Patient’s Right to Request Restriction to Health Plan
“Self-Pay Restriction”
Frequently Asked Questions

What is Washington University Physicians obligation to this rule?

A covered entity must agree to an individual’s request to restrict disclosure to health plan if the individual or person on individual’s behalf pays for the item or service out of pocket in full:

- For payment or healthcare operations
- Unless required by law

Do we need to separate those medical records under this restriction?

The provisions do not require that covered healthcare providers create separate medical records or otherwise segregate protected health information subject to a restricted healthcare item or service.

If we do not have to segregate records how will staff know what is restricted?

Healthcare providers will need to employ some method to flag or make a notation in the record with respect to the PHI that has been restricted to ensure such information is not inadvertently sent to or made accessible to the health plan for payment or healthcare operations such as audits by the health plan. The patient’s Allscript chart will be flagged with the alert “Restricted Health Information”

A new FSC has been created for use only with the Request for Restriction to Health Plan. The FSC is “RHI” for restricted health information. Once the patient has placed his/her request for the restriction, department staff will need to update the patient’s account with RHI as the plan for the visit and fax the completed Request for Restriction form to the HIPAA Privacy Office and to Physician Billing Services. The HIPAA Privacy Office will set the restriction alert on the patient’s account and PBS staff will set up a case for the visit.

What about Medicare and other disclosures required by law?

The final rule continues to allow disclosures that are otherwise required by law, notwithstanding that an individual has requested a restriction.

- If a provider is required by State or other law to submit a claim to a health plan for a covered service, and there is no exception or procedure for individuals wishing to pay out of pocket for the service, then the disclosure is required by law and is an exception to the right to request a restriction.
There is an exception to the Medicare rule where a beneficiary refuses to authorize the submission of a bill to Medicare. In such cases a provider is not required to submit a claim to Medicare for the service.

**How do I handle a request to restrict a service or item that may be bundled with others?**

Providers are expected to counsel patients on the ability of the provider to unbundle items or services and the impact of doing so. If a provider is able to unbundle the item or service and accommodate the individual’s wishes it should do so. If a provider is unable to unbundle items or services then the individual should be given the opportunity to restrict and pay out of pocket for the entire bundle of times or services.

- Items that are unbundled may be identified by the payer based on contracts.

**What is our obligation to inform other providers involved in the care of a request?**

Although not required, providers are encouraged to counsel patients that they would need to request a restriction and pay out of pocket with other downstream providers for the restrictions to apply to the disclosures by such providers.

- In cases concerning a prescribed medication, the prescribing provider can provide the patient with a paper prescription to allow the individual an opportunity to request a restriction and pay the pharmacy before it has submitted a bill to the health plan.

**What if the individual fails to pay for the service or item?**

Providers are required to make a reasonable effort to secure payment from the individual, prior to billing a health plan. If the restriction is related to outpatient services, our policy requires the patient to pay in full at the time of service. If the restriction is related to inpatient services and/or there is a charge that was not collected at the time of service, Physician Billing Services (PBS) will notify the patient of the balance and the patient will be expected to pay the balance in full within 30 days. If the patient fails to pay or refuses to pay, the restriction will be voided, and we may bill the patient’s insurance.