Legal Health Record and the Designated Record Set Policy

Effective Date: August 2018

Policy Statement

The Columbia University Healthcare Component (CUHC) will comply with all regulatory requirements including the Legal Health Record and Designated Record Set as set forth by applicable state law and in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Reason(s) for the Policy

The HIPAA Privacy Rule affords patients certain rights related to their health information, including the right to examine and obtain a copy of certain health records, and to request corrections to their health information in those records. This policy informs workforce members how to administer a patients' Legal Health Record and the Designated Record Set as required by applicable state law and the HIPAA Privacy Rule.

Primary Guidance to Which This Policy Responds

45 CFR 164.501
45 CFR 164.524, 526

Responsible University Office & Officer

Health Information Management (HIM) Department, HIM Manager

Revision History

Issued: May 2013
Revised: August 2018

Who is Governed by This Policy

All CUHC workforce members

Who Should Know This Policy

All CUHC workforce members

Policy Text

Definitions of the Legal Health Record and Designated Record Set(s)

The CUHC defines the health record as follows:
A hybrid health record for patients seen in the private practice setting that may include both paper and electronic documents, and may use both manual and electronic processes. The health record is

comprised of the following components: the Legal Health Record and the Designated Record Set(s).

The Legal Health Record is the formally defined legal business record for the patients seen in the private practice setting by members of the CUHC. It includes:

1. documentation of the healthcare services provided to a patient in any aspect of healthcare delivery by a healthcare provider in his or her specialty within their individual clinical departments; and
2. information that the healthcare professional has used or relied upon in the treatment of that patient.

The Legal Health Record may contain records and reports obtained from third parties. CUHC cannot confirm the completeness or accuracy of such external records and each provider will use his or her own professional judgment regarding whether, and to what extent, to rely on such external records.

The Designated Record Set is a group of records which is maintained by or for the CUHC that includes:

1. medical and billing records about individuals; or
2. records used in whole or in part by or for CUHC to make decisions about a patient.

Components of the Legal Health Record

These records, as described above, may exist in both electronic and paper versions (historical documents may be on paper).

General Guidelines. The items that are entered or interfaced into the electronic health record (EHR) will be considered part of the Legal Health Record once assessed and accepted by the provider (i.e., finalized and/or verified). Research records that are separately designated or flagged as such in the EHR, however, are not considered part of the Legal Health Record or the Designated Record Set.

Scanned documents are part of the Legal Health Record if used for clinical decision making, and are of the types of components described below.

The following categories will be included as components of the Legal Health Record:

1. Clinical components included in the legal health record (if applicable):
    a. initial, follow-up, consult and procedure notes;
        i. patient communication documents, including event notes, telephone notes, email communications result letters, “no show” notes;
    b. orders;
    c. clinical images, results and reports (e.g., laboratory, radiology and pathology, and dermatopathology);
    d. vital signs;
    e. medication list;
    f. problem list;
    g. allergies;
    h. immunizations;
    i. patient, family, social, and surgical histories
    j. diagnostic tracings, videos, photos or slides;
    k. flowsheets;
    l. screenings and assessments;

m. treatment and education plans; and
n. authorizations and consents (inclusive of Advanced Directives).

2. Included in the Legal Health Record may be external records referenced for patient care or records provided upon transfer of a patient from one provider to another. These will be scanned into the EHR.

The following records are not part of the Legal Health Record:

1. Administrative Data is Patient-identifiable data used for administrative, regulatory, and healthcare operations purposes. Examples include but are not limited to:
    a. Correspondence concerning requests for records.
    b. Birth and death certificates.
    c. Event history/audit trails.
    d. Draft coding worksheets, including Patient-identifiable abstracts in coding system pending provider approval.
    e. Patient identifiable data compiled for quality assurance or utilization management.
    f. Administrative reports.
    g. Patient complaints and grievances.
2. Derived Data consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples:
    a. Accreditation reports
    b. Best practice guidelines created from aggregate patient data.
    c. ORYX reports, public health records and statistical reports.
3. Draft Documents / Work in Progress. Electronic processes and workflow Management require methods to manage work in progress. Draft documents are not considered to be included in the official Medical Record until signed by an authorized signer.
4. Psychotherapy Notes. Psychotherapy notes are not part of the Legal Health Record.

Components of the Designated Record Set(s)

These records include all of the items identified in the Legal Health Record above, as well as the following records:

1. Administrative and financial records, including:
    a. Remittance advice and records of payments;
    b. Case management records for coordination of care;
    c. Patient statements; and
    d. Claim forms.
2. Other information that may be used in whole or in part to make decisions about a patient.

Responsibilities

CUHC workforce members must comply with this policy.

Definitions

Designated Record Set – means a group of records maintained by or for the CUHC that is: (1) the medical and billing records about individuals; or (2) used, in whole or in part, by or for the CUHC to make decisions about individuals.

HIPAA Rules - The HIPAA Privacy, Security, Breach Notification, HITECH and Enforcement Rules as

amended from time to time 45 CFR Parts 160 and 164.

Protected Health Information (PHI) is individually identifiable health information:
(1) Except as provided in section (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium *(includes paper and oral communications)*.
(2) Protected health information excludes individually identifiable health information: (i) In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) In records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (iii) In employment records held by a covered entity in its role as employer; and (iv) Regarding a person who has been deceased for more than 50 years.

Contacts

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