ColumbiaDoctors The Physicians and Surgeons of Columbia University	Faculty Practice Organization: Policies & Procedures Section - Administrative Policy – 3.06
Subject: **Legal Health Record and the Designated Record Set**	**Date Issued:** **May 2013**

Definition

ColumbiaDoctors, the Physicians and Surgeons of Columbia University define the health record as follows:

A hybrid health record for patients seen in the private practice setting that includes both paper and electronic documents, and uses both manual and electronic processes. The hybrid health record is comprised of two components, the legal health record, and the designated record set. The following is definition of each:

> The **Legal Health Record** is the formally defined legal business record for the patients seen in the private practice setting by members of ColumbiaDoctors, the faculty practice organization for Columbia University. It includes 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. The health records of care delivered by these healthcare professionals in the course of providing patient care services in the outpatient setting includes information that the healthcare professional has used or relied upon in the treatment of that patient.

The legal health record maintained by ColumbiaDoctors may contain records and reports obtained from third parties. ColumbiaDoctors cannot confirm the completeness or accuracy of such external records and each ColumbiaDoctors provider will use his or her own professional judgment regarding whether, and to what extent, to rely on such external records.

> As per HIPAA privacy rule, the **Designated Record Set**[1] is "a group of records" which is maintained by or for ColumbiaDoctors that includes:
>
> 1) Medical and billing records about individuals maintained by or for a healthcare provider;
> 2) Enrollment, payment, claims adjudication, and case or medical management records maintained by or for a health plan; or
> 3) Records used in whole or in part by or for the provider to make clinical decisions about patients.

1. Components of ColumbiaDoctors Legal Health Record:

These records, as described above, may exist in both electronic and paper versions (historical documents are on paper). The current electronic legal health record is known as CROWN (Clinical Records On-line Web Network)

- **General Guidelines:** The items that are entered or interfaced into CROWN in electronic format will be considered part of the legal health record once assessed and accepted by the provider (i.e. "finalized" and/or "verified").
- Those notes that are not finalized should not be used/shared and/or disclosed and are not part of the legal health record. Only orders finalized and/or "committed" by identified providers are considered part of the legal health record.

[1] Federal Registry 45 CFR 164.501

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

The following categories will be included as components of the legal health record:

a. Clinical Record Components Included in the Legal Health Record:
   - Initial, Follow-up, Consult and Procedure Notes
   - Patient Communication Documents:
     - Includes: Event notes, telephone notes, email communications (where patients have consented as per CU Policy), result letters, "No Show" notes.
   - Orders
   - Clinical results and reports (e.g. Laboratory, Radiology and Pathology reports)
   - Vital signs
   - Medication List
   - Problem List
   - Allergies
   - Immunizations
   - Authorizations and consents (inclusive of Advanced Directives)

b. Clinical Data Components in the Legal Health Record:
   - Radiology Images
   - Diagnostic Images
   - Fetal monitoring strips
   - Diagnostic Videos or photos
   - Pathology slides
   - EKG tracings
   - EEG/EMG tracings

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

2. <u>Components of the Designated Record Set for ColumbiaDoctors:</u>

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

a. Administrative and Financial
- Remittance advice and records of payments
- Case Management records for coordination of care
- Patient Statements
- Claim Forms

b. Exclusions:
The Designated Record Set DOES NOT INCLUDE and the patient MAY NOT ACCESS:
- Psychotherapy notes about the patient
- Personal notes and observations about the patient created by health care provider(s) (provided that such notes are not included in health record CROWN)
- PHI that is compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding
- PHI that is subject to CLIA 1988

3. <u>Handling of historical paper records (prior to the go-live of CROWN)</u>:

a. Each practice/specialty/department will follow the scanning policy (CROWN Policy 2.31 "Scanning Policy") and scan the minimum data set into CROWN. The minimum data set includes:
- Last comprehensive visit note
- Last progress note
- Insurance cards (UNLESS THEY CONTAIN SOCIAL SECURITY #, SSN must be masked(removed) before cards are scanned into the EMR)
- HIPAA Acknowledgement – HIPAA acknowledgement must be signed once by every ColumbiaDoctors patient.
- Signed patient consents
- Referral Letters
- Provider to Provider Correspondence
- Health Care Proxy and/or Advanced Directives

b. The paper record in each specialty/department will be reviewed to determine any additional paper documents that they determine should be scanned into CROWN.

c. Once a practice/specialty/department has completed the scanning and review of their specified required documents into CROWN, the paper version of the document will be shredded according to CROWN Scanning policy 2.31.

d. Any remaining paper documents will be sent to storage and kept as per applicable federal and state medical record retention requirements.

4. Procedure for Responding to Record Requests:

a. General Guidelines for Copying Medical Records - Responding to Record Requests
- Check the dates of service/treatment - ONLY provide a copy of visits occurring within the date range or on specific date(s)
- Check specialties – ONLY provide a copy of visits to designated specialtie(s)
- Check provider – ONLY provide a copy of visits to the specified provider

b. Legal Health Records Requests (e.g. in the case of a subpoena)
- If the authorization requests information that has not been limited to one of the above notify the Quality Division (for example, a subpoena that names ColumbiaDoctors rather than a specific practice or provider)
- Ensure that the patient has authorized the release of his/her health information in writing per the Authorization to Disclose Patient Information Patient Access – Use and Disclosure of Medical Information PolicyScan the subpoena and signed release of information form into the legal documents folder in CROWN.
- Confirm that NYP Patient Services and ColumbiaDoctors Quality Division is aware of the request (as per the Patient Complaint Resolution Policy PC 1.09)
- Only provide information used for clinical care by the named provider and his/her staff
- Do Not include outside/external records.
- Use the Legal Health Record definition and components described above

c. Patient Record Requests:
- Ensure that the patient has authorized the release of his/her health information in writing per the Release of Information – Patient Access Policy H 118.
- Scan the signed release into the legal documents folder in CROWN.
- Use the Designated Record Set definition and components described above
- Only provide information specifically requested on the authorization or subpoena

5. Access and/ or Amendment of the Designated Record Set

For policies and procedures related to access and/or amendment of the designated record set http://www.cumc.columbia.edu/hipaa/pdf/Privacy_Program_Patient_Rights_Policy.pdf

References:

Section 33.16 of the State Mental Hygiene Law Article 81 of the Mental Hygiene Law

The Health Insurance Portability and Accountability Act of 1996 (HIPPA)

N.Y. Public Health Law Article 29-CC (The Family Health Care Decisions Act)

Article 27F of the New York State Health Law

NYS Public Health Law § 18

Authorization to Disclose Medical Information

Patient Complaint Resolution Policy PC 1.09

CLIA 1988

Scanning Policy for CROWN – Implementation Guidelines and Ongoing Management