Privacy - MODEL Facility Policy

POLICY NAME: Designated Record Set

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

Purpose: To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and the Information Blocking restrictions set forth at 45 CFR Part 171 and issued pursuant to the 21st Century Cures Act, and all Federal regulations and interpretive guidelines promulgated thereunder. To establish guidelines for the definition and content of the designated record set (§164.501).

Policy: A facility must specifically define, maintain and allow patient's/patient's personal representative (as defined by HIPAA and state law) certain rights to a designated record set (DRS) per the procedure outlined below. The DRS will encompass information beyond the traditional medical record and billing record. A facility must include information received from another facility during the patient's visit in their DRS unless they have documented facts that the information was not used in whole or in part to make a decision about the patient. Information received from other facilities after the patient is discharged must be sent back to the originator, placed into the shredding bin and destroyed or incorporated into the DRS.

The DRS impacts the definition of electronic health information (EHI) for purposes of and the Information Blocking restrictions set forth at 45 CFR Part 171 and issued pursuant to the 21st Century Cures Act. Electronic PHI that is part of the DRS will be considered EHI. EHI is not limited to information that is created or received by a health care provider, health plan, health care clearinghouse, public health authority, employer, life insurer, school, or university. EHI may be provided, directly from an individual, or from technology that the individual has elected to use, to an actor covered by the information blocking provisions.

It is important to note that the DRS does not equate to the United States Core Data for Interoperability (USCDI), as the USCDI data elements are a subset of the DRS.

Some states have separate patient privacy laws that may apply additional legal requirements. Consult your Operations Counsel to identify and comply with any such additional legal mandates.

Refer to the HIPAA Privacy Standards, 45 CFR Parts 160.103, and 164.501, and IP.PRI.001, the Patient Privacy Program Requirements Policy, for definitions.

Procedure:

1. Each facility must identify which forms and reports, when present in a patient's paper or electronic file, will be included in the DRS based on the HIPAA DRS definition. At a minimum, the following forms and reports must be included in the facility's DRS:
   - Facesheet
   - Coding summary
   - Discharge summary or labor and delivery summary
   - History and physical examination report or prenatal record

- Obstetrical and newborn forms
- Consultation report
- Operative, surgery or procedure report
- Pathology reports
- Results of any special tests or treatments (depending on the study, the results may or may not include tracings, but when final will include the interpretation (e.g., EKG/ECGs, holter monitors, stress test, pulmonary function study, blood transfusion records, or sleep study))
- Progress Notes (including medical student notes that are co-signed by the supervising physician (*with or without an addendum*))
- Order or prescription for a test/treatment
- Nursing documentation, including items such as vital sign graphics, intake and output records, neurocheck, medication sheets, intravenous fluid flow sheets, shift assessments, nursing notes, telemetry, admission history, care plan, discharge instructions, and release of body form.
- Interdisciplinary education record
- Laboratory reports, including blood typing or crossmatching
- Imaging/Radiology reports
- Cardiology reports
- Fetal and newborn monitoring strips
- Peri-operative documentation, including items such as surgery checklist, anesthesia records, intraoperative nursing forms, and recovery room forms
- Documentation of miscellaneous services, including social service, case management, food and nutrition, physical therapy, speech therapy, occupational therapy, respiratory treatments, arterial blood gas reports, and ventilator sheets
- Medication administration records
- Transfer forms
- Emergency Room (ER) records, including items such as facesheet, triage sheet, order sheet, T-chart, EMS form, and ER point form
- Consent to treat and any other admission forms signed by the patient
- A form acknowledging a patient is leaving against medical advice
- Informed consent forms for items such as surgery, blood, and dialysis
- Patient education records/discharge instructions
- Copies from physician offices or other healthcare facilities used to make health care decisions, such as a history and physical examination or surgical records
- Hospital Issued Denials or Advanced Beneficiary Notice forms
- Advanced Directives (e.g., durable power of attorney or living will), power of attorney, custody papers or other legal papers
- Detail Bill (includes detail of charges; also known as “itemized statement”)
- Uniform Bill (UB-04)

2. The following information is usually considered part of the source data of the DRS. A narrative of the interpretation from the source data would generally be acceptable. In most cases, individuals cannot interpret source data, so such data is meaningless. There may be times, however, when an individual has a legitimate need to access source data. When such a need arises, the covered entity will want to provide the individual with greater rights of access, allowing the individual access to or copies of the source data when possible. A specific request, authorization or subpoena is required to produce the original or to obtain a copy (if retained and/or able to copy) of this information:

- Birth certificates, birth certificate worksheets, paternity papers
- Imaging/Radiology films
- Electrocardiology tracings (EKG or fetal/newborn monitoring)
- Videotapes and digital recordings of procedures.
- Photographs that are not maintained as part of the medical record
- All release of information related correspondence (e.g., requests for copies from insurance companies, authorization forms, interdepartmental requests for records, and fax cover sheets)
- Copies of driver's licenses, insurance or social security cards

3. The following are not part of the DRS:
   - Psychotherapy notes as defined by the Standards for Privacy of Individually Identifiable Health Information (§164.501)
   - Peer review information
   - Incident reports
   - Infection control reports
   - Administrative, attorney-client privileged and any other protected reports
   - Medical student notes not co-signed by the supervising physician
   - Temporary notes or worksheets, reminders, and concurrent coding worksheets
   - Incomplete record coversheets, clarification notes to/from physicians, etc.
   - Pricing information not included in the patient's billing records, such as Chargemaster data and payer contract terms

4. The facility must have a process in place for the patient/patient's personal representative to access and amend on the use or disclosure of their DRS.

References:

1. Patient Privacy Program Requirements Policy, IP.PRI.001
2. Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information 45 CFR Part 164
3. Privacy Official Policy, IP.PRI.002
4. Patients' Right to Access Policy, IP.PRI.004
5. Patients' Right to Amend Policy, IP.PRI.005
6. Patients' Right to Request Privacy Restrictions Policy, IP.PRI.006
7. Accounting of Disclosures Policy, IP.PRI.009
8. Authorization for Uses and Disclosures of Protected Health Information Policy, IP.PRI.010
9. Records Management Policy, EC.014
10. *Journal of AHIMA* 74, no.1 (2003): 64A-D.
11. Privacy Act of 1974. 5 USC, Section 552A
12. Information Blocking Rule Compliance Policy, IP.GEN.006