication of personal injury claim.
10. Date or event on which this authorization will expire: _____ If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months from the date of signature.

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, if requested. I, the undersigned, hereby certify that I have the authority to approve and sign this Authorization for Release of Health Information. A copy, a facsimile, or an electronic transmission of this Authorization shall serve with the same effect as an original.

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, Relationship to Client _____

STATE OF UTAH)
) : ss.
COUNTY OF _____)

On this ____ day of _____, 20____, before me, a notary public, personally appeared _____, who proved on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged (he/she) executed the same.

Notary Public

COST OF RECORDS

- Utah State Code 78B-5-618 outlines reasonable fees for records.
 - \$21.16 location fee
 - 53cents per page for the first 40 pages and 32 cents per page for each additional page.
- Check each invoice you receive to make sure it was billed accordingly.

Utah Code

Effective 5/12/2015

78B-5-618 Patient access to medical records -- Third party access to medical records.

- (1) Pursuant to Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R., Parts 160 and 164, a patient or a patient's personal representative may inspect or receive a copy of the patient's records from a health care provider as defined in Section 78B-3-403, when that health care provider is governed by the provisions of 45 C.F.R., Parts 160 and 164.
- (2) When a health care provider as defined in Section 78B-3-403 is not governed by Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R., Parts 160 and 164, a patient or a patient's personal representative may inspect or receive a copy of the patient's records unless access to the records is restricted by law or judicial order.
- (3) A health care provider who provides a copy of a patient's records to the patient or the patient's personal representative:
 - (a) shall provide the copy within the deadlines required by the Health Insurance Portability and Accountability Act of 1996, Administrative Simplification rule, 45 C.F.R. Sec. 164.524(b); and
 - (b) may charge a reasonable cost-based fee provided that the fee includes only the cost of:
 - (i) copying, including the cost of supplies for and labor of copying; and
 - (ii) postage, when the patient or patient representative has requested the copy be mailed.
- (4) Except for records provided by a health care provider under Section 26-1-37, a health care provider who provides a copy of a patient's records to a third party authorized to receive records:
 - (a) shall provide the copy within 30 days after receipt of notice; and
 - (b) may charge a reasonable fee, but may not exceed the following rates:
 - (i) \$21.16 for locating a patient's records, per request;
 - (ii) reproduction charges may not exceed 53 cents per page for the first 40 pages and 32 cents per page for each additional page;
 - (iii) the cost of postage when the third party has requested the copy be mailed; and
 - (iv) any sales tax owed under Title 59, Chapter 12, Sales and Use Tax Act.

WHAT IS THE HITECH ACT

- HITECH Act: Health Information Technology for Economic and Clinical Health Act
- Was passed as a part of the American Recovery and Reinvestment Act of 2009 with a goal to expand individual's rights to receive electronic copies of their health information at a reasonable price
- <https://www.theexpertinstitute.com/top-ten-rules-for-requesting-low-cost-medical-records-under-hitech-hipaa/>



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HITECH LETTER CONTENTS

- HITECH Letter Contents
- Patient Name and Address
- Health Care Provider's Name and Address
- Patient Date of Birth
- Patient Social Security Number
- Dates of Service
- Plain Letter (No Letterhead)
- Each Letter must have **client's original signature**
- HIPAA authorization not required
- Letter can be sent by Mail, Email, Fax

SAMPLE LETTER

My name is John Doe. I am a patient of University of Utah. Please provide me with a full and complete copy of my medical records, including all radiological films, billing records and other records maintained. ***It is specifically requested that you provide the record copies in .pdf format on CD, per the requirements of 45 C.F.R. § 164.524(c)(2)(ii), as amended effective September 23, 2013.*** As you know, this Federal regulation preempts Utah State law, and provides, in pertinent part:

“...[I]f the protected health information that is the subject of a request for access is maintained in one or more designated record sets electronically and if the individual requests an electronic copy of such information, the covered entity must provide the individual with access to the protected health information in the electronic form and format requested by the individual...”

As I'm sure you are aware, 42 U.S.C. § 17935(e)(2) and 45 C.F.R. § 164.524(c)(4) limit the cost of obtaining the records to the actual labor costs for reproducing them in the requested electronic format, the actual cost of the portable media (in this case, CD), and postage.

As allowed by 42 U.S.C. § 17935(e)(1), please send the records to *****, as follows:

Attorney Name **(DO NOT NAME LAW FIRM!)**

Law Firm Address

Salt Lake City, UT 84111

Thank you for your compliance with this request within 30 days of your receipt of this letter, as required by 45 C.F.R. § 164.524(b)(2)(i).



NON-COMPLIANCE

- Must try to obtain compliance before filing complaint
- Complaints filed with DHHS – OCR
 - Take anywhere from 3 months – 18 months to resolve
- Fines for non-compliance are very high – incentive to comply

ORGANIZATION

- Reviewing and organizing your records
- Finding hidden medical records
- Reviewing lien ledgers

LIENS & INSURANCE

Types of Liens

1. Hospital Lien
2. Private Health Care Lien
3. Medicaid Lien
4. Medicare Lien
5. Funding Lien
6. Attorney or Provider Lien



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HOSPITAL LIENS



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- Liens created by statute U.C.A. 38-7-1. Filed with District Court. (Cardon, MedData).

PRIVATE HEALTH CARE LIEN

SUBROGATION

- Liens/Right of recovery by private health insurers paying costs of care.
- Subrogation Actions may be brought by the insurer in the name of its insured 31A-21-108 (www.Utah.gov).
- We have a duty to notify our clients health insurance of the claim. This can be done by sending a letter of representation as well as a HIPPA release so that they will speak with you about any balances.

July 13, 2018

Subrogation Department
Select Health
Via fax (801) 442-0311

Re: [REDACTED]
Insured: [REDACTED]
ID# 80173774601

To Whom It May Concern,

Please be advised that this law firm has been retained to represent [REDACTED] for the injuries sustained as a result of an automobile crash of March 3, 2017. Please direct any and all future correspondence and inquiries directly to this office.

If you intend to assert a lien against any proceeds that may be collected in [REDACTED] case, please provide us with a lien ledger itemizing the charges you are requesting be reimbursed to Select Health.

Please do not hesitate to contact me with additional questions or concerns.

Sincerely,

[REDACTED]

MEDICAID/MEDICARE LIENS

- Medicaid Liens: for claims paid by State Medicaid.
- Medicare Liens: for claims paid by federal Medicare.
- Check/compare ledgers with your lists of providers.

COLLECTION AGREEMENT

This collection agreement is authorized by Utah Code Ann. Section 26-19-7(c)(1) and is entered into on the date of execution below, between the Utah Department of Human Services, Office of Recovery Services (ORS), and the attorney and recipient identified below:

Law Firm: [REDACTED]
Attorney: [REDACTED]
Address: [REDACTED]
Phone: SALT LAKE CITY, UT 84111-1919
(801)531-2000

Recipient:
Address:
Phone:

ORS Case #: C
ORS Agent: [REDACTED]
Address: C/O 515 E 100 S
PO BOX 45025
SALT LAKE CITY,
UT 84145-0025
Phone: (801)536-8798
Extension: 14749

Description of Incident: BODILY INJURY
Incident Date: 09/20/2017
Incident Location: UTAH
Potential Obligated Third Party(s): PLEASE PROVIDED
Estimated Medicaid Claim Amount: \$7,348.13

(NOTE: The Medicaid claim amount may change as bills are received and paid; ORS will update claim amounts.)

ORS, on behalf of the Utah State Department of Health, Division of Health Care Financing is charged with enforcing the statutory claim pursuant to Utah Code Ann. Section 26-19-5. Attorney is representing the recipient in the incident described above to recover damages for the recipient. Recipient has received (or will receive) medical assistance from the State of Utah and has assigned his/her rights to the Department of Health/ORS for recovery of medical assistance paid, or to be paid, for which the above-named third party may be obligated.

Wherefore, it is agreed as follows:

1. **CONSENT:** Upon execution of this Collection Agreement, ORS agrees that the Attorney and Recipient may include medical costs paid by the State of Utah when making a claim against a third party for recovery of medical costs for an injury, disease, or disability.
2. **MEDICAID CLAIM:** Attorney and Recipient acknowledge the State's Medicaid claim for the medical expenses paid or to be paid on behalf of the Recipient and its direct right of recovery against proceeds payable by an

Page 1 of 4
Initials: Attorney [Signature] Recipient [Signature] ORS [Signature]

tc

75.8%

vk

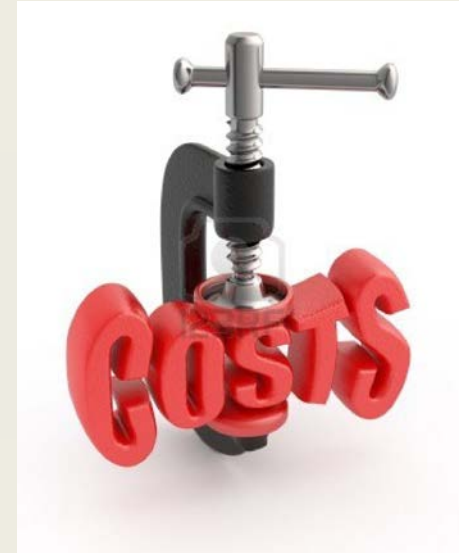
FUNDING LIENS

- Liens or Sums paid by Third Party Lenders for care/expenses



REDUCTION REQUESTS

- Standard Requests is a 1/3 reduction
- Standard Documents provided with requests:
 1. Police Report
 2. Settlement Agreement/Potential Outcome of Case
 3. Cost Ledgers
 4. Complete List of all Liens Against Settlement
 5. Letter from Treating Physician Regarding the Extent of Injuries
 6. Expert Reports from Life Care Planners/Economists for Future Care Needs



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REDUCTIONS FROM CARDON

The screenshot shows the ChartSwap website interface. At the top, there's a navigation bar with 'Home', 'Cart', 'Reports', 'Help', and 'Check Request Status'. A search bar is present with the text 'Search all Requests'. Below the navigation, a large grey box contains the heading 'Begin your request by searching for a Provider'. Inside this box, there's a search input field with 'cardon' entered, a dropdown menu, and a 'Search for Provider' button. To the right of the search box is a help tooltip with instructions on how to use the search function. Below the search box, it says '1 - 20 of 31' and 'Page 1 of 2'. The main content area displays '31 results for "cardon"' and a table of results. The table has columns for Provider, Attention, Facility Location, Address, Dates, and Record Types. Each row includes 'Add Favorite' and 'New Request' buttons. The bottom of the page shows a taskbar with several open files: 'SUPREME COURT...pdf', 'WEEK6.pdf', '43509412_101561...jpg', and 'Med Recs.jpg'.

Provider	Attention	Facility Location	Address	Dates	Record Types		
Intermountain Healthcare (IHC)	Intermountain Medical Center	Utah	5121 Cottonwood Street Murray, UT 84107	NA - Present	Balance Verification and Lien Reduction	Add Favorite	New Request
Intermountain Healthcare (IHC)	McKay-Dee Hospital	Utah	4401 Harrison Boulevard Ogden, UT 84403	NA - Present	Balance Verification and Lien Reduction	Add Favorite	New Request
University of Utah Hospital - Salt Lake City		Utah	50 N Medical Dr Salt Lake City, UT 84112	NA - Present	Balance Verification and Lien Reduction	Add Favorite	New Request
Intermountain Healthcare (IHC)	Dixie Regional Medical Center	Utah	1380 East Medical Center Drive St. George, UT 84790	NA - Present	Balance Verification and Lien Reduction	Add Favorite	New Request
Intermountain Healthcare (IHC)	Utah Valley Hospital (formerly Utah Valley Regional Medical Center)	Utah	1034 North 500 West Provo, UT 84604	NA - Present	Balance Verification and Lien Reduction	Add Favorite	New Request
Intermountain	Riverton Hospital	Utah	3741 West 12600 South	NA - Present	Balance	Add Favorite	New Request

- To request Cardon lien reductions you must now use Chart Swap

THE END

For any questions

Candace: cgleed@egclegal.com

Sasha: scuno@egclegal.com