LOUISIANA STATE UNIVERSITY
HEALTH CARE SERVICES DIVISION
BATON ROUGE, LA

POLICY NUMBER:	7529-24	
CATEGORY:	HIPAA	
CONTENT:	Designated Record Set	
APPLICABILITY:	This policy applies to the Health Care Services Division Administration (HCSDA) and Lallie Kemp Medical Center (LKMC) to include employees, physicians/practitioners, vendors and/or affiliates.	
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INQUIRIES TO	Health Care Services Division Compliance Section Post Office Box 91308 Baton Rouge, LA 70821	

Note: Approval signatures/titles are on the last page

LSU HEALTH CARE SERVICES DIVISION

Designated Record Set

I. STATEMENT OF POLICY

This policy will define documents patients have a right to access or amend within their medical and billing files and in accordance with the Health Insurance Portability Accountability Act (HIPAA) and other Federal, State, regulatory agency laws.

Note: Any reference herein to Health Care Services Division (HCSD) also applies and pertains to Lallie Kemp Medical Center (LKMC).

II. IMPLEMENTATION

This policy and subsequent revisions to the policy shall become effective upon approval and signature of the HCSD Chief Executive Officer or Designee.

III. DEFINITIONS

A. Designated Record Set (DRS) – a group of records maintained by or for a covered entity that is:

1. The medical and billing record(s) about a patient,
2. The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan, or
3. Used, in whole or part, by or for the covered entity to make decisions about patients.

For purposes of this definition, the term "record" means any item, collection or grouping of information that includes Protected Health Information (PHI) and is maintained, collected, used or disseminated by or for the facility; the term "record" includes (a) patient information originated by another healthcare provider and used by the facility to make decisions about the patient, and (b) tracings, photographs, videotapes, digital and other images that may be recorded to document care of the patient.

B. Protected Health Information (PHI) – Individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. Includes demographic data that relates to:

- the individual's past, present, future or physical, mental health condition;

- the provisions of health care to the individual, or;
- the past, present, future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. PHI includes many common identifiers such as name, address, birth date, social security number, etc.

C. Psychotherapy Notes – notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or group, joint or family counseling session and that are separated from the rest of the individual's record. Psychotherapy notes do not include: medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

IV. PROCEDURES

HCSD includes, but is not necessarily limited to, the following as being a Designated Record Set whether in paper or electronic format:

A. Inpatient/Outpatient Medical Records

1. Face sheet
2. Advanced Directives
3. Physician/Non-Physician Practitioner Orders
4. Telephone Consultations
5. Problem Lists
6. Emergency Room Record (i.e. Triage, Assessment and Examination, etc.)
7. Ambulance Record
8. Consent Forms
9. Discharge Summary Reports
10. History and Physical Reports
11. Progress Notes
12. Ancillary Reports
13. Therapy Notes
14. Operative, Surgery or Procedure Reports
15. Nurses Notes/Assessments
16. Medication Administration Record (MAR)
17. Intake/Output Records
18. Visit Sheets
19. Consults
20. Authorizations/Consents
21. Patient Submitted Documentation

22. Records obtained from other providers are a part of the designated record set for access only. Requests for amendments of such records will need to be directed to the provider of such information.
23. Source data not interpreted or summarized in the medical record (i.e. EKG strips, fetal monitor strips, etc)

B. Financial Records

1. Detailed Bills
2. Remittance Advices
3. UB 04, HCFA 1500
4. Insurance Information
5. Charge Sheets
6. Records of Payment
7. Adjustments
8. Advanced Beneficiary Notices (ABNs)
9. Financial Screening Record
10. Eligibility Information
11. Enrollment Records

C. Other records used to make decisions about patients:

1. Audiotapes not transcribed (e.g. dictation tapes, taped sessions with patients/family that would not be considered psychotherapy notes)
2. Videos/photographs of patients
3. Utilization review worksheets

D. Business Associate Records – Records maintained by a Business Associate that fall within the definition of Designated Record Set, that are **not** merely duplicates of information maintained by the facility, and which are required to determine compliance with HIPAA regulations and HCSD policy.

V. EXCLUSIONS

The HCSD Designated Record Set does not include health information generated, collected, or maintained for purposes that do not include decision making about the patient or which is exempt from disclosure to the patient:

A. Research records while the individual is part of a clinical trial, while the clinical trial is in progress.
B. Data collected and maintained for peer review purposes
C. Data collected and maintained for performance improvement purposes

D. Data collected and maintained for compliance purposes
E. Data collected and maintained for quality control purposes
F. Risk Management records
G. Appointment and surgery schedules
H. Birth and death registers
I. Surgery registers
J. Cancer Registry information
K. PHI that may not be released because it is covered by the Clinical Laboratory Improvements Amendments of 1988 (CLIA).
L. Psychotherapy Notes
M. Substance Abuse Treatment Records (pertaining to 42 CFR Part 2)
N. Information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding.
O. All employee health records
P. Copies of reports/documentation/forms wherein the originals are maintained in an "official" record maintained by the organization.
Q. Source Data – Interpreted or summarized in the individual's medical record (for example):

    1. Pathology slides
    2. Diagnostic films
    3. Electrocardiogram tracings from which interpretations are derived
    4. Photographs
    5. Fetal Monitor strips

VI. MAINTENANCE

The Designated Record Set materials will be maintained by each HCSD facility as required by Louisiana State law and/or federal rules and regulations.

VII. RESPONSIBILITY

Each facility must identify who is responsible, within the facility, for receiving and processing requests for access by individuals and processes for tracking requests for access and/or amendment (refer to HCSD Policy 7508).

VIII. EXCEPTION

The HCSD CEO or designee may waive, suspend, change, or otherwise deviate from any provision of this policy deemed necessary to meet the needs of the agency as long as it does not violate the intent of this policy, state and/or federal laws, Civil Service Rules and Regulations, LSU policies/Memoranda, or any other governing body regulations.

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