

UNIVERSITY POLICY

Policy Name:	Protected Health Information – Destruction and Disposal				
Section #:	100.1.6	Section Title:	HIPAA Policies		Formerly Book: 00-01-15-45:00
Approval Authority:	RBHS Chancellor/Executive Vice President for Health Affairs	Adopted:	4/5/2004	Reviewed:	3/11/2016
Responsible Executive:	Senior Vice President and Chief Enterprise Risk Management, Ethics and Compliance Officer	Revised:	6/22/2011; 7/1/2013, 3/11/2016		
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 shall apply to the disposal or destruction of protected health information (“PHI”) generated during the provision of health care or health care payments to patients as well as Human Subjects research by:

- I. The Rutgers Covered Entity, individuals who may send or receive facsimile documents containing Restricted or Protected Health Information (PHI), 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 or any independent contractor, business associate or other vendor providing services and engaged by Rutgers that works with Protected Health Information (PHI).
- IV. Other University departments that assist the Rutgers Covered Components in certain activities including, but not limited to, the Office of Information Technology and the Office of the Senior Vice President and General Counsel.

2. Reason for Policy

To establish a policy to ensure Rutgers schools, units and departments that are covered entities and other Rutgers schools, units and departments that bill for healthcare goods and services and that are covered entities comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the HITECH Act (2009) and the Omnibus Rule (2013) by avoiding improper disclosure of PHI when destroying or disposing of documents or electronic assets that contain PHI.

3. Who Should Read This Policy

- I. Within the Rutgers Covered Entity and Covered Components within that entity, individuals who may send or receive facsimile documents containing Restricted or Protected Health Information (PHI), 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 engaged in the provision, coordination, or management of health care and related services among providers (including third parties and consultations regarding a patient and patient referrals).
- IV. Any Rutgers University workforce member or any independent contractor, business associate or other vendor providing services and engaged by Rutgers that works with Protected Health Information (PHI).
- V. Other University departments that assist the Rutgers Covered Components in certain activities including, but not limited to, the 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. Related Documents

- I. 45 CFR, 160, Code of Federal Regulations, Title 45, Part 160, Subpart C, General Administrative Requirements, Compliance and Enforcement.
- II. 45 CFR, 164.514(e), Code of Federal Regulations, Title 45, Part 164, Subpart E, Security and Privacy, Privacy of Individually Identifiable Health Information.
- III. 45 CFR, 164.530, Code of Federal Regulation, Security and Privacy, Administrative Requirements.
- IV. Records Management, Policy 30.4.5
- V. Records Management <http://recordsmanagement.rutgers.edu>.
- VI. Uses and Disclosures of Health Information With and Without an Authorization, Policy 100.1.1

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 be considered active PHI for 50 years after death.
- II. Business Associates (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 Components or arrangement, or from another business associate of such Components or arrangement, to the person.
- III. Covered Entity (CE): Either a (1) health care provider, (2) health plan or (3) health care clearinghouse that transmits any health information in electronic form in connection with a transaction covered by 45 CFR 160.103. Covered Entities must comply with HIPAA regulations, including the HITECH Act (2009), the Omnibus Rule (2013) and related state and federal law.
 - IV. Rutgers Covered Entity: The collective term referring to all units, schools or departments which 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 related state and federal law.
 - V. Rutgers Covered Components: Refers to a single unit, school or department within the Rutgers Covered Entity.
 - VI. 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.
6. **The Policy**
- I. The destruction and disposal of PHI will be carried out by the Rutgers Covered Entity Workforce in accordance with HIPAA regulations, including the HITECH Act (2009) and the Omnibus Rule (2013), related state and federal law, and University policy. All PHI will be destroyed in a manner in which it cannot be recovered nor reconstructed. Medical records will be maintained and destroyed in accordance with the University policy, Records Management.
 - II. The destruction/disposal of all PHI will be accomplished by shredding, incineration or other comparable fashion that ensures PHI cannot be recovered nor reconstructed. Material that has been destroyed must be stored in a secure container or receptacle, in a location not publicly accessible, until such time that the materials are collected by Custodial Services or any outside agency responsible for trash collection.
 - III. Until such time as destruction/disposal of PHI is permissible, all PHI, including that stored in hard drives or other electronic media, will be secured stored in a locked area to ensure against unauthorized or inappropriate access.
 - IV. If utilizing an outside agency for destruction/disposal of PHI, a contract and a Business Associate agreement must be executed between the Rutgers Covered Entity and the outside agency. The contract must state that, upon termination of same, the agency will return or destroy/dispose of all PHI, including proof of destruction/disposal and the methodology by which the material was destroyed.