RUTGERS
THE STATE UNIVERSITY
OF NEW JERSEY

UNIVERSITY POLICY

Policy Name:	HIPAA Minimum Necessary Requirement					
Section #:	100.1.11	**Section Title:**	HIPAA Policies		**Formerly Book:**	
Approval Authority:	RBHS Chancellor/Executive Vice President for Health Affairs		**Adopted:**	3/8/2016	**Reviewed:**	3/8/2016
Responsible Executive:	Senior Vice President and Chief Enterprise Risk Management, Ethics and Compliance Officer		**Revised:**			
Responsible Office:	Office of Enterprise Risk Management, Ethics and Compliance		**Contact:**	Office of Enterprise Risk Management, Ethics and Compliance: 973-972-8093		

1. **Policy Statement**
   This policy describes the Minimum Necessary Requirement under HIPAA regulation, including the HITECH Act (2009) and the Omnibus Rule (2013). The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

2. **Reason for Policy**
   To establish the requirement that the Rutgers Covered Entity use and disclosure of PHI is within the Minimum Necessary Requirement as set forth by the federal government. The Minimum Necessary Requirement is a key protection of PHI based on sound practice that Protected Health Information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function.

3. **Who Should Read this Policy**
   This policy applies to and should be read by:

   I. The Rutgers Covered Entity and Covered Components within that entity, including faculty, employees, students, volunteers, trainees, and other persons whose conduct, in the performance of work for Rutgers and/or its units, is under the direct control of such Entity, whether or not they are paid by Rutgers.

   II. Any Rutgers University workforce member of any Rutgers school, unit or department that bills federal and/or state programs for the provision of medical care to patients, or engages in human subject research sponsored by federal, state or private programs.

   III. Any Rutgers University workforce member of any Rutgers school, unit or department that is engaged in the provision, coordination, or management of health care and related services among providers including third parties, consultations regarding a patient and patient referrals.

IV. Any Business Associate, independent contractor or other vendor providing services engaged by the Rutgers Covered Entity.

V. Other University departments that assist the Rutgers Covered Entity in certain activities including, but not limited to, Office of Enterprise Risk Management, Ethics and Compliance, the Office of Information Technology and the Office of the Senior Vice President and General Counsel.

4. **Resources**

I. 45 CFR 164.502(b) Code of Federal Regulations. Title 45, Part 164, Section 502(b), Security and Privacy, General Uses and Disclosures

II. 45 CFR 164.514(d) Title 45, Part 164, Section 514(d), Security and Privacy, Uses and

5. **Definitions**

I. Protected Health Information (PHI): Protected health information means individually identifiable health information that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual and identifies or could reasonably be used to identify the individual.

A. Except as provided in paragraph two (2) of this definition that is: a) transmitted by electronic media; b) maintained in electronic media; or c) transmitted or maintained in any other form or medium.

B. Protected health information excludes individually identifiable health information in: a) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; b) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and c) Employment records held by a covered entity in its role as employer.

C. Relevant individually identifiable health information of deceased individuals should considered active PHI for 50 years after death.

II. Business Associate (BA) A business associate is any organization (an individual person can be an organization, e.g. an independent consultant) that creates, receives, maintains, or transmits PHI on behalf of a covered entity (CE), including but not limited to the following:

A. a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management and re-pricing; or

B. any other function or activity regulated by HIPAA regulations; or

C. provides legal, actuarial, accounting, auditing, consulting, data aggregation (as defined in CFR § 164.501), management, administrative, accreditation, or financial services to or for Rutgers and/or its units, or to and/or for an organized health care arrangement in which Rutgers and or its units participate, where the provision of the service involves the disclosure of individually identifiable health information from such entities or arrangement, or from another Business Associate of such entities or arrangement, to the person.

III. Workforce: Faculty, employees, students, volunteers, trainees, and other persons whose conduct, in the performance of work for Rutgers and/or its units, is under the direct control of the Rutgers Covered Entity, whether or not they are paid by Rutgers.

IV. HITECH ACT (2009): Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) that was enacted on February 17, 2009.

V. HIPAA Omnibus Rule (2013): Enhancements to the HIPAA Privacy, Security, Enforcement and breach notification rules under HITECH and GINA. 45 CFR parts 160 and 164. See Federal Register, Vol 78 (17), Friday, January 25, 2013.

VI. Covered Entity: Either a (1) A health care provider, (2) health plan or (3) health care clearinghouse who transmits any health information in electronic form in connection with a transaction covered by 45 CFR 160.103. Covered Entities must comply with the HIPAA regulation, including the HITECH Act (2009), the Omnibus Rule (2013) and related state and federal law.

VII. Rutgers Covered Entity: The collective term referring to all units, schools or departments that meet the definition of a Covered Entity as put under 45 CFR 160.103 and are required to follow HIPAA regulation, including the HITECH Act (2009), the Omnibus Rule (2013) and other related state and federal law.

VIII. Rutgers Covered Component: Refers to a single unit, school or department within the Rutgers Covered Entity.

6. **The Policy**

I. Under this standard, the Rutgers Covered Entity must develop policies and procedures that limit information uses, disclosures and requests to those necessary to carry out the Rutgers Covered Entity work. Information that exceeds the minimum necessary will be withheld, or if required, redacted prior to release. Special attention will be given to information relating to alcohol or drug abuse, genetic testing, psychiatric care and confidential HIV-related information.

II. For disclosures made under a valid authorization, disclose the information to the extent specified in the authorization.

III. Absent an authorization, the Workforce of each Rutgers Covered Component must make reasonable effort to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose and will not access PHI that is not necessary for the performance of their relevant job duties.

IV. A Patient's entire medical record will only be provided if the entire medical record can be specifically justified as the minimum amount under the particular circumstance.

V. For routine and recurring requests, individual, case-by-case review is not required. The Rutgers Covered Entity will limit Workforce members' access to PHI to the minimum necessary through the appropriate safeguards, including but not limited to:
   A. restricting user access to systems that contain PHI based on job function (role) and duties,
   B. providing only the minimum necessary access level consistent with those duties, and
   C. in conjunction with Security policies and procedures.

VI. For non-routine or non-recurring requests individual, case-by-case review is required. The Rutgers Covered Entity will limit the amount of PHI disclosed to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. A review of non-routine disclosures should take into consideration reasonable criteria to limit the released data to the minimum necessary. Such criteria should include at a minimum:
   A. The purpose and importance of the request;
   B. Who is requesting the information;
   C. The data elements required to fulfill the request;
   D. The individuals who would receive the PHI;
   E. The inclusion of sensitive health information such as information related, but not limited to, mental health, drug and alcohol abuse and HIV-related data;

F. The extent of additional persons with access to the PHI; and
G. Other factors and information specific to each request

VII. Rutgers Covered Components will, for the purpose of providing PHI access concomitant with appropriate job settings, identify:
A. Those persons or classes of persons within the Rutgers Covered entity workforce, who need access to PHI to carry out their duties;
B. For each such person or class of persons, the category or categories of PHI to which access is needed; and
C. The conditions appropriate for such access.

VIII. The minimum necessary rule does not apply to the following circumstances:
A. Disclosures to or requests by a health care provider for treatment purposes.
B. Disclosures to the individual, or personal legal representative, who is the subject of the information.
C. Uses and disclosures made pursuant to an authorization.
D. Uses or disclosures required for compliance with the standardized HIPAA electronic transactions.
E. Disclosures to the Department of Health and Human Services when disclosure of information is required under HIPAA for enforcement purposes.
F. Uses and disclosures that are required by law.

IX. Rutgers Covered Components may, but are not required to, rely (if such reliance is reasonable) on a requested disclosure being the minimum necessary for the stated purpose when:
A. The covered entity is making disclosures to a public official where no authorization or consent is required, and the public official represents that the information requested is the minimum necessary;
B. The information is requested by another health care provider, health plan or health care clearing house covered under HIPAA;
C. The information is requested by a professional who is a member of the Rutgers Covered Entity Workforce or a Rutgers Covered Entity Business Associate if the professional represents that the information requested is the minimum necessary for the stated purpose; or
D. Documentation or representations are made that comply with the requirements of 45 CFR 164.512(i) (regarding uses and disclosures involving research).

X. Verification Requirement
A. Prior to the release PHI, Workforce members within each Rutgers Covered Component must verify the identity and authority of person(s) receiving PHI. Information will not be released until the person's right to receive the information is verified.
B. If the requesting person is a public official or someone acting on his or her behalf, the Rutgers Covered Component may rely upon the following:
1. Agency identification badge, credentials or other proof of status;
2. Government letterhead, if request is by letter;
3. A written statement of the legal authority (or, if impracticable, an oral statement) under which the information is requested.
4. If a request is made pursuant to a legal process, warrant, subpoena, order, or other legal process, it is presumed to constitute legal authority.
5. For persons acting on behalf of the official, a written statement on government letterhead or other evidence or documentation that establishes that the person is acting under the public official's authority (such as contract for services, memo of understanding). In this event, units must contact the Office of Legal Management to inform of such request by Public Officials.