PROCEDURE STATEMENT:
Health Quest Systems, Inc. and its’ affiliates (“HQ”) have a procedure for processing requests for designated record sets.

PROCEDURE:
HQ 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 HQ 5.2.18, 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 Health Quest 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 in-patient, out-patient, physician practice or emergency service environment:

1. 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 Health Quest 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
<table>
<thead>
<tr>
<th>Title:</th>
<th>Designated Record Sets Procedures</th>
<th>Reference Number:</th>
<th>HQ 5.2.23</th>
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<td>Signature:</td>
<td>Chief Compliance Officer</td>
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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 Health Quest 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 Life Time 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 Health Quest 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.

REFERENCES:
45 CFR, Parts 160 and 164
45 CFR 164.501
45 CFR 164.524(a)
5.2.23 Designated Record Sets Policy

POLICY HISTORY:
Supersedes: 2/27/14
Original Implementation Date: 2/27/14
Date Reviewed: 3/13/19, 3/26/20
Date Revised: 2/27/14, 3/13/19, 3/26/20

APPROVAL:

Policy Owner by 3.31.20