

SUNY DOWNSTATE MEDICAL CENTER
UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

No. HIPAA-15

Subject: MINIMUM NECESSARY
GUIDELINES

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I. PURPOSE

To ensure that uses, disclosures and requests for protected health information (PHI) are limited to the minimum amount of information that is reasonably necessary to perform their duties in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

A. Routine Activities- For all routine activities, each department must develop its own procedures limiting the uses and disclosures of PHI to the minimum amount reasonably necessary to achieve the intended purpose.

1. The following factors should be considered for each role/ function within each department:
 - a. Who may access/ receive the PHI? (Ex: Nurses)
 - b. Which types of PHI may be accessed/ received? (Ex: All PHI necessary for treatment)
 - c. In the records of which patients? (Ex: Patients in their assigned ward)

- d. During what time period, for what activities or under what conditions? (Ex: While on duty)
2. The above factors should be considered and appropriate minimum necessary guidelines documented for all routine:
 - a. Uses of PHI;
 - b. Disclosures of PHI; and
 - c. Requests for PHI.
3. All computer systems must be redesigned to include only the documented minimum necessary PHI for each role/ function within each department.

B. Non-Routine Activities- For all non-routine uses, disclosures or requests, the following criteria should be reviewed by the department supervisor, on an individual basis, in determining the minimum necessary standard:

1. What is the purpose of the use, disclosure or request?
2. What type of information is needed to accomplish the intended purpose?
3. What information is likely to be attached to this information and is the attached information also needed to accomplish the intended purpose?

C. Disclosures to Selected Individuals- When the following individuals/ organizations request PHI, the requested information may be released if the individual represents that it is the minimum necessary for the stated purpose:

1. Risk Management, Case Management, Quality Management, Legal Counsel or Compliance and Auditing personnel;
2. Court-ordered subpoenas;
3. Healthcare providers required to comply with the HIPAA privacy regulations;
4. Health plans providing or paying the cost of medical care that are required to comply with the HIPAA privacy regulations;
5. Healthcare clearinghouses converting health information to and from standard and non-standard formats that are required to comply with the HIPAA privacy regulations;
6. Researchers with appropriate documentation from the IRB that meets the requirements in the policy on Uses & Disclosures for Research.
7. Public officials with appropriate documentation and representation (See policy on Verification of Identity for additional guidelines).

D. Entire Medical Record

1. The specific justification for using, disclosing or requesting an entire medical record for routine and non-routine activities must always be documented.
2. Healthcare students and trainees may have access to the entire medical record, as needed, to appropriately complete their internships and training. Case studies or any other materials/ reports removed from SUNY Downstate premises must be de-identified.

E. HIV, Mental Health, Alcohol and Substance Abuse Information- There are special requirements related to HIV, mental health, alcohol and substance abuse information. The specific policies addressing these types of information should be reviewed before using, disclosing or requesting this information.

F. De-Identification & Limited Data Sets- When specific patient information is not necessary to accomplish the intended purpose, the information should be de-

identified or a limited data set should be used (Ex: Aggregate data for national outcome measurement).

G. Exceptions- The following uses, disclosures and requests are not limited by the minimum necessary guidelines:

1. Requests from, or disclosures to, another healthcare provider for treatment purposes;
2. Disclosures to the patient or personal representative;
3. Uses or disclosures made pursuant to an authorization;
4. Disclosures made to the Secretary of the Department of Health and Human Services (HHS) in determining or investigating compliance;
5. Uses and disclosures required by law; and
6. Uses and disclosures that are required in order to complete the electronic transaction and code set standards.

III. DEFINITIONS

None

IV. RESPONSIBILITIES

It is the responsibility of all medical staff members and hospital staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Hospital staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the hospital.

V. PROCEDURE/GUIDELINES

The development of the procedure section is the responsibility of the respective department. It is dependent upon the unique needs of each department's operating structure and shall be advanced and customized accordingly.

VI. ATTACHMENTS

None

VII. REFERENCES

Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.514(d)

	Revision	Required	Responsible Staff Name and Title
	Yes	No	Adeola O. Dabiri, Director of Regulatory Affairs
	Yes	No	
	Yes	No	
	Yes	No	