

POLICY INFORMATION		
Policy Title: Designated Record Sets Policy and Procedure		
Departmental Owner: Chief Compliance, Audit, and Privacy Officer		
Version Effective Date: 2/28/24		
Last Reviewed: 2/28/24		
SCOPE		
This policy applies to the following individuals and/or groups: ☑All of the below categories □All Employees □CT Employees □NY Employees □Remote Employees □Contractors□Volunteers □Students/Interns □Vendors		
This policy applies to all above listed Nuvance Health workforce members including but not limited to the following locations:		
\square All of the below entities		
□ Nuvance Health Systems		
$\hfill\Box$ Danbury Hospital (including New Milford Hospital Campus)	☐ Health Quest Systems, Inc. "(HQSI)"	☐ Western Connecticut Home Care, Inc ("WCHN")
⊠ Northern Dutchess Hospital	☐ Health Quest Home Care, Inc	☐ Western Connecticut Health Network Physician Hospital Organization ACO, Inc.
□ Norwalk Hospital	\boxtimes Hudson Valley Cardiovascular Practice, P.C. (aka The Heart Center) ("HVCP")	☐ Western Connecticut Home Care, Inc
☑ Putnam Hospital	☑ Other HQSI-affiliated Entities Not Listed	☐ Other WCHN-affiliated Entities Not Listed
Sharon Hospital		☑ Nuvance Health Medical Practices (NHMP PC, NHMP CT, ENYMS & HVCP)
⊠ Vassar Brothers Medical Center		

POLICY STATEMENT/PURPOSE

The purpose of this policy is to detail elements included in the Designated Record Set to which individuals have access and detail records that are exceptions to the Designated Record Set.

DEFINITIONS

See HIPAA Glossary

POLICY

The Designated Record Set is established for use throughout Nuvance Health and its affiliates ("Nuvance") for purposes of identifying that information to which individuals may have the right to request access to, that is subject to the HIPAA Privacy Rule requirement.

With limited exceptions, the HIPAA Privacy Rule gives individuals the right to access, upon request, the medical records and billing records about them in one or more Designated Record Set(s) maintained by or for Nuvance to make decisions about the individual.



PROCEDURE

Nuvance has a procedure for processing requests for designated record sets.

Nuvance shall, with limited exceptions, provide individuals and/or their personal representative(s) access to their respective designated record set upon proper authorization. The designated record set only applies when the information requested is released to the patient and/or personal representative and when the patient and/or personal representative request an amendment (see Patient's Right to Request Amendment to PHI).

This procedure outlines elements contained in the designated record which includes the following medical records and billing records:

A. IDENTIFYING THE NUVANCE DESIGNATED MEDICAL RECORD SET

The designated medical record set includes some or all of the following information depending on the patient's illness or injury and whether the patient was seen in the inpatient, out-patient, physician practice or emergency service environment:

- Identification Sheet/Face Sheet
- 2. Advance Directives
- 3. Problem List
- 4. History and Physical
- 5. Progress Notes (including interdisciplinary documentation)
- 6. Consultations
- 7. Physicians' Orders
- 8. Diagnostic Imaging Reports
- 9. Laboratory Reports
- 10. EKG Reports
- 11. EEG Reports
- 12. Pathology Reports
- 13. Anesthesia Records
- 14. Reports of Operations/Procedures
- 15. Therapy Reports
- 16. Recovery Room Records
- 17. Graphic Sheets
- 18. Medication Records
- 19. Nursing Documentation
- 20. Immunization Records
- 21. Discharge Instructions
- 22. Discharge Summary
- 23. Consents and Authorizations
- 24. Home Health Documentation
- 25. Transfer Records
- 26. Photographs (if included in the medical record)
- 27. W-10 Interagency Referral Forms
- 28. T19 Hysterectomy Consent Form
- 29. T19 Sterilization Form
- 30. Requests for Amendment



- 31. Amendments
- 32. Denials of Requests for Amendment

B. ITEMS EXEMPT FROM THE NUVANCE HEALTH DESIGNATED MEDICAL RECORD SET, INCLUDE BUT ARE NOT LIMITED TO, THE FOLLOWING:

- 1. Psychotherapy notes
- 2. Quality Assessment or Improvement Records
- 3. Peer Review Files
- 4. Practitioner or provider performance records
- 5. Patient safety activity records
- 6. Business planning, development and management for general business purposes. (e.g. formulary development records with an individual's PHI but used for general purposes)
- 7. Photographs, unless physically attached to a page of the medical record
- 8. Diagnostic images
- 9. Fetal monitoring strips, unless physically attached to a page of the medical record
- 10. EKG or other monitoring strips, unless physically attached to a page of the medical record
- 11. Pathology slides
- 12. Video tapings
- 13. Copies of prescriptions unless transcribed onto a progress note or computerized chart note
- 14. Copies of medical records from other facilities/physicians, except when specifically addressed to the institution or physician
- 15. Case management and other quality improvement/utilization management and operational documents
- 16. Other digitally recorded media

C. IDENTIFYING THE NUVANCE DESIGNATED BILLING RECORD SET

The designated billing record set includes some or all of the following forms depending on the patient's form of payment, location of service, Medicare eligibility, and whether a medical release or a response to a complaint was necessary:

- 1. Medical Release Forms
- 2. Medicare ABN Letter
- 3. Medicare Lifetime Reserve Letter
- 4. Medicare Notice of Non-Coverage Letter
- 5. Payment Agreement
- 6. Billing Statement
- 7. Charges/Adjustments/Payments Printout
- 8. Detail Bill
- 9. Requests for Amendment
- 10. Amendments
- 11. Denials of Requests for Amendment
- D. ITEMS EXEMPT FROM THE NUVANCE HEALTH DESIGNATED BILLING RECORD SET, INCLUDE BUT ARE NOT LIMITED TO, THE FOLLOWING:



- 1. Billing Screen (this is essentially part of a process that produces a detailed bill that is included in the designated billing record set).
- 2. Insurance information provided through the mail (the information is loaded into the billing system and then the paper copy is discarded).
- 3. Payer/Provider correspondence such as remittance advice/Explanation of Benefits and denial letters
- 4. Referral papers (The information is loaded into the billing system and then the paper copy is discarded.)

E. OTHER ELEMENTS OF A DESIGNATED RECORD SET MAY INCLUDE:

- a. The enrollment, payment, claims adjudication, case or medical management records maintained by and for a health plan
- b. Information used whole or in part or for the covered entity to make decisions about individuals.

ENFORCEMENT

All individuals whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate remedial and/or disciplinary action, up to and including termination of any employment or other relationship, in accordance with this policy.

REFERENCES

45 CFR, Parts 160 and 164 45 CFR 164.501 45 CFR 164.524(a)

APPROVAL

DocuSianed by: 6D04982F5DB24D1

2/28/2024

Signature

Date