TITLE

HIPAA Complaints and Investigations

PURPOSE

In accordance with 45 CFR Subpart D and 45 CFR § 164.530(d), this procedure provides guidance to The University of Arizona ("UA") Health Hare Components ("HCCs") on the appropriate response to complaints from individuals regarding potential HIPAA violations, with the exception of breaches of e-PHI. Breaches of e-PHI are addressed in the Procedure "Breach of Protected Health Information."

REVIEW/REVISIONS

- 06/2015

REFERENCES AND RELATED FORMS

- Capitalized terms are defined in HIPAA Privacy Program Guidance (Definitions of Key Words) and 45 CFR Parts 160 and 164
- HIPAA Privacy Program Procedure 130 (Breach of Protected Health Information)

PROCEDURES

1. How to File Complaints: Any person who believes there has been a violation of the HIPAA Privacy, Security and Breach Notification Policy has the right to file a complaint with:
    A. The HIPAA Privacy Program. Complaints can be made orally or in writing, and can be made anonymously. Contact information is found at: http://rgw.arizona.edu/compliance/hipaa-privacy-program.
    B. The Secretary of the Office for Civil Rights (OCR) within the Department of Health and Human Services. Instructions are found at: http://www.hhs.gov/ocr/privacy/hipaa/complaints.

2. Retaliation as a Result of Filing a Complaint: Any person who believes there has been a violation of the UA HIPAA Privacy, Security and Breach Notification Policy may file a complaint with the Secretary of the Department of Health and Human Services or the HIPAA Privacy Program.
    A. No UA employee or workforce member may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for exercising their rights established under HIPAA, including the filing of a complaint.

B. The Arizona Board of Regents has a written "whistle-blower" policy to prohibit anyone from taking adverse personnel action against an employee, or failing to take an otherwise appropriate action, as a result of the employee's good faith disclosure of alleged wrongful conduct to a public body or to a designated University officer on HIPAA. Anyone who discloses and subsequently suffers an adverse personnel action as a result is subject to the protection of this Policy. See ABOR Policy 6-914 Protection of Employees from Reprisal for Whistleblowing.

3. Receipt of Complaints from OCR: The HIPAA Privacy Officer is the principal point of contact for investigations conducted by the OCR. HCCs that receive inquiries from OCR must direct OCR to the HIPAA Privacy Program.

4. Investigation of Complaints: The HIPAA Privacy Program reviews all complaints received, to determine whether a violation of HIPAA Policies and Procedures has occurred. If warranted by the initial review, the HIPAA Privacy Program will initiate an investigation within 10 business days after receipt of the complaint.
   A. Investigations may include review of documentation, interviews with personnel or other research, as deemed necessary by the HIPAA Privacy Program. Investigations may be conducted in coordination with Research Compliance Services (RCS), the Information Security Officer (ISO), the Office of General Counsel (OGC) or law enforcement, as appropriate.
   B. The HIPAA Privacy Program, in consultation with the ORCR, ISO or OGC, as appropriate, will identify an appropriate corrective action plan which aims to mitigate and/or remedy the issue that led to the complaint and to prevent future occurrences.
   C. All personnel must cooperate fully with the HIPAA Privacy Program, ORCR, ISO, OCG or law enforcement, as applicable, in the performance of an investigation.
   D. Confidentiality of all participants in the reported situation shall be maintained to the extent reasonably possible throughout any resulting investigation. The investigator(s) will conduct the necessary and appropriate investigation commensurate with the level of breach and the specific facts. This investigation may include, but is not limited to, interviewing the individuals involved, interviewing other individuals, obtaining specific facts surrounding the violation/breach and reviewing pertinent documentation.

5. Responses to Identified Complainants: The HIPAA Privacy Program will provide the complainant with an acknowledgment of receipt within 10 business days via the contact information provided or otherwise on file.
    A. Upon conclusion of the investigation, the HIPAA Privacy Program will provide a written response to the complainant within 60 days of filing the complaint.
    B. In the event that the review and investigation cannot be completed within 60 days of the filing of the Complaint, the HIPAA Privacy Officer will, when possible, communicate this determination to the complainant in writing and include an estimated timeframe for completion of the investigation.

6. Monitoring and Documentation: The HIPAA Privacy Program will document all complaints received and their disposition, if any, as required by the standards established at 45 CFR § 164.530(d) and (j). The HIPAA Privacy Program monitors complaints to identify patterns and develop process improvements to enhance the confidentiality, integrity and availability of PHI.

7. Reporting: If a policy violation is found, the HIPAA Privacy Program will consult with the ISO, OGC and the Office for Research & Discovery (ORD), as appropriate, to determine whether patient, OCR or media notification is required. If the person(s) whose information was involved is not to be notified of the confirmed privacy incident, the HIPAA Privacy Program will document the basis for this decision. If notification is required, the HIPAA Privacy Program will coordinate notice to the affected individuals with the assistance of the unit in question and other appropriate administrative units (see HIPAA Procedure 130: “Breach of PHI”). Violations that meet the definition of Breach under the HIPAA/HITECH will be reported as required to OCR.