

2007 DRAFTING REQUEST

Bill

Received: **12/18/2007**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Health and Family Services 266-2907**

By/Representing: **Cheryl McIlquham**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters:

Subject: **Health - miscellaneous
Mental Health - miscellaneous**

Extra Copies:

Submit via email: **YES**

Requester's email: **McilqCJ@dhfs.state.wi.us**

Carbon copy (CC:) to: **robin.ryan@legis.wisconsin.gov**

Pre Topic:

No specific pre topic given

Topic:

Patient health care records and treatment records; ehealth

Instructions:

See Attached

Drafting History:

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Required</u>
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/P1			pgreensl 01/08/2008	_____	sbasford 01/08/2008		S&L
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/2	dkennedy	csicilia	pgreensl	_____	lparisi		S&L

↓
for assembly
& sent to
Rep. Masterson
per attached

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/4	dkennedy 02/07/2008	csicilia 02/07/2008	pgreensl 02/07/2008	_____	mbarman 02/07/2008		S&L
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intro*

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Handwritten notes:
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 [Signatures]

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/? dkennedy

Handwritten notes in the Drafting History table:

- Under Reviewed: 1/19/08
- Under Typed: 1/8/08
- Under Proofed: 1/8/08
- Under Submitted: [Signature]

FE Sent For:

<END>

Kennedy, Debora

From: McIlquham, Cheryl [McilqCJ@dhfs.state.wi.us]
Sent: Monday, December 17, 2007 8:53 AM
To: Kennedy, Debora
Subject: [Possible Spam] Drafting Request

Importance: Low

Hi Debora,
How are ya? Hope all is well w/ you as we head into the holidays.

I am working on some drafting instructions related to our eHealth Initiative that I'd like to talk with you about. We hope to send them over to you tomorrow or first thing on Wednesday.

Could you please give me a call on this? I want to make sure I'm following proper procedures on this as it is the first time I've had to do this in my new position (Director of the Office of Policy Initiatives and Budget...formerly, the Office of Strategic Finance, with Fredi Bove as the former Director).

Thanks much,
Cheryl

6-2907

* * * * *

NOTICE: This email and any attachments may contain confidential information. Use and further disclosure of the information by the recipient must be consistent with applicable laws, regulations and agreements. If you received this email in error, please notify the sender; delete the email; and do not use, disclose or store the information it contains.

* * * * *

Cheryl McIlquham, Director
Office of Policy Initiatives and Budget
Wisconsin Department of Health & Family Services
608-266-2907

Kennedy, Debora

From: McIlquham, Cheryl [McilqCJ@dhfs.state.wi.us]
Sent: Tuesday, December 18, 2007 8:35 AM
To: Kennedy, Debora
Cc: Farnsworth, Kathleen - DHFS; Webb, Denise B - DHFS
Subject: [Possible Spam] Statutory Language Request

Importance: Low

Attachments: LRB drafting instructions 51.30.pdf; LRB drafting instructions 146.pdf



LRB drafting instructions 51.3...



LRB drafting instructions 146....

Hi Debora,

As we discussed on the phone, I am sending the attached drafting instructions related to several privacy and security provisions of the statutes as it impacts our eHealth Initiative.

The drafting instructions were prepared by Beth DeLair (with our input/review). Beth is our primary consultant on these issues. She happens to also be an attorney. So, you'll notice that the instructions may be a bit more prescriptive than what you are accustomed to seeing from us in terms of references to the actual statutes.

Kathy Farnsworth is the primary contact for us. However, if you are not able to reach her, you may also contact me. In fact, if you could copy me on any correspondence to Kathy, that would be helpful. We will also keep Beth in the loop as we work together to complete these drafts.

Recognizing that the holidays are upon us, I am hoping you'll be able to take a first look at these this week yet so that we can at least begin to respond to any questions you may have. Kathy and I will both be around some next week, so would be able to do that while you are out. As I mentioned yesterday, our time frame is short as we would like to have this introduced during the January session.

Thanks in advance for your work on this.

Cheryl

* * * * *

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* * * * *

Cheryl McIlquham, Director
Office of Policy Initiatives and Budget
Wisconsin Department of Health & Family Services
608-266-2907

Changes to WI Stat. 51.30

Current Language

Current Wisconsin Statute 51.30(4)(b)8g permits the release the following health care information without patient consent:

To health care providers in a related health care entity, or to any person acting under the supervision of such a health care provider who is involved with an individual's care, if necessary for the current treatment of the individual. Information that may be released under this subdivision is limited to the individual's name, address, and date of birth; the name of the individual's mental health treatment provider; the date of mental health service provided; the individual's medications, allergies, and diagnosis; and other relevant demographic information necessary for the current treatment of the individual. In this subdivision, "related health care entity" means one of the following:

51.30(4)(b)8g.a.

An entity that is within a clinically integrated care setting in which individuals typically receive health care from more than one health care provider.

51.30(4)(b)8g.b.

An organized system of health care in which the health care providers hold themselves out to the public as participating in a joint arrangement and jointly participate in activities.

Proposed Change

1. Re-write 51.30(4)(b)g as follows:

To health care providers, or to any person acting under the supervision of such a health care provider who is involved with an individual's care, if necessary for the current treatment of the individual. Information that may be released under this subdivision is limited to the individual's name, address, and date of birth; the name of the individual's mental health treatment provider; the date of mental health service provided; the individual's medications, allergies, diagnosis; **diagnostics, symptoms**, and other relevant demographic information necessary for the current treatment of the individual.

2. Add the following definition under section 51.30(1):

“Diagnostics,” means, for purposes of this section, the clinical testing of biological parameters such as lab values, radiology tests, EKG’s etc. In this section, diagnostics does not mean psychological or neuropsychological testing such as IQ or personality testing.

The proposed changes reflect the removal of the phrase “in a related health care entity” and its accompanying definitions, and the addition of “diagnostics” and “symptoms” to the list of information that may be released without patient consent. The proposed change also adds a definition of “diagnostics” to clarify what is meant by the term.

Background and Rationale for Change

On November 2, 2005, Governor Doyle created the eHealth Care Quality and Patient Safety Board (“eHealth Board”) by Executive Order. Its purpose was to develop a strategic action plan for the statewide adoption and exchange of electronic health records in 5 years.

In response to the Executive Order, the eHealth Board developed the *Wisconsin eHealth Action Plan*, a roadmap for the adoption of electronic health records and exchange of health information in Wisconsin. The Action Plan states: “No patient should ever be harmed by lack of information at the point of patient care . . . [This] is a plan to save lives, improve the health status of the people of Wisconsin and achieve a better return on the investment in health care . . . Wisconsin, and the nation must achieve this vision.”

The *Wisconsin eHealth Action Plan* balances privacy rights with providers’ need to share information for safe effective treatment. A key concern identified in the Plan is the requirement to exchange the information in a way that is secure and promotes patient privacy and safety. In March of 2006, Wisconsin applied for the Health Information Security and Privacy Collaboration (“HISPC”) contract (a federal grant) to study and address the issues of privacy and security related to electronic exchange. Wisconsin was one of 34 states and territories awarded the contract. The resulting project is called the Wisconsin Security and Privacy Project.

Phase I of the Wisconsin Security and Privacy Project began in the fall of 2006. Four different workgroups were created. The workgroups were comprised of individuals representing various stakeholders (e.g. physicians, provider groups, associations, patient advocates, HIM professionals, law enforcement, attorneys etc.) affected by potential changes to current Wisconsin Law. The first workgroup reviewed 18 scenarios developed under the grant to identify current business practice related to health information exchange. The second workgroup took those same scenarios and analyzed applicable legal issues and barriers. The third workgroup was charged with developing proposed solutions to the barriers raised by the first two workgroups. The fourth workgroup was charged with developing a plan to implement the proposed solutions. The final workgroup of Phase I finished its work in March of 2007.

Prior to the completion of work under Phase I, in November of 2006, the Consumer Interests Advisory Group of the eHealth Board made the following recommendation: “Amend Wisconsin law governing disclosure of health information to providers to be consistent with HIPAA, which

does not require patient consent to disclose information to providers about mental health and

developmental disabilities for treatment purposes.” This recommendation was not unanimously supported. The eHealth Board strongly supported this recommendation, but noted the potential controversy and dissatisfaction by some stakeholders. The eHealth Board recommended holding its formal recommendation until further consideration in Phase I.

The final workgroup from Phase I had the following recommendations regarding perceived barriers to electronic health information related to WI stat. 51.30: (1) form a representative workgroup charged with identifying specific elements that can be exchanged among providers for treatment purposes without consent; and (2) Use 4 potential options for change that were generated by the final workgroup as the starting point for discussion in the Phase II workgroup.

Phase II of the Wisconsin Security and Privacy Project began in the summer of 2007 after additional funds were granted under the HISPC project. A workgroup consisting of mental health, developmental disability, and alcohol and drug providers and advocates, IT vendors, and others representing health care provider interests convened in August of 2007. Five, three hour meetings were held between August 9, 2007 and October 4, 2007. The workgroup considered the initial four proposed options from Phase I, one of which coincided with what the Consumer Interests Advisory Group of the e-Health Board recommended, and added additional options for consideration. The proposed changes listed above reflect the consensus decisions (not unanimous) of the workgroup.

Justification for each proposed change is as follows:

1. Remove “in a related health care entity” and add additional types of information that may be exchanged without consent to the current list

The above two changes reflect the changes to WI Stat. 51.30 that the various stakeholders in the Phase II workgroup agreed upon. Adding “diagnostics” and “symptoms” to the list of types of information that could be exchanged without consent enhances the quantity and quality of information that can be exchanged among providers under the proposed change. The workgroups discussed the value of adding these two additional elements, while minimizing privacy concerns.

Removing “in a related health care entity” significantly aids the electronic exchange of health information because under the proposed change, providers outside a “related health care entity” would be able to receive the types of information listed above without patient consent. This is important because often patients seek or need to obtain healthcare outside of the facility that they generally receive (e.g. for emergency or specialty services) and often these patients are not available or able to provide consent in order for their health information to be disclosed to a subsequent provider. By allowing the expanded list of types of information to be exchanged to providers outside a related health care entity, subsequent providers can have access to information (e.g. medications) important in their assessment and care of the patient presenting to them.

Although the 51.30 workgroup recommended changing 51.30(4)(b)(g) to include the phrase, “to health care providers with a need to know,” the proposed change does not use this exact

terminology because what is meant by “need to know” is reflected in current statutory language.

Current statutory language states “to health care providers, or to any person acting under the supervision of such a health care provider who is involved with an individual's care, if necessary for the current treatment of the individual.” “If necessary for the current treatment of the individual” is, in essence, what “need to know” means, and therefore captures the intent of the 51.30 workgroup.

2. Define Diagnostics

The Phase II workgroup agreed that the sharing of biological diagnostics (e.g. laboratory tests, EKG's, radiology tests etc) was important for the quality and safety of care provided to patients. However, a number of stakeholders expressed concern that psychological or neuropsychological testing not be included in the definition of “diagnostics” because such testing is often of a very sensitive nature and does not really affect the assessment and delivery of clinical care in any way. The proposed definition reflects this concern and consensus decision.

Desired Effective Date: 6 months after passage or January 1, 2009, whichever is later
Agency: DHFS
Agency Contact: Kathy Farnsworth
Phone: 267-2082

12/27/07
3:32 p.m.

Kennedy, Debora

To: McIlquham, Cheryl J - DHFS; Farnsworth, Kathleen - DHFS
Subject: Patient treatment records; review of drafting request

I have reviewed your proposed changes to s. 51.30 (4) (b) 8g., stats., and have these questions or comments:

1. The term "treatment records" is defined under s. 51.30 (1) (b) to be "registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence" Nevertheless, s. 51.20 (4) (b) 8g. (intro.), stats., refers only to an individual's "mental health treatment provider" and "mental health service" provided. Do you want this expanded to refer to treatment or services for developmental disabilities, alcoholism, or drug dependence?

2. Your proposal is that the definition of "diagnostics" be created under s. 51.30 (1), stats.; the effect of placement of the definition here is to apply it wherever the term is used throughout s. 51.30, stats. Yet it is in fact used only in s. 51.30 (4) (b) 8g. I believe it should be defined for that subdivision only; if, at a later date, the term is used in another part of the section, it can then be defined for the section as a whole.

3. As to the wording of the definition:

A. It is unnecessary to include "for the purposes of this section"; that is usually handled by the words "In this section [subsection, paragraph, subdivision, etc.]".

B. It seems to me that "diagnostics," as used in the context proposed, does not mean "testing"; instead it means the results of testing. And, in looking at other statutes in which the term is used, it seems more appropriate to use the term "diagnostic evaluation".

Therefore, I would propose:

"In this subdivision, "diagnostic evaluation" means the results of clinical testing of biological parameters, such as laboratory values, radiology tests, and electrocardiograms [do you mean EEG--electroencephalogram--rather than EKG?].

"Diagnostic evaluation" does not mean the results of psychological or neuropsychological testing, such as intelligence quotient or personality testing."

I'm continuing to work on this proposal and will send you my questions or comments about the proposed changes to ch. 146, stats., as soon as I can.

Debora A. Kennedy

Managing Attorney
Legislative Reference Bureau
(608) 266-0137
debora.kennedy@legis.state.wi.us

Kennedy, Debora

From: Postmaster@dhfs.state.wi.us on behalf of Cheryl McIlquham [McilqCJ@dhfs.state.wi.us]
Sent: Thursday, December 27, 2007 3:32 PM
To: Kennedy, Debora
Subject: Re: Patient treatment records; review of drafting request (Outof Office)

I will be out of the office on Friday, December 21 and Thursday and Friday, December 27 - 28.

For urgent matters that cannot wait until I return, please call Kelly Starr in the Office of Policy Initiatives and Budget at 608-266-3816.

Thank you.

>>> Debora.Kennedy 12/27/07 15:31 >>>

I have reviewed your proposed changes to s. 51.30 (4) (b) 8g., stats., and have these questions or comments:

1. The term "treatment records" is defined under s. 51.30 (1) (b) to be "registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence" Nevertheless, s.

51.20 (4) (b) 8g. (intro.), stats., refers only to an individual's "mental health treatment provider" and "mental health service" provided.

Do you want this expanded to refer to treatment or services for developmental disabilities, alcoholism, or drug dependence?

2. Your proposal is that the definition of "diagnostics" be created under s. 51.30 (1), stats.; the effect of placement of the definition here is to apply it wherever the term is used throughout s. 51.30, stats. Yet it is in fact used only in s. 51.30 (4) (b) 8g. I believe it should be defined for that subdivision only; if, at a later date, the term is used in another part of the section, it can then be defined for the section as a whole.

3. As to the wording of the definition:

A. It is unnecessary to include "for the purposes of this section"; that is usually handled by the words "In this section [subsection, paragraph, subdivision, etc.]".

B. It seems to me that "diagnostics," as used in the context proposed, does not mean "testing"; instead it means the results of testing. And, in looking at other statutes in which the term is used, it seems more appropriate to use the term "diagnostic evaluation".

Therefore, I would propose:

"In this subdivision, "diagnostic evaluation" means the results of clinical testing of biological parameters, such as laboratory values, radiology tests, and electrocardiograms [do you mean EEG--electroencephalogram--rather than EKG?]. "Diagnostic evaluation" does not mean the results of psychological or neuropsychological testing, such as intelligence quotient or personality testing."

I'm continuing to work on this proposal and will send you my questions or comments about the proposed changes to ch. 146, stats., as soon as I can.

Debora A. Kennedy
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Changes to WI Stat. 146.81-146.83

Current Language

Wisconsin Statute 146.81-146.84 governs “general” health information. Currently, Wisconsin law includes the following relevant provisions:

1. 146.82(2)(d)
For each release of patient health care records under this subsection, the health care provider shall record the name of the person or agency to which the records were released, the date and time of the release and the identification of the records released.

146.83(3)

The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

2. 146.82(2)(b)
Except as provided in s. 610.70 (3) and (5), unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.
3. 146.81(4) “Patient health care records” means all records related to the health of a patient prepared by or under the supervision of a health care provider. . . .

146.82(1) Confidentiality. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient. This subsection does not prohibit reports made in compliance with s. 146.995, 253.12 (2) or 979.01; testimony authorized under s. 905.04 (4) (h); or releases made for purposes of health care operations, as defined in 45 CFR 164.501, and as authorized under 45 CFR 164, subpart E.

146.836 Applicability. Sections 146.815, 146.82, 146.83 (4) and 146.835 apply to all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics.

Proposed Change

1. Delete Wisconsin Statutes 146.82(2)(d) and 146.83(3)(c)

2. Re-write and renumber 146.82(2)(b) as follows: ?

Create
Sub (4)
?

146.82(c) Re-disclosure

what to do about current (2)(c) ?

(1) Covered entities as defined under 45 C.F.R. § 160.103 may re-disclose the health information it receives pursuant to this section without patient consent if the purpose for the re-disclosure is otherwise permitted by this section.

(2) Individuals and organizations that do not meet the definition of covered entity as defined under 45 C.F.R. § 160.103 may only re-disclose the patient health information it receives pursuant to this section provided:

- (a) the patient or their legally authorized representatives provides written consent to do so;
- (b) a court order requires re-disclosure; or
- (c) the re-disclosure is limited to the purpose for which the information was initially obtained.

3. Add 146.82(2)(am) Releases for Involvement in the Patient's Care and Notification Purposes.

1. Permitted releases to person's involved in the patient's care.

a. Notwithstanding sub. (1), a health care provider may, in accordance with paragraphs (am) 2 or 3 of this section, release to a family member, other relative, or a close personal friend of the patient, or any other person identified by the patient, those portions of patient health care records directly relevant to such person's involvement with the patient's care, except the health care provider may not release copies of the patient health care record pursuant to this 146.82(2)(am).

what does this mean ?

b. Notwithstanding sub. (1), a health care provider may release those portions of the patient health care records necessary to notify, or assist in the notification of (including identifying or locating), a family member, or another person responsible for the care of the patient of the patient's location, general condition, or death. Any such release of healthcare records for such notification purposes must be in accordance with paragraphs (am)(2) or (3) of this section, as applicable.

2. Releases with the patient present. If the individual patient is present for, or otherwise available prior to a release permitted by paragraph (am)(1) of this section, and has the capacity to make health care decisions, the health care provider may release the patient health care records if it obtains the patient's agreement.

3. Releases when the patient is not present. If the patient is not present or the opportunity to obtain agreement cannot practicably be provided because of the patient's incapacity or an emergency circumstance, the health care provider may, in the exercise of

professional judgment, determine whether the release is in the best interest of the patient, and if so, release only those portions of the patient health care records that are directly relevant to the person's involvement in the patient's health care, except that the health care provider may not release copies of patient health care records to the person pursuant to this subsection.

Current statutory language uses the phrase, "health care records," not "health care information." However, proposed change # 3 is really trying to permit the release of health care information, not the actual records (releases of copies from the medical record would still require patient consent). As currently defined and used under 146.81-146.84, "health care records" renders proposed change #3 somewhat confusing or awkward. It may be worth considering making changes to the definition of "health care records" and/or adding a definition for "health care information."

Background and Rationale for Change

On November 2, 2005, Governor Doyle created the eHealth Care Quality and Patient Safety Board ("eHealth Board") by Executive Order. Its purpose was to develop a strategic action plan for the statewide adoption and exchange of electronic health records in 5 years.

In response to the Executive Order, the eHealth Board developed the *Wisconsin eHealth Action Plan*, a roadmap for the adoption of electronic health records and exchange of health information in Wisconsin. The Action Plan states: "No patient should ever be harmed by lack of information at the point of patient care . . . [This] is a plan to save lives, improve the health status of the people of Wisconsin and achieve a better return on the investment in health care . . . Wisconsin, and the nation must achieve this vision."

The *Wisconsin eHealth Action Plan* balances privacy rights with providers' need to share information for safe effective treatment. A key concern identified in the Plan is the requirement to exchange the information in a way that is secure and promotes patient privacy and safety. In March of 2006, Wisconsin applied for the Health Information Security and Privacy Collaboration ("HISPC") contract (a federal grant) to study and address the issues of privacy and security related to electronic health information exchange. Wisconsin was one of 34 states and territories awarded the contract. The resulting project is called the Wisconsin Security and Privacy Project.

Phase I of the Wisconsin Security and Privacy Project began in the fall of 2006. Four different workgroups were created. The workgroups were comprised of individuals representing various stakeholders (e.g. physicians, provider groups, associations, patient advocates, HIM professionals, law enforcement, attorneys etc.) affected by potential changes to current Wisconsin Law. The first workgroup reviewed 18 scenarios developed under the grant to identify current business practice related to health information exchange. The second workgroup took those same scenarios and analyzed applicable legal issues and barriers. The third workgroup was charged with developing proposed solutions to the barriers raised by the first two workgroups. The fourth workgroup was charged with developing a plan to implement the proposed solutions. The final workgroup of Phase I finished its work in March of 2007.

Phase II of the Wisconsin Security and Privacy Project began in the summer of 2007. One set of recommendations from Phase I of the Project included making legislative changes to Wisconsin statutes 146.82 and 146.83. These proposed changes are intended to help facilitate electronic exchange of patient information as well as bring Wisconsin Statutes more in line with HIPAA. Phase II of Project required that these proposed changes be presented to a number of stakeholders potentially affected by the changes. A Privacy Consultant working on behalf of the Department of Health and Family Services met with a number of potentially affected stakeholders to discuss proposed changes to WI Stat. 146.82 and 146.83. The proposed changes listed above reflect compromise positions based on discussions with potential stakeholders.

Justification and Rationale

Justification for each proposed change is as follows:

1. Delete WI. Stats. 146.82(2)(d) and 146.83(3)(c)

Wisconsin law requires the documentation of *every* disclosure of patient health care records, whether oral, written, or electronic made pursuant to sections 146.82 and 146.83. These provisions are similar, yet different to requirements under the federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

HIPAA does not require tracking for all disclosures of patient health care information. Under HIPAA, health care providers do not have to track disclosures for purposes related to treatment (providing and coordinating care), payment (billing for services rendered), or health care operations (internal business), or for any disclosure made pursuant to a written authorization. However, HIPAA does require tracking of disclosures of patient health information that may be of more concern to consumers—disclosures that the patient might not think is permitted or required to be made. Examples of disclosures that would have to be tracked, or documented, include, but are not limited to, disclosures made that are required or permitted by law (e.g. mandatory child and elder and adult-at-risk-abuse, and public health reporting), disclosures to law enforcement and coroners, and disclosures for research activities.

Moreover, HIPAA affirmatively provides patients with a right to request an “accounting” of those disclosures required to be tracked. Wisconsin law, on the other hand, does not clearly provide patients with an affirmative right to access or see what a health care provider has documented regarding disclosures of their health care information. Wisconsin law requires providers to grant patients or their legally authorized representatives access to their medical record; however, Wisconsin law does not dictate that information required for tracking purposes under the statutory provisions cited above be included in the medical record, and thus, available to the patient. Anecdotally, numerous stakeholders have indicated that patients do not exercise their right to an accounting of disclosures as permitted under HIPAA. Wisconsin law governing documentation of disclosures is viewed by affected parties as administratively burdensome, unrealistic, and time consuming, while providing no apparent benefit. Additionally, since Wisconsin law regarding documentation of disclosures of patient health information differs from federal law, compliance with both laws is challenging.

Deleting these provisions would have the effect of having HIPAA's documentation requirements prevail via pre-emption. This proposed change to Wisconsin law is intended to ease provider's administrative burdens and clarify what and when tracking is required when disclosing patient health care information, while retaining a patient's right to an accounting of disclosures under federal law.

Why not say so?

2. Re-write 146.82(2)(b)

This provision under Wisconsin law addresses re-disclosure of patient health care information. Wisconsin Stat. 146.82(2)(a)(2) allows health care providers to receive patient health care information without the patient's consent for any purpose related to providing care to the patient. However, Wisconsin Stat. 146.82(2)(b) prohibits a health care provider that has received patient health care information from an outside institution from re-disclosing that same information to a subsequent health care provider. This prohibition has a significant impact on electronic exchange based on how electronic health care systems are configured and how exchange is likely to occur via different models for electronic exchange. For example under current law, Meriter hospital could receive health information of a patient from UW and may incorporate that information into its record. However, if St. Mary's then requested information from Meriter about that same patient, Meriter could release its "own" information about that patient to St. Mary, but could not release the information it had on the patient it received from UW.

The proposed change allows for re-disclosure for treatment purposes, which is an important and necessary step to help facilitate the exchange of patient health information electronically. The proposed change makes a distinction between how re-disclosure is permitted based on whether the individuals and/or organizations are covered entities under HIPAA or not. This distinction is made to create additional protections where privacy protections might otherwise be lost by simply allowing re-disclosure under any circumstance. Organizations and individuals that meet the definition of covered entities are required under federal law to have policies and procedures in place that protect patient health care information. Individuals and organizations that do not meet the definition of covered entities under HIPAA are not required to have policies and procedures that protect health information. For example, a State department or agency may receive patient health care information for public health purposes. However, that agency may not meet the definition of a covered entity under HIPAA, and therefore, may not have policies and procedures requiring it protect health information. Limiting re-disclosure by this agency helps to maintain some protections of health information that would not otherwise be present because of a lack of required policies and procedures.

3. Releases for Involvement in the Patient's Care and Notification Purposes.

This proposed change addresses disclosures of patient health care information to family and friends "involved in the care of the patient." Currently, state and federal law have contradictory provisions.

Wisconsin law requires written consent from the patient or the patient's legally authorized representative before disclosing information in these and other similar situations. HIPAA, on the other hand, recognizes that one or more individuals may be "involved in the care of the

patient” and creates provisions that make it easier for a health care provider to disclose health care information about that patient commensurate with that individual’s involvement in the patient’s care. For example, a spouse or significant other may accompany a patient to the emergency room and would like to know what has happened to the patient, what their prognosis might be, and what the treatment plan is. Similarly, an adult child might be responsible for coordinating care for their elderly parent and may need to know clinic visit dates and times, laboratory tests and results, as well as medications.

HIPAA requires that when patient health care information is being disclosed to family and/or friends, either the patient agrees or has the right to object to the disclosure, or the health care provider uses his or her professional judgment and determines that the patient does not object to the disclosure or that the disclosure is in the patient’s best interest. The amount of information disclosed is limited to that person’s involvement in the care of the patient.

The proposed change is more closely aligned with HIPAA than current state law. Language proposed above is based heavily on language found currently in HIPAA. However, the proposed change requires that health care providers obtain the patient’s agreement (as opposed to the formal requirement of written consent) to disclose information to family and friends involved in the patient’s care unless the patient was not present or cognitively able to provide such agreement. By drafting an “agreement” standard rather than an “informed consent” standard, providers will have flexibility in creating an informal process, such as verbally asking permission or having some kind of form that documents a patient’s wishes regarding who information can be shared (or who it cannot be shared with). If the patient is not physically or cognitively able to provide such permission, then the clinician may use his or her professional judgment to decide whether the disclosure is in the patient’s best interests. Under the proposed change, informed consent would still be required for a health care provider to release copies of patient health care records to family and friends involved in the care of the patient.

Although not specifically discussed, proposed change 146.82(2)(am)(1)(b) is included in this draft because a parallel provision exists in HIPAA, and the circumstances described in this provision is consistent with the intent and rationale for permitting disclosures under this section (146.82(2)(am)) generally. Arguably, the provisions under proposed 146.82(2)(am)(1)(a) could be broadly construed as including circumstances contemplated by proposed change 146.82(2)(am)(1)(b). However, because a parallel provision exists under HIPAA, providers attempting to implement these proposed changes might think that since this specific provision (governing notification) exists in HIPAA but not in State law, that state law would not permit this kind of disclosure. Thus, proposed change 146.82(2)(am)(1)(b) was added in order to avoid any confusion regarding whether these types of disclosures could be made or not.

The statutory placement of this proposed change is at 146.82(2)(am) because of existing language and statutory construction of 146.82(1) and 146.82(2). 146.82(1) requires all patient health care records be released only to those “persons . . . with the informed consent of the patient . . .” Thus, any new delineated disclosures would have to fall under 146.82. The proposed change does not really fit under 146.82(a), because it says, “notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the

following circumstances.” However, the proposed change is closely related to 146.82(2), and should thus be placed in proximity to it.

Desired Effective Date: Upon passage
Agency: DHFS
Agency Contact: Kathy Farnsworth
Phone: 267-2082

1/4/08 10:15 a.m.

Kennedy, Debora

To: McIlquham, Cheryl J - DHFS
Cc: Farnsworth, Kathleen - DHFS
Subject: RE: Patient treatment records; review of drafting request

Cheryl:

You have asked whether the legislation will be "ready to go" by the week of the 14th. I am unable to answer that question. At this point, I have received nothing from DHFS other than an acknowledgement of receipt of the e-mail I sent with numerous questions on Thursday, Dec. 27, more than a week ago.

Right now, I am completing my preliminary drafting of the DHFS proposed changes to ch. 146, stats. I have numerous questions about and comments on the material proposed. I intend to have this material into editing today; I will incorporate into it my questions about the proposed changes to s. 51.30 and any drafting that I can do to that section. I will ask that the material be edited, typed, and submitted to you by Tuesday. Note that the draft will be a preliminary draft and not introducible; I am not sure that I will have time to include in it an analysis by the end of today. I have, obviously, placed it as a priority for my work, in the face of legislative requests I received before this one.

Debora Kennedy

-----Original Message-----

From: Cheryl McIlquham [mailto:McilqCJ@dhfs.state.wi.us]
Sent: Friday, January 04, 2008 8:59 AM
To: Farnsworth, Kathleen - DHFS; Kennedy, Debora
Subject: Re: Patient treatment records; review of drafting request

Hi Debora,
How are things going on all this? Are you getting what you need from us?

I wanted to ask you if you'll be able to send the first draft over by next week sometime? Since we last talked, we have been communicating with the Gov's Office on this. They are very interested in us having this legislation in hand and ready to go by the week of the 14th. Could you please let me know if this is doable?

Thanks Debora.

* * * * *

NOTICE: This email and any attachments may contain confidential information. Use and further disclosure of the information by the recipient must be consistent with applicable laws, regulations and agreements. If you received this email in error, please notify the sender; delete the email; and do not use, disclose or store the information it contains.

* * * * *

Cheryl McIlquham, Director
Office of Policy Initiatives and Budget
Wisconsin Department of Health & Family Services
608-266-2907

>>> "Kennedy, Debora" <Debora.Kennedy@legis.wisconsin.gov> 12/27/2007
>>> 3:31 PM >>>

I have reviewed your proposed changes to s. 51.30 (4) (b) 8g., stats., and have these questions or comments:

1. The term "treatment records" is defined under s. 51.30 (1) (b) to be "registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence"

Nevertheless, s.

51.20 (4) (b) 8g. (intro.), stats., refers only to an individual's "mental health treatment provider" and "mental health service" provided.

Do you want this expanded to refer to treatment or services for developmental disabilities, alcoholism, or drug dependence?

2. Your proposal is that the definition of "diagnostics" be created under s. 51.30 (1), stats.; the effect of placement of the definition here is to apply it wherever the term is used throughout s. 51.30, stats. Yet it is in fact used only in s. 51.30 (4) (b) 8g. I believe it should be defined for that subdivision only; if, at a later date, the term is used in another part of the section, it can then be defined for the section as a whole.

3. As to the wording of the definition:

A. It is unnecessary to include "for the purposes of this section"; that is usually handled by the words "In this section [subsection, paragraph, subdivision, etc.]".

B. It seems to me that "diagnostics," as used in the context proposed, does not mean "testing"; instead it means the results of testing. And, in looking at other statutes in which the term is used, it seems more appropriate to use the term "diagnostic evaluation".

Therefore, I would propose:

"In this subdivision, "diagnostic evaluation" means the results of clinical testing of biological parameters, such as laboratory values, radiology tests, and electrocardiograms [do you mean EEG--electroencephalogram--rather than EKG?]. "Diagnostic evaluation" does not mean the results of psychological or neuropsychological testing, such as intelligence quotient or personality testing."

I'm continuing to work on this proposal and will send you my questions or comments about the proposed changes to ch. 146, stats., as soon as I can.

Deborah A. Kennedy
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146.81(i) - def. of he provided
48.422(a)(b)
50.36 (3d)(a) (intro.)
51.30 (i)(ag)
71.07 (5i) (b), or by Act 20
71.28 (5i) (b) " " " "
71.47 (5i) (b) " " " "
103.10 (i)(e)
146.50 (12) (a)
146.81 (i)
146.905 (i)
146.96
153.01 (4t)
250.03 (3) (b)
252.05 (i)
252.15 (1)(ar) i.
302.388 (1)(a)
440.9805 (i)
601.41 (9) (a)
610.65
631.89 (2) (bm)
632.725 (i)
632.87 (4)
857.035



TUES. 1/2
State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-3672/P1

DAK:.....

D-NOTE

cjs

SAV
X-rd/sv

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

Gen Cat

1 AN ACT ...; relating to: treatment records and patient health care records.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided on a subsequent version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

2 SECTION 1. 48.422 (9) (b) of the statutes is amended to read:
3 48.422 (9) (b) If a birth parent does not comply with par. (a), the court shall
4 order any health care provider as defined under s. 146.81 (1) (1r) known to have
5 provided care to the birth parent or parents to provide the court with any health care
6 records of the birth parent or parents that are relevant to the child's medical
7 condition or genetic history. A court order for the release of alcohol or drug abuse
8 treatment records subject to 21 USC 1175 or 42 USC 4582 shall comply with 42 CFR
9 2.

1 **SECTION 2.** 50.36 (3d) (a) (intro.) of the statutes is amended to read:

2 50.36 (3d) (a) (intro.) A hospital shall develop and maintain a system under
3 which the hospital may grant emergency staff privileges to a health care provider,
4 as defined in s. 146.81 (1) (1r), to whom all of the following apply:

History: 1971 c. 211; 1975 c. 383 s. 4; 1975 c. 413 ss. 4, 18; 1975 c. 421; Stats. 1975 s. 50.36; 1977 c. 29; 1979 c. 34; 1981 c. 135; 1985 a. 340; 1989 a. 37; 1991 a. 129; 1993 a. 16, 30, 270; 1995 a. 27 ss. 3245, 3246, 9116 (5); 1997 a. 175; 1999 a. 9; 2001 a. 109; 2007 a. 20.

5 **SECTION 3.** 51.30 (1) (ag) of the statutes is amended to read:

6 51.30 (1) (ag) "Health care provider" has the meaning given in s. 146.81 (1) (1r).

History: 1975 c. 430; 1977 c. 26 s. 75; 1977 c. 61, 428; 1979 c. 110 s. 60 (1); 1983 a. 27, 292, 398, 538; 1985 a. 29, 176; 1985 a. 292 s. 3; 1985 a. 332 ss. 97, 98, 251 (1); 1987 a. 352, 355, 362, 367, 399, 403; 1989 a. 31, 334, 336; 1991 a. 39, 189; 1993 a. 196, 445, 479; 1995 a. 169, 440; 1997 a. 35, 231, 237, 283, 292; 1999 a. 32, 78, 79, 109; 2001 a. 16, 38; 2005 a. 25, 344, 387, 388, 406, 434; 2005 a. 443 s. 265; 2005 a. 444, 449, 485; 2007 a. 20 ss. 1817, 9121 (6) (a).

7 **SECTION 4.** 51.30 (4) (b) 8g. (intro.) of the statutes is renumbered 51.30 (4) (b)

8 8g. bm. and amended to read:

9 51.30 (4) (b) 8g. bm. To ~~health care providers in a related health care entity, a~~
10 health care provider or to any person acting under the supervision of such a health
11 care provider, who is involved with an individual's care, if necessary for the current
12 treatment of the individual. Information that may be released under this
13 subdivision is limited to the individual's name, address, and date of birth; the name
14 of the individual's mental health treatment provider; the date of mental health
15 service provided; the individual's medications, allergies, and diagnosis, diagnostic
16 evaluations, and symptoms; and other relevant demographic information necessary
17 for the current treatment of the individual. ~~In this subdivision, "related health care~~
18 ~~entity" means one of the following:~~

History: 1975 c. 430; 1977 c. 26 s. 75; 1977 c. 61, 428; 1979 c. 110 s. 60 (1); 1983 a. 27, 292, 398, 538; 1985 a. 29, 176; 1985 a. 292 s. 3; 1985 a. 332 ss. 97, 98, 251 (1); 1987 a. 352, 355, 362, 367, 399, 403; 1989 a. 31, 334, 336; 1991 a. 39, 189; 1993 a. 196, 445, 479; 1995 a. 169, 440; 1997 a. 35, 231, 237, 283, 292; 1999 a. 32, 78, 79, 109; 2001 a. 16, 38; 2005 a. 25, 344, 387, 388, 406, 434; 2005 a. 443 s. 265; 2005 a. 444, 449, 485; 2007 a. 20 ss. 1817, 9121 (6) (a).

19 **SECTION 5.** 51.30 (4) (b) 8g. a. of the statutes is repealed.

20 **SECTION 6.** 51.30 (4) (b) 8g. am. of the statutes is created to read:

21 51.30 (4) (b) 8g. am. In this subdivision, "diagnostic evaluation" means the
22 results of clinical testing of biological parameters, such as laboratory values,

1 radiology tests, and electroencephalograms. "Diagnostic evaluation" does not mean
2 the results of psychological or neuropsychological testing, such as intelligence
3 quotient or personality testing.

4 SECTION 7. 51.30 (4) (b) 8g. b. of the statutes is repealed.

5 SECTION 8. 71.07 (5i) (b) of the statutes, as created by 2007 Wisconsin Act 20,
6 is amended to read:

7 71.07 (5i) (b) *Filing claims.* Subject to the limitations provided in this
8 subsection, for taxable years beginning after December 31, 2009, a claimant may
9 claim as a credit against the taxes imposed under s. 71.02, up to the amount of those
10 taxes, an amount equal to 50 percent of the amount the claimant paid in the taxable
11 year for information technology hardware or software that is used to maintain
12 medical records in electronic form, if the claimant is a health care provider, as defined
13 in s. 146.81 (1) (1r).

History: 1987 a. 312; 1987 a. 411 ss. 63, 79 to 82, 85, 86; 1987 a. 419, 422; 1989 a. 31, 44, 56, 100, 359; 1991 a. 39, 269, 292; 1993 a. 16, 112, 204, 471, 491; 1995 a. 27 ss. 3377m to 3393m, 9116 (5); 1995 a. 209, 227, 400, 453; 1997 a. 27, 41, 237, 299; 1999 a. 5, 9, 10, 32; 1999 a. 150 s. 672; 1999 a. 198; 2001 a. 16, 109; 2003 a. 72, 99, 135, 183, 255, 267, 326; 2005 a. 25, 49, 72, 74, 97, 177, 254, 361, 387, 479, 483, 487; 2007 a. 11, 20.

14 SECTION 9. 71.28 (5i) (b) of the statutes, as created by 2007 Wisconsin Act 20,
15 is amended to read:

16 71.28 (5i) (b) *Filing claims.* Subject to the limitations provided in this
17 subsection, for taxable years beginning after December 31, 2009, a claimant may
18 claim as a credit against the taxes imposed under s. 71.23, up to the amount of those
19 taxes, an amount equal to 50 percent of the amount the claimant paid in the taxable
20 year for information technology hardware or software that is used to maintain
21 medical records in electronic form, if the claimant is a health care provider, as defined
22 in s. 146.81 (1) (1r).

History: 1987 a. 312; 1987 a. 411 ss. 88, 130 to 139; 1987 a. 422; 1989 a. 31, 44, 56, 100, 336, 359; 1991 a. 39, 292; 1993 a. 16, 112, 232, 491; 1995 a. 2; 1995 a. 27 ss. 3399r to 3404c, 9116 (5); 1995 a. 209, 227; 1997 a. 27, 41, 237, 299; 1999 a. 5, 9; 2001 a. 16; 2003 a. 72, 99, 135, 255, 267, 326; 2005 a. 25, 74, 97, 361, 387, 452, 479, 483, 487; 2007 a. 20; s. 13.93 (2) (c).

1 **SECTION 10.** 71.47 (5i) (b) of the statutes, as created by 2007 Wisconsin Act 20,
2 is amended to read:

3 71.47 **(5i)** (b) *Filing claims.* Subject to the limitations provided in this
4 subsection, for taxable years beginning after December 31, 2009, a claimant may
5 claim as a credit against the taxes imposed under s. 71.43, up to the amount of those
6 taxes, an amount equal to 50 percent of the amount the claimant paid in the taxable
7 year for information technology hardware or software that is used to maintain
8 medical records in electronic form, if the claimant is a health care provider, as defined
9 in s. 146.81 ~~(1)~~ (1r).

History: 1987 a. 312, 411, 422; 1989 a. 31, 44, 56, 100, 336, 359; 1991 a. 39, 292, 315; 1993 a. 16, 112; 1995 a. 27 ss. 3407m to 3412m, 9116 (5); 1995 a. 209, 227, 417; 1997 a. 27, 41, 237, 299; 1999 a. 5, 9; 2001 a. 16; 2003 a. 72, 99, 135, 255, 267, 326; 2005 a. 25, 74, 97, 361, 387, 452, 479, 483, 487; 2007 a. 20; s. 13.93 (2) (c).

10 **SECTION 11.** 103.10 (1) (e) of the statutes is amended to read:

11 103.10 **(1)** (e) "Health care provider" means a person described under s. 146.81
12 ~~(1)~~ (1r), but does not include a person described under s. 146.81 ~~(1)~~ (1r) (hp).

History: 1987 a. 287; 1989 a. 228; 1991 a. 39; 1993 a. 446; 1995 a. 27 s. 9130 (4); 1997 a. 3, 156; 2001 a. 74; 2003 a. 33.

13 **SECTION 12.** 146.50 (12) (a) of the statutes is amended to read:

14 146.50 **(12)** (a) All records made by an ambulance service provider, an
15 emergency medical technician or a first responder in administering emergency care
16 procedures to and handling and transporting sick, disabled or injured individuals
17 shall be maintained as confidential patient health care records subject to ss. 146.81
18 to 146.84 and, if applicable, s. 252.15 (5) (a) (intro.), (6), (8) and (9). For the purposes
19 of this paragraph, an ambulance service provider, an emergency medical technician
20 or a first responder shall be considered to be a health care provider under s. 146.81
21 ~~(1)~~ (1r). Nothing in this paragraph permits disclosure to an ambulance service
22 provider, an emergency medical technician or a first responder under s. 252.15 (5)
23 (a), except under s. 252.15 (5) (a) 11.

History: 1973 c. 321; 1975 c. 39 ss. 645 to 647d, 732 (2); 1975 c. 224; 1977 c. 29, 167; 1979 c. 321; 1981 c. 73, 380; 1981 c. 391 s. 211; 1983 a. 189; 1985 a. 120, 135; 1987 a. 70, 399; 1989 a. 31; 1989 a. 102 ss. 20, 21, 36 to 59; 1991 a. 39, 238; 1993 a. 27, 29, 105, 183, 251, 399; 1997 a. 79, 191, 237; 1999 a. 7, 56; 2001 a. 109; 2005 a. 25, 486.

1 ~~SECTION 13. 146.81 (1) of the statutes is renumbered 146.81 (1r).~~

2 SECTION 14. 146.81 (1g) of the statutes is created to read:

3 146.81 (1g) "Health information" has the meaning given in 45 CFR 160.103.

4 SECTION 15. 146.81 (4) of the statutes is amended to read:

5 146.81 (4) "Patient health care records" means all records related to the health
6 of a patient prepared by or under the supervision of a health care provider, including
7 the records required under s. 146.82 (2) (d) and (3) (e), but not those records subject
8 to s. 51.30, reports collected under s. 69.186, records of tests administered under s.
9 252.15 (2) (a) 7., 343.305, 938.296 (4) or (5) or 968.38 (4) or (5), records related to sales
10 of pseudoephedrine products, as defined in s. 961.01 (20c), that are maintained by
11 pharmacies under s. 961.235, fetal monitor tracings, as defined under s. 146.817 (1),
12 or a pupil's physical health records maintained by a school under s. 118.125. "Patient
13 health care records" also includes health summary forms prepared under s. 302.388
14 (2).

History: 1979 c. 221; 1981 c. 39 s. 22; 1983 a. 27; 1983 a. 189 s. 329 (1); 1983 a. 535; 1985 a. 315; 1987 a. 27, 70, 264; 1987 a. 399 ss. 403br, 491r; 1987 a. 403; 1989 a. 31, 168, 199, 200, 229, 316, 359; 1991 a. 39, 160, 269; 1993 a. 27, 32, 105, 112, 183, 385, 443, 496; 1995 a. 27 s. 9145 (1); 1995 a. 77, 98, 352; 1997 a. 27, 67, 75, 156, 175; 1999 a. 9, 32, 151, 180, 188; 2001 a. 38, 70, 74, 80, 89; 2005 a. 262, 387.

15 SECTION 16. 146.82 (2) (b) of the statutes is repealed.

16 SECTION 17. 146.82 (2) (d) of the statutes is repealed.

17 SECTION 18. 146.82 (3) (c) of the statutes is repealed.

18 SECTION 19. 146.82 (4) of the statutes is created to read:

19 146.82 (4) RELEASE OF HEALTH INFORMATION TO CERTAIN PERSONS. (a) In this
20 subsection:

21 1. "Immediate family" has the meaning given in s. 350.01 (8m).

22 2. "Incapacitated" has the meaning given in s. 54.94 (1) (b).

23 (b) Notwithstanding sub. (1), if a patient is incapacitated or is not present, or
24 if an emergency makes obtaining the patient's informed consent impracticable, and

50

1 if a health care provider determines, in the exercise of his or her professional
 2 judgment, that release of the patient's health information is in the best interest of
 3 the patient, the health care provider may release ^{portions of} the health information, but not
 4 copies of the patient's patient health care record, ^{under the following circumstances:} *as follows*

5 1. To a member of the patient's immediate family, another relative of the
 6 patient, a close personal friend of the patient, or an individual identified by the
 7 patient, those portions of the patient's health information that are directly relevant
 8 to the involvement by the member, relative, friend, or individual in the patient's care.

9 2. To any person, those portions of the patient's health information that are
 10 necessary to identify, locate, or notify a member of the patient's immediate family or
 11 another person that is responsible for the care of the patient concerning the patient's
 12 location, general condition, or death.

13 **SECTION 20.** 146.82 (5) of the statutes is created to read:

14 146.82 (5) REDISCLOSURE. (a) In this subsection, "covered entity" has the
 15 meaning given in 45 CFR 160.103.

16 (b) Notwithstanding sub. (1), a covered entity may redisclose a patient's health
 17 information it receives under this section without consent by the patient or person
 18 authorized by the patient if ~~the purpose for~~ the redisclosure is otherwise permitted
 19 under this section.

20 (c) Notwithstanding sub. (1), an entity that is not a covered entity may
 21 redisclose ~~any~~ ^{one} patient's health information it receives under this section only under
 22 ~~any~~ of the following circumstances:

23 1. The patient or a person authorized by the patient provides written consent
 24 for the redisclosure.

25 2. A court orders the redisclosure.

made for a purpose for which a release of health information is

1 3. The redisclosure is limited to the purpose for which the patient's health
2 information was initially ~~obtained~~ *received*.

3 **SECTION 21.** 146.905 (1) of the statutes is amended to read:

4 146.905 (1) Except as provided in sub. (2), a health care provider, as defined
5 in s. 146.81 (1) ~~(1r)~~, that provides a service or a product to an individual with coverage
6 under a disability insurance policy, as defined in s. 632.895 (1) (a), may not reduce
7 or eliminate or offer to reduce or eliminate coinsurance or a deductible required
8 under the terms of the disability insurance policy.

9 History: 1991 a. 250; 1995 a. 225.

9 **SECTION 22.** 146.96 of the statutes is amended to read:

10 **146.96 Uniform claim processing form.** Beginning no later than July 1,
11 2004, every health care provider, as defined in s. 146.81 (1) ~~(1r)~~, shall use the uniform
12 claim processing form developed by the commissioner of insurance under s. 601.41
13 (9) (b) when submitting a claim to an insurer.

14 History: 2001 a. 109.

14 **SECTION 23.** 153.01 (4t) of the statutes is amended to read:

15 153.01 (4t) "Health care provider" has the meaning given in s. 146.81 (1) ~~(1r)~~
16 and includes an ambulatory surgery center.

17 History: 1987 a. 399; 1993 a. 16, 185, 491; 1997 a. 27, 231; 1999 a. 9 s. 2280ge; 1999 a. 32; 2003 a. 33; 2005 a. 228, 253; 2007 a. 20 s. 9121 (6) (a).

17 **SECTION 24.** 250.03 (3) (b) of the statutes is amended to read:

18 250.03 (3) (b) Biennially, after first consulting with the adjutant general, local
19 health departments, health care providers, as defined in s. 146.81 (1) ~~(1r)~~, and law
20 enforcement agencies, as defined in s. 165.77 (1) (b), the department shall submit to
21 the legislature under s. 13.172 (2) and to the governor a report on the preparedness
22 of the public health system to address public health emergencies.

23 History: 1993 a. 27; 2001 a. 109; 2005 a. 198.

23 **SECTION 25.** 252.05 (1) of the statutes is amended to read:

1 ~~252.05 (1) Any health care provider, as defined in s. 146.81 (1) (1r), who knows~~
 2 ~~or has reason to believe that a person treated or visited by him or her has a~~
 3 ~~communicable disease, or having a communicable disease, has died, shall report the~~
 4 ~~appearance of the communicable disease or the death to the local health officer. The~~
 5 ~~health agency of a federally recognized American Indian tribe or band may report~~
 6 ~~this information to the local health officer. The local health officer shall report this~~
 7 ~~information to the department or shall direct the person reporting to report to the~~
 8 ~~department. Any person directed to report shall submit this information to the~~
 9 ~~department.~~

10 History: 1971 c. 164 s. 91; 1981 c. 291; 1993 a. 16; 1993 a. 27 ss. 286 to 291, 293, 294, 471; Stats. 1993 s. 252.05; 1993 a. 183; 2001 a. 109; 2005 a. 198.

SECTION 26. ~~252.15 (1) (ar) 1. of the statutes is amended to read:~~

11 ~~252.15 (1) (ar) 1. A person or entity that is specified in s. 146.81 (1) (1r), but does~~
 12 ~~not include a massage therapist or bodyworker issued a certificate under ch. 460.~~

13 History: 1985 a. 29, 73, 120; 1987 a. 70 ss. 13 to 27, 36; 1987 a. 403 ss. 136, 256; 1989 a. 200; 1989 a. 201 ss. 11 to 25, 36; 1989 a. 298, 359; 1991 a. 269; 1993 a. 16 s. 2567; 1993 a. 27 ss. 332, 334, 337, 340, 342; Stats. 1993 s. 252.15; 1993 a. 32, 183, 190, 252, 395, 491; 1995 a. 27 ss. 6323, 9116 (5), 9126 (19); 1995 a. 77, 275; 1997 a. 54, 80, 156, 188; 1999 a. 9, 32, 79, 151, 162, 188; 2001 a. 38, 59, 69, 74, 103, 105; 2003 a. 271; 2005 a. 155, 187, 266, 344, 387; s. 13.93 (2) (c).

14 **SECTION 27.** ~~302.388 (1) (a) of the statutes is amended to read:~~

15 ~~302.388 (1) (a) "Health care provider" has the meaning given in s. 146.81 (1)~~
 16 ~~(1r).~~

17 History: 1999 a. 151.

18 **SECTION 28.** ~~440.9805 (1) of the statutes is amended to read:~~

19 ~~440.9805 (1) "Health care provider" means a health care provider, as defined~~
 20 ~~in s. 146.81 (1) (1r), a person licensed or issued a training permit as an emergency~~
 21 ~~medical technician under s. 146.50, or a person certified as a first responder under~~
 22 ~~s. 146.50 (8).~~

23 History: 2005 a. 292; s. 13.93 (1) (b).

SECTION 29. ~~601.41 (9) (a) of the statutes is amended to read:~~

1 601.41 (9) (a) In this subsection, "health care provider" has the meaning given
2 in s. 146.81 (1) (1r).

History: 1977 c. 339 s. 43; 1979 c. 89, 102, 177; 1983 a. 358 s. 14; 1985 a. 29; 1985 a. 182 s. 57; 1987 a. 247; 1989 a. 187 s. 29; 1989 a. 201, 336; 1991 a. 39; 1993 a. 16; 1995 a. 201; 1997 a. 27, 51, 252; 1999 a. 150 s. 672; 2001 a. 16, 65, 109; 2003 a. 261, 302; 2005 a. 74, 249.

3 **SECTION 30.** 610.65 of the statutes is amended to read:

4 **610.65 Uniform claim processing form.** Beginning no later than July 1,
5 2004, every insurer shall use the uniform claim processing form developed by the
6 commissioner under s. 601.41 (9) (b) when processing a claim submitted by a health
7 care provider, as defined in s. 146.81 (1) (1r).

History: 2001 a. 109.

8 **SECTION 31.** 631.89 (2) (bm) of the statutes is amended to read:

9 631.89 (2) (bm) Require or request directly or indirectly a health care provider,
10 as defined in s. 146.81 (1) (1r), who is or may be providing or who has or may have
11 provided health care services to an individual to reveal whether the individual or a
12 member of the individual's family has obtained a genetic test or what the results of
13 the test, if obtained by the individual or a member of the individual's family, were.

History: 1991 a. 269; 1997 a. 74.

14 **SECTION 32.** 632.725 (1) of the statutes is amended to read:

15 632.725 (1) DEFINITION. In this section, "health care provider" has the meaning
16 given in s. 146.81 (1) (1r).

History: 1991 a. 250; 1995 a. 27 s. 9126 (19); 2007 a. 20 s. 9121 (6) (a).

17 **SECTION 33.** 632.87 (4) of the statutes is amended to read:

18 632.87 (4) No policy, plan or contract may exclude coverage for diagnosis and
19 treatment of a condition or complaint by a licensed dentist within the scope of the
20 dentist's license, if the policy, plan or contract covers diagnosis and treatment of the
21 condition or complaint by another health care provider, as defined in s. 146.81 (1)
22 (1r).

History: 1975 c. 223, 371, 422; 1981 c. 205; 1983 a. 27; 1985 a. 29; 1987 a. 27; 1991 a. 39, 269; 1995 a. 412; 2005 a. 194.

23 **SECTION 34.** 655.275 (8) of the statutes is amended to read:

1 655.275 (8) PATIENT RECORDS. The council may obtain any information relating
2 to any claim it reviews under this section that is in the possession of the
3 commissioner or the board of governors. The council shall keep patient health care
4 information confidential as required by s. 146.82 (2) (b) (5) (c).

History: 1985 a. 340; 1989 a. 187; 1991 a. 214, 315; 1999 a. 9; 2003 a. 111; 2007 a. 20.

5 **SECTION 35.** 857.035 of the statutes is amended to read:

6 **857.035 Disposition of patient health care records.** If the decedent was
7 a health care provider, as defined under s. 146.81 (1) (1r), who was an independent
8 practitioner, the personal representative shall comply with s. 146.819.

History: 1991 a. 269.

9

(END)

d-note

**DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-3672/dn

DAK:.....

cjs

P1

To Cheryl McIlquham and Kathy Farnsworth:

This bill is drafted in preliminary form, because many issues arose in the course of drafting. The first item, below, is a recapitulation of questions I asked in my e-mail of December 27, 2007.

1. I have drafted several of your proposed changes to s. 51.30 (4) (b) 8g., stats., and have these questions or comments:

a. The term "treatment records" is defined under s. 51.30 (1) (b), stats., to be "registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence" Nevertheless, s. 51.20 (4) (b) 8g. (intro.), stats., refers only to an individual's "mental health treatment provider" and "mental health service" provided. Do you want this expanded to refer to treatment or services for developmental disabilities, alcoholism, or drug dependence?

b. Your proposal is that the definition of "diagnostics" be created under s. 51.30 (1), stats.; the effect of placement of the definition here is to apply it wherever the term is used throughout s. 51.30, stats. Yet it is in fact used only in s. 51.30 (4) (b) 8g. I believe it should be defined for that subdivision only; if, at a later date, the term is used in another part of the section, it can then be renumbered to be defined for the section as a whole.

c. As to the wording of the definition:

I. It is unnecessary to include "for the purposes of this section"; that is usually handled by the words "in this section [subsection, paragraph, subdivision, etc.]".

II. It seems to me that "diagnostics," as used in the context proposed, does not mean "testing"; instead, it means the results of testing. And, in looking at other statutes in which the term is used, it seems more appropriate to use the term "diagnostic evaluation". Please review.

III. The proposed language used the term "electrocardiograms"; did you mean "electroencephalogram," as drafted?

2. As requested, I have repealed ss. 146.82 (2) (d) and 146.83 (3) (c), stats. As you explain in your instructions, the effect of the repeal of these provisions is to have

STET

HIPAA's documentation requirements prevail under preemption. Please note that another effect of the repeal is to make prosecution of violations of the documentation requirements only possible in federal court, and not also in state court. In addition, because only federal law specifies the right of a patient to request an "accounting" of the disclosures that are required to be tracked, a patient with access to Wisconsin statutes but not federal statutes may have no knowledge that this right may be pursued. Lastly, please note that the repeal of s. 146.82 (2) (d) and ~~146.83~~ (3) (c), stats., necessitates the amendment of s. 146.81 (4), stats. (the definition of "patient health care records"), which refers to these paragraphs. That means that, under Wisconsin law, unless s. 146.81 (4), stats., is further amended to refer to redisclosure, any record of a redisclosure made will not be considered a "patient health care record". Is this the result you want? Is it possible that this may make federal prosecution of violations of HIPAA's documentation requirements more difficult?

2. I have repealed s. 146.82 (2) (b), stats., as requested, and have created s. 146.82 (5), regarding redisclosure. (Note the definition of "covered entity" created under s. 146.82 (5) (a).) However, the repeal of s. 146.82 (2) (b), stats., raises these problems, which must be resolved:

a. Section 146.82 (2) (b), stats., currently excepts s. 610.70 (3) and (5), stats., from its requirements. Section 610.70 (3), stats., permits an individual or an authorized representative of an individual access to the individual's recorded personal medical information in the possession of an insurer. Section 610.70 (5), stats., permits redisclosure to others of an individual's personal medical information under certain circumstances. The language of s. 146.82 (5) (b), as proposed and drafted, permits redisclosure "if the purpose for the redisclosure is otherwise permitted *under this section*" (i.e., s. 146.82, stats.); deleting reference to s. 610.70 (5), stats., without more, may not allow redisclosure under that statute because no mention of it otherwise occurs in s. 146.82, stats., and because not all of the purposes listed under s. 610.70 (5), stats., may be purposes permitted by s. 146.82, stats. Please advise.

b. Section 655.275 (8), stats. (the injured patients and families compensation fund council) currently must keep patient health care information confidential "as required by s. 146.82 (2) (b)". I have assumed that the council is not a "covered entity" under the definition in 45 CFR 160.103; correct? Please review my amendment of s. 655.275 (8), stats. As drafted, this means that, for redisclosure of the information the council receives, s. 146.82 (5) (c), as created in this draft, applies. However, I'm not actually sure what s. 146.82 (5) (c) means in this context and whether the language of that paragraph is appropriate. Yet another problem is that nowhere in s. 146.82, stats., is the council permitted to have access to this information in the first place. Should a new exception in s. 146.82 (2), stats., be created for this purpose?

c. Please note that I have used the term "patient's health information" throughout this subsection. Is that what you intended? Note that I have drafted a definition of "health information" under s. 146.81 (1g), referring to the federal regulations; the definition is also applicable under s. 146.82 (4) in this draft.

3. Please review s. 146.82 (4). I did not draft this as s. 146.82 (2) (am), as proposed, because s. 146.82 (2) (intro.) *requires*, rather than *permits*, release of patient health

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4.

care records. I also did not include the material proposed as s. 146.82 (2) (am) 2. ("Releases with the patient present") because ^{it echoes} they echo current law under s. 146.82 (1), stats.; in fact, s. 146.82 (1), stats., is more broad than the material proposed. I have these questions:

a. Why is a "person authorized by the patient" not required to be consulted for consent before the health care provider releases the health information?

b. As s. 146.82 (4) (b) (intro.) is written, the health care provider is authorized to release the patient's health information (if other requirements are met) if a patient "is not present." That phrase is not limited and is, therefore, vague. Is there a way to qualify this nonpresence somehow? ✓

Debora A. Kennedy
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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3672/P1dn
DAK:cjs:pg

January 8, 2008

To Cheryl McIlquham and Kathy Farnsworth:

This bill is drafted in preliminary form, because many issues arose in the course of drafting. The first item, below, is a recapitulation of questions I asked in my e-mail of December 27, 2007.

1. I have drafted several of your proposed changes to s. 51.30 (4) (b) 8g., stats., and have these questions or comments:

a. The term "treatment records" is defined under s. 51.30 (1) (b), stats., to be "registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence" Nevertheless, s. 51.30 (4) (b) 8g. (intro.), stats., refers only to an individual's "mental health treatment provider" and "mental health service" provided. Do you want this expanded to refer to treatment or services for developmental disabilities, alcoholism, or drug dependence?

b. Your proposal is that the definition of "diagnostics" be created under s. 51.30 (1), stats.; the effect of placement of the definition here is to apply it wherever the term is used throughout s. 51.30, stats. Yet it is in fact used only in s. 51.30 (4) (b) 8g. I believe it should be defined for that subdivision only; if, at a later date, the term is used in another part of the section, it can then be renumbered to be defined for the section as a whole.

c. As to the wording of the definition:

I. It is unnecessary to include "for the purposes of this section"; that is usually handled by the words "in this section [subsection, paragraph, subdivision, etc.]".

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HIPAA's documentation requirements prevail under preemption. Please note that another effect of the repeal is to make prosecution of violations of the documentation requirements only possible in federal court, and not also in state court. In addition, because only federal law specifies the right of a patient to request an "accounting" of the disclosures that are required to be tracked, a patient with access to Wisconsin statutes but not federal statutes may have no knowledge that this right may be pursued. Lastly, please note that the repeal of s. 146.82 (2) (d) and (3) (c), stats., necessitates the amendment of s. 146.81 (4), stats. (the definition of "patient health care records"), which refers to these paragraphs. That means that, under Wisconsin law, unless s. 146.81 (4), stats., is further amended to refer to redisclosure, any record of a redisclosure made will not be considered a "patient health care record." Is this the result you want? Is it possible that this may make federal prosecution of violations of HIPAA's documentation requirements more difficult?

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Debora A. Kennedy

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Kennedy, Debora

From: Cheryl McIlquham [McIlqCJ@dhfs.state.wi.us]
Sent: Monday, January 07, 2008 7:44 AM
To: Kennedy, Debora
Cc: Farnsworth, Kathleen - DHFS
Subject: RE: Patient treatment records; review of drafting request

Debora,
Our responses to your questions on 51.30 are below. With the holidays, it took a day or so longer for us to review given that people were out. I realize the holiday schedule added challenges for all of us.

Anyway, with regard to your questions sent on the 27th:

- yes 1. I believe you are actually referring to s. 51.30 (4)(b) 8g and not 51.20 (4)(b) 8g. Assuming this is the case, we agree that section should be changed to allow for broader exchange of information...and not limited to "mental health" treatment provider and services. Would it work to perhaps word these phrases more generically like "name of the individual's provider and "date of services provided?"
- ok 2. We agree with what you propose.
- ok 3a. We agree with your suggestion here.
- ok 3b. We also generally agree with this suggestion, but wanted to confirm that you would view this to be comprehensive enough to include, for example, an MRI? yes ("such as")

Please let us know if you need anything further on the above.

Also, we do appreciate that you have given this priority and your plans for Tuesday sound great. We will review the draft immediately and get back to you within 2 days thereafter.

Thanks again.

* * * * *

NOTICE: This email and any attachments may contain confidential information. Use and further disclosure of the information by the recipient must be consistent with applicable laws, regulations and agreements. If you received this email in error, please notify the sender; delete the email; and do not use, disclose or store the information it contains.

* * * * *

Cheryl McIlquham, Director
Office of Policy Initiatives and Budget
Wisconsin Department of Health & Family Services
608-266-2907

>>> "Kennedy, Debora" <Debora.Kennedy@legis.wisconsin.gov> 1/4/2008 10:06 AM >>>
Cheryl:

You have asked whether the legislation will be "ready to go" by the week of the 14th. I am unable to answer that question. At this point, I have received nothing from DHFS other than an acknowledgement of receipt of the e-mail I sent with numerous questions on Thursday, Dec. 27, more than a week ago.

Right now, I am completing my preliminary drafting of the DHFS proposed changes to ch. 146, stats. I have numerous questions about and comments on the material proposed. I intend to have this material into editing today; I will incorporate into it my questions about the proposed changes to s. 51.30 and any drafting that I can do to that section. I

will ask that the material be edited, typed, and submitted to you by Tuesday. Note that the draft will be a preliminary draft and not introducible; I am not sure that I will have time to include in it an analysis by the end of today. I have, obviously, placed it as a priority for my work, in the face of legislative requests I received before this one.

Debora Kennedy

-----Original Message-----

From: Cheryl McIlquham [mailto:McilqCJ@dhfs.state.wi.us]
Sent: Friday, January 04, 2008 8:59 AM
To: Farnsworth, Kathleen - DHFS; Kennedy, Debora
Subject: Re: Patient treatment records; review of drafting request

Hi Debora,
How are things going on all this? Are you getting what you need from us?

I wanted to ask you if you'll be able to send the first draft over by next week sometime? Since we last talked, we have been communicating with the Gov's Office on this. They are very interested in us having this legislation in hand and ready to go by the week of the 14th. Could you please let me know if this is doable?

Thanks Debora.

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Cheryl McIlquham, Director
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Wisconsin Department of Health & Family Services
608-266-2907

>>> "Kennedy, Debora" <Debora.Kennedy@legis.wisconsin.gov> 12/27/2007 3:31 PM >>>

I have reviewed your proposed changes to s. 51.30 (4) (b) 8g., stats., and have these questions or comments:

1. The term "treatment records" is defined under s. 51.30 (1) (b) to be "registration and all other records that are created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence" Nevertheless, s. 51.20 (4) (b) 8g. (intro.), stats., refers only to an individual's "mental health treatment provider" and "mental health service" provided. Do you want this expanded to refer to treatment or services for developmental disabilities, alcoholism, or drug dependence?

2. Your proposal is that the definition of "diagnostics" be created under s. 51.30 (1), stats.; the effect of placement of the definition here is to apply it wherever the term is used throughout s. 51.30, stats. Yet it is in fact used only in s. 51.30 (4) (b) 8g. I believe it should be defined for that subdivision only; if, at a later date, the term is used in another part of the section, it can then be defined for the section as a whole.

3. As to the wording of the definition:

A. It is unnecessary to include "for the purposes of this section"; that is usually handled by the words "In this section [subsection, paragraph, subdivision, etc.]".

B. It seems to me that "diagnostics," as used in the context proposed, does not mean "testing"; instead it means the results of testing. And, in looking at other statutes in which the term is used, it seems more appropriate to use the term "diagnostic evaluation".

Therefore, I would propose:

"In this subdivision, "diagnostic evaluation" means the results of clinical testing of biological parameters, such as laboratory values, radiology tests, and electrocardiograms [do you mean EEG--electroencephalogram--rather than EKG?]. "Diagnostic evaluation" does not mean the results of psychological or neuropsychological testing, such as intelligence quotient or personality testing."

I'm continuing to work on this proposal and will send you my questions or comments about the proposed changes to ch. 146, stats., as soon as I can.

Debora A. Kennedy
Managing Attorney
Legislative Reference Bureau
(608) 266-0137
debora.kennedy@legis.state.wi.us

1/10/08

Meeting w/ Cheryl McQuigham, Kathy Farnsworth +
Beth DeLair

608 274-1094

From Drafter's Note

1. Use diagnostic test results" instead of "diagnostic eval"
 2. Discard examples under §1.30(4)(b) Eq. am.
 3. # 2. DN ok
 4. # 3 a. p. 4, l. 6 add "except as provided in s. 610.70 (3) and (5)"
 - # 3 b. Yes
 - # 3 c. Substitute "pt with care record" for "patient's health info" — delete definition HERE
 5. # 4. Add def of "health info" in 146.82(+)
 - restore: Releases w/ patient present
 - a. Include "person authorized by the pt"
 - b. Substitute "physically available" for "present"
- ~~to Renumber 146.82(2)(c) to 146.82(2)(a)~~

→ But will get back to DAK re this

Kennedy, Debora

From: Beth DeLair [bdelair@meaderoach.com]
Sent: Monday, January 14, 2008 3:21 PM
To: Farnsworth, Kathleen - DHFS; Kennedy, Debora
Cc: McIlquham, Cheryl J - DHFS
Subject: RE: Treatment records

Debora,

I have not heard back from Dr. Witkowsky yet. However, I like the input we received from Dr. Rod Miller about going with "option 2." My main reason to touch base with Dr. W. is to make sure we understand what he means by neuropsychology testing.

I will call him again tomorrow if he does not get back to me today.

-----Original Message-----

From: Kathleen Farnsworth [mailto:FarnsK@dhfs.state.wi.us]
Sent: Monday, January 14, 2008 3:03 PM
To: Debora Kennedy
Cc: Cheryl McIlquham; bdelair@meaderoach.com
Subject: Re: Treatment records

I am checking in with Beth. I received one input from Dr. Rod Miller here and will compare it with what Beth gets and get back to you. Kathy

* * * * *

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* * * * *

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Fax: (608) 267-0358
E-mail: FarnsK@dhfs.state.wi.us

>>> "Kennedy, Debora" <Debora.Kennedy@legis.wisconsin.gov> 1/14/2008
>>> 2:47 PM >>>

At our meeting on the 10th Beth De Lair stated that she would get back to me concerning the use of the term "diagnostic test results," rather than "diagnostic evaluation". I have not heard from Beth. Please advise, concerning your desired draft submittal date of the 15th.

Thanks.

Debora

Debora A. Kennedy
Managing Attorney
Legislative Reference Bureau
(608) 266-0137
debora.kennedy@legis.state.wi.us

Kennedy, Debora

From: Beth DeLair [bdelair@meaderoach.com]
Sent: Monday, January 14, 2008 3:51 PM
To: Farnsworth, Kathleen - DHFS; Kennedy, Debora
Cc: McIlquham, Cheryl J - DHFS
Subject: RE: Treatment records

Debora,

I think it is a good idea if we go with "option 2" regarding the definition of diagnostic test results. My purpose in talking with the physician is to clarify what he meant by the distinction between psychological and neuropsychological. I do not think what he says to me will change our definition, especially now that we are taking out examples. Thanks.
Beth.

-----Original Message-----

From: Kathleen Farnsworth [mailto:FarnsK@dhfs.state.wi.us]
Sent: Monday, January 14, 2008 3:03 PM
To: Debora Kennedy
Cc: Cheryl McIlquham; bdelair@meaderoach.com
Subject: Re: Treatment records

I am checking in with Beth. I received one input from Dr. Rod Miller here and will compare it with what Beth gets and get back to you. Kathy

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At our meeting on the 10th Beth De Lair stated that she would get back to me concerning the use of the term "diagnostic test results," rather than "diagnostic evaluation". I have not heard from Beth. Please advise, concerning your desired draft submittal date of the 15th.

Thanks.

Debora

Debora A. Kennedy
Managing Attorney
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debora.kennedy@legis.state.wi.us

Kennedy, Debora

From: Cheryl McIlquham [McilqCJ@dhfs.state.wi.us]
Sent: Tuesday, January 15, 2008 2:02 PM
To: Farnsworth, Kathleen - DHFS; Kennedy, Debora
Subject: Re: Treatment records

Okay, thanks Debora. I'll be talking w/Beth later today, so will see how this is progressing.

* * * * *

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Wisconsin Department of Health & Family Services
608-266-2907

>>> "Kennedy, Debora" <Debora.Kennedy@legis.wisconsin.gov> 1/15/2008 1:54 PM >>>

I have just spoken with Beth De Lair; she is still waiting to hear from her consultant concerning the definition of "diagnostic test results" in the draft. I clarified a couple of other points with her as well. In the interest of efficiency, and so as to reduce the need for yet another redraft, I'm going to wait until I hear from her before sending the draft into editing--according to Beth, that should be very soon, so I expect that the draft will be able to be submitted to you tomorrow (Wednesday).

Debora A. Kennedy
Managing Attorney
Legislative Reference Bureau
(608) 266-0137
debora.kennedy@legis.state.wi.us

Kennedy, Debora

From: Miller, Rodney K - DHFS
Sent: Thursday, January 10, 2008 2:40 PM
To: Easterday, John T - DHFS; Farnsworth, Kathleen - DHFS; Gloe, Steve M - DHFS; Johnson, Kathy L - DHFS; Zimmerman, Daniel S - DHFS
Cc: McIlquham, Cheryl J - DHFS; Webb, Denise B - DHFS; bdelair@meaderoach.com
Subject: Re: request for confidential review of 51.30 legislativelanguage draft

Greetings Kathleen,

I agree that it is generally not a good idea to provide examples in statute since it is likely impossible to have a comprehensive list and thus there is always room for challenging that which was and was not included. So for that reason, option 1 is not a good choice. In looking at options 2 and 3 an issue does arise. If the intent is to exclude the results of psychological and neuropsychological tests, then you may want to use option 2 which specifically does exclude these two classes.

The reason I say this is that one could probably argue that neuropsychological tests do test biological parameters. For example, one of the most widely used neuropsychological tests, the Halsted-Reitan, tests hand dominance, grip strength, left vs. right hand speed, ability to identify shapes via touch, certain tonal parameters, etc. One could argue fairly cogently that these are biological markers or parameters and thus that these results should be included. Neuropsychological tests use performance on various dimensions to infer the presence of a biologically based disorder (i.e. some damage to a portion of the brain).

Hopefully this is helpful in your decision making.

Rod Miller

>>> On 1/10/2008 at 12:08 PM, in message <47860ACC.C685.005C.0@dhfs.state.wi.us>, Kathleen Farnsworth wrote:

Hello All,

Requested response time: by Noon Friday 1/11 if feasible.

Dr. Miller, you were referred to us by Denise Webb.

Cheryl, Beth and I are working with LRB legislation drafter on development of legislative language to go along with the 51.30 workgroup and eHealth Board's policy change recommendations.

Just wondering if you will could on short notices take a quick look at the information below and indicate to me whether you have a preference among the three options. We would like to tap your expertise on this one section of the legislative drafting dealing with the 51.30 workgroup recommendation on the inclusion of "diagnostics" in information that can be shared without consent to providers with a need to know.

Legal advisors have indicated that listing test examples can cause implementation and possibly legal challenges if we do not choose the "correct" set of examples for the legislative language. Additionally with the rapid evolution of types of diagnostic testing we also want to write a statute where language will not eliminate some types of testing that are under development not but public may not be generally be aware of the categories of diagnostic testing (lab, rad, etc).

Three options for drafting the definition of diagnostic test results:

1. In this subdivision, "diagnostic test results" means the results of

Kennedy, Debora

From: Kathleen Farnsworth [FarnsK@dhfs.state.wi.us]
Sent: Thursday, January 17, 2008 12:34 PM
To: Kennedy, Debora
Cc: McIlquham, Cheryl J - DHFS; bdelair@meaderoach.com
Subject: drafting instructions

Attachments: Re: request for confidential review of 51.30 legislative language draft; Kathleen Farnsworth.vcf



Re: request for confidential r... Kathleen Farnsworth.vcf (257 B)

Hello Debora,

This confirms my email message left earlier, call with any questions or clarifications you need....

Cheryl and Beth and I have all communicated and we want to convey that our drafting instructions is to use number 2 in the attached email for the definition of "diagnostic test results".

This is the email I referred to in my voice message. Dr. Rod Miller is Planning and Analysis Administrator for mental health in our Department's Division of Mental Health and Substance Abuse Services.

Thanks for your follow up.

Kathy

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clinical testing of biological parameters, such as laboratory values, radiology tests, and cardiology tests. Diagnostic test results do not include the results of psychological or neuropsychological testing." (Basically keep original draft as is except changes the terms "diagnostic evaluation" to "diagnostic test results.")

2. In this subdivision, "diagnostic test results" means the results of clinical testing of biological parameters. Diagnostic test results do not include the results of psychological or neuropsychological testing. (Changing diagnostic evaluation to diagnostic test results and dropping the examples in both what is and what is not diagnostic test results).

3. In this subdivision, "diagnostic test results" means the results of clinical testing of biological parameters. (take out what diagnostic test results are not, plus take out examples).

Many thanks in advance for your assistance.

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Kennedy, Debora

To: Kathleen Farnsworth
Subject: RE: option 2

I understand. I am going to draft it as ""Diagnostic test results" means the results of clinical testing of biological parameters but does not mean the results of psychological or neuropsychological testing."

-----Original Message-----

From: Kathleen Farnsworth [mailto:FarnsK@dhfs.state.wi.us]
Sent: Thursday, January 17, 2008 1:29 PM
To: Kennedy, Debora
Cc: McIlquham, Cheryl J - DHFS; bdelair@meaderoach.com
Subject: option 2

Debora:

I've cut and paste the email response from Dr. Miller below.

Cheryl, Beth and I have concurred that the option 2 which is repeated here, be the definition of "diagnostic test results". In the draft legislation we used when we met, this option 2 is replacement language for the section beginning on lines 11 - 15 on page two:

" In this subdivision, "diagnostic test results" means the results of clinical testing of biological parameters. Diagnostic test results do not include the results of psychological or neuropsychological testing."

In other words, we are asking to change "diagnostic evaluation" to "diagnostic test results" and drop the examples ("such as's") in both what is (on lines 12 and 13) and what is not (line 14 and 15) diagnostic test results.

email from Dr. Miller:

Greetings Kathleen,

I agree that it is generally not a good idea to provide examples in statute since it is likely impossible to have a comprehensive list and thus there is always room for challenging that which was and was not included. So for that reason, option 1 is not a good choice. In looking at options 2 and 3 and issue does arise. If the intent is to exclude the results of psychological and neuropsychological tests, then you may want to use option 2 which specifically does exclude these two classes.

The reason I say this is that one could probably argue that neuropsychological tests do test biological parameters. For example, one of the most widely used neuropsychological tests, the Halsted-Reitan, tests hand dominance, grip strength, left vs. right hand speed, ability to identify shapes via touch, certain tonal parameters, etc. One could argue fairly cogently that these are biological markers or parameters and thus that these results should be included. Neuropsychological tests use performance on various dimensions to infer the presence of a biologically based disorder (i.e. some damage to a portion of the brain).

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(Changing diagnostic evaluation to diagnostic test results and dropping the examples in both what is and what is not diagnostic test results).

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