

CASE NO. 14-1055

In the Supreme Court of Ohio

ON APPEAL FROM THE STARK COUNTY COURT OF APPEALS,
FIFTH APPELLATE DISTRICT
CASE NO. 2013 CA 00142

GENE'A GRIFFITH, EXECUTRIX FOR THE ESTATE
OF HOWARD E. GRIFFITH, DECEASED,
Plaintiff-Appellant,
v.
AULTMAN HOSPITAL.
Defendant-Appellee.

MERIT BRIEF OF APPELLEE AULTMAN HOSPITAL

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I. STATEMENT OF FACTS AND PROCEDURAL HISTORY

A. THE MEDICAL-RECORDS CASE

Appellant's decedent, Howard Griffith, died in May of 2012, while a patient at Aultman Hospital, and appellant requested the medical record. At the time, Aultman contracted with a business (HealthPort) to process requests for medical records. (Appellant Supp. p.7; Reagan-Nichols depo. vol. I, p.22)

HealthPort's production to Appellant, however, was incomplete (Id., p.60), and Appellant commenced this medical-records action on February 12, 2013, under R.C. 3701.74, to compel production of the medical record.¹ Aultman produced a copy of the medical record on February 28, 2013, in response to a request for production Appellant submitted with her complaint.

After Aultman produced the record, Appellant deposed Jennifer Reagan-Nichols, Aultman's Director of Medical Records, who testified that the medical record of a patient consists of the patient's chart, minus "any type of document that does not belong as part of the permanent medical record." (Appellant Supp. p.5; Depo., p.17.)

Aultman then moved for summary judgment on March 14, 2013, arguing that the action was resolved in light of the production. Appellant opposed the motion, arguing that more things "should be part of [Howard Griffith's] medical record" but were not produced. (Appellant's Brief Opposing Summary Judgment, p.12). In its reply brief of April 4, 2013, Aultman explained that it had produced the documents maintained as the medical record, and cited to its sworn interrogatory answer that "[a] complete copy of the chart [of Howard Griffith] is provided in response to the request for production of documents."

¹ At page 6 of her merit brief, plaintiff includes a section heading that "Aultman refused to provide Mr. Griffith's complete medical record...." There was no "refusal," but a performance failure by the medical records company. Plaintiff's charge of obstruction is one of two purposeful acts of misdirection she makes in this appeal. The other is discussed *infra* at pages 3-4.

The court held a hearing on the summary judgment motion on June 28, 2013. After the hearing, the court granted the motion on the same day.

Appellant appealed the judgment to the Stark County Court of Appeals, Fifth Appellate District, and the court affirmed the summary judgment on March 25, 2014. Appellant then moved the appellate court for reconsideration, and the court denied that motion on April 11, 2014.

Appellant appealed the summary judgment to the Stark County Court of Appeals, Fifth Appellate District. As she argues in her merit brief, Appellant argued to the appellate court that summary judgment was improper because there could, or should, be more data in the medical record, noting types of patient-specific data that were not part of the medical record produced.

That argument confuses the medical record with the universe of all patient-related data at the hospital. As Aultman explained in discovery, the medical record consists of information medical providers have deemed appropriate to maintain for the care of a patient. It is maintained in a discrete collection for that purpose. Necessarily, much patient-related information is generated that is not part of the record because providers have not determined it to be useful for patient care. For example, some equipment used in hospitals (such as heart monitors) generate enormous volumes of electronic data, which is not included in the medical record.

The Ohio law definition of medical record recognizes a discretionary process in its composition. Aultman produced what it maintained as the medical record of Howard Griffith.

Appellant, however, argued, as she does now, there are no limits to what qualifies as the medical record of a patient, and that it contains anything and everything the hospital has that pertains to the patient.

The appellate court rejected that argument, holding that the medical record consisted of the records that were maintained as such at Aultman Hospital. At paragraph 22, the court quoted from the argument of Aultman's counsel at the summary judgment hearing that "the critical word in [R.C. 3701.74] was maintained," and that "the only meaning that can attached to it, is that the hospital record is to be that which the hospital maintains, not that which a Plaintiff in a legal malpractice case – on in a medical malpractice case thinks should be maintained, not everything having to do with the patient, but that which a hospital determines needs to be maintained by a health care provider in the process of a patient's health care."

Stating, "We agree," the appellate court held:

Thus, the medical record consists of what was maintained by the medical records department and information that the provider decides not to maintain is not part of the medical record. Opinion, at ¶22. (App. 9)

Appellant moved for reconsideration, and the appellate court denied that motion on May 7, 2014.

Appellant brought a discretionary appeal to this Court, and the Court granted her jurisdictional motion.

B. THE MEDICAL NEGLIGENCE CASE

On May 6, 2013, after having filed this medical-records case, Appellant brought a separate action against Aultman Hospital and other defendants for medical negligence and wrongful death. Stark County Court of Common Pleas, Case No. 2013CV01234. Appellant conducted extensive discovery in that action, including discovery related to the existence of certain medical records.

In December of 2014, the parties settled the medical negligence case, and a judgment entry of dismissal was filed. Based on that dismissal, Aultman filed a motion to this Court to dismiss the appeal as improvidently granted.

Appellant filed a brief opposing the dismissal motion on February 8, 2015. At page 3 of that brief, Appellant wrote that Aultman Hospital “fails to tell this Court that the parties expressly excluded this appeal and the underlying controversy from that settlement,” and she quoted from the settlement agreement that “[t]his agreement is not a settlement of the claims and sought relief asserted [in the medical-records case] currently pending as Ohio Supreme Court case No. 2014-1055.”

Appellant is saying Aultman Hospital reneged on its settlement by moving for dismissal. She knows that is not the case, as is clear from the sentence immediately following the portion of the settlement agreement quoted by Appellant: “Plaintiff intends to pursue those claims and defendant reserves the right to argue they should be dismissed based on the dismissal entry filed as a result of this settlement.” (Supp.p.18.)

Thus, while the parties settled only the medical negligence case, Aultman did not agree to waive any argument that the settlement made this medical-records action moot. Appellant has attempted to mislead the Court on that point.

II. ARGUMENT

PROPOSITION OF LAW NO. 1

THE MEDICAL RECORD OF A PATIENT CONSISTS OF MEDICAL DATA AND INFORMATION CONCERNING THE PATIENT THAT THE PROVIDER HAS DETERMINED TO MAINTAIN AS THE MEDICAL RECORD.

Under R.C. 3701.74(A)(8), “medical record” is defined to mean, “data in any form that pertains to a patient’s medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient’s health care treatment.” (App. 19.) There are two aspects, therefore, to the meaning of the term: first, it is a patient’s health information “generated” by a health care provider; and, second, the information must be “maintained” by the provider. Information that the provider decides not to maintain, therefore, is not part of the medical record.

Appellant deposed Aultman's Director of Medical Records, Jennifer Reagan-Nichols, and questioned her on how patient medical records are created:

Q. Okay. Your only distinction as to what is made a part of a patient's medical record at Aultman Hospital is what the medical provider gives to you, correct?

A. Correct.

Q. And it is your testimony that it is at the discretion of the medical provider as to what they provide to you, correct?

A. Correct.

(Supp. p. 8; Reagan-Nichols depo. no.II, pp.103, 104.)

The appellate court agreed with Aultman Hospital and its director of Medical Records, stating, at paragraph 22 of the opinion:

Thus, the medical record consists of what was maintained by the medical records department and information that the provider decides not to maintain is not part of the medical record. (App. 9)

Appellant's challenge to the decision below has two features: (1) it rejects any limitation as to what constitutes a patient's medical record; and (2) it misrepresents the appellate court's decision as something meaningless and mechanical, i.e., that the record is determined by where records are physically stored.

A. The medical record consists of patient records that were selected for inclusion.

Appellant disputes that the medical record is in any way limited through a selection process. At page 16 of her brief, Appellant offers her definition of a patient's medical record:

... any data produced and preserved during the course of medical treatment is included in the patient's medical record.

Appellant says the medical record consists of any data "produced and preserved." Accordingly, any information produced during a patient's care that exists is the medical record. This definition bypasses any filtering process to separate information that no provider has deemed of value. Appellant's view is that every piece of data concerning a patient's medical care that exists is the medical record.

Her amici—associations of trial lawyers who would have no responsibility for managing a managing a medical record of the type contemplated by Appellant—share her view:

In short, a medical record is anything that pertains to the patient's medical history, diagnosis, prognosis or medical condition that was generated in the process of the patient's treatment.²

The flaw in Appellant's understanding is that it contradicts the statutory definition. The medical record of a patient is a record that is "maintained" by the hospital. The word "maintain" connotes a level of management that brings the data or information into a discrete set of records. Plaintiff reads the word "maintained" to mean only that the information still exists, whether or not any provider has determined it should be part of the patient's medical record. That interpretation strips all meaning of the word "maintained" in the statute. If the legislature intended to say that the medical record means all data and information concerning a patient's medical care, it would have said so.

A settled rule of statutory construction is that all the words used in a statute are presumed to have been included for meaning. See, e.g., *Marvin v. State*, 7 Ohio Dec. 204, 205, 1898 Ohio Misc. LEXIS 37 (1898) ("It is presumed that every word in the statute is inserted for some purpose."); *State v. Kasnett*, 30 Ohio App.2d 77, 84-85, 283 N.E.2d 686 (1972) ("...we wish to state that a cardinal rule is that the legislature will be presumed to have inserted every part of a statute for a purpose and to have intended that every part should be carried into effect. Indeed, it is also a cardinal rule that significance and effect should be accorded every part of the statute including every section, paragraph, sentence, clause, phrase and word. *United States v. Fisher* (1883), 109 U.S. 143, 3 S.Ct. 154, 27 L.Ed. 885; *McDonald v. Thompson* (1938), 305 U.S. 263, 59 S.Ct. 176, 83 L.Ed. 164."); R.C. 1.47(B)

² Brief of Amici Stark County Association for Justice and Southwest Ohio Trial Lawyers Association, at p.5.

(“In enacting a statute, it is presumed that ...[t]he entire statute is intended to be effective.”)

The legislature intended some meaning to the word “maintained” as used in the definition of medical record stated in R.C. 3701.74(A)(8). Appellant’s view is that information is maintained if it exists. That understanding strips any meaning from the word “maintained”; the statute could have the effect suggested by Appellant without the word, i.e.:

Medical record” means data in any form that pertains to a patient’s medical history, diagnosis, prognosis, or medical condition and that is generated ... by a health care provider in the process of the patient’s health care treatment.

The fact that the legislature included the word “maintained” means the data and information must have been selected for inclusion as part of the record. At pages 14 and 15 of her brief, Appellant writes that the word “maintain” “provides no inherent limitation on where or how the data is retained.” Under her view, therefore, if it exists—if it has not been destroyed—the data is “maintained.”

This reading ignores the meaning of a purposeful act that underlies the word maintain. Appellant offers the dictionary definition of the word on page 14 of her brief, as “to keep in an existing state; preserve or retain.” Citing the American Heritage Dictionary (5th Ed. 2014). This entails a deliberate act, that the data or information is preserved as part of the patient’s medical record.

As discussed extensively by Aultman’s amici, there are important patient-care considerations in defining what constitutes a patient’s medical record. If the record is deemed to include all the data in the hospital concerning the patient, the sheer volume of information (assuming it could all be included) would degrade the usefulness of the record for physicians. The electronic data stored in medical devices alone could run thousands of

pages, and a physician reviewing the record to care for the patient would lose the benefit of any sorting by other care providers based on relevance.

Appellant, obviously, anticipated this over-inclusion objection to her reading of the statute, because, at page 16, she writes “[t]his is not to say that health care providers have an obligation to preserve all data generated during the treatment process.” That statement contradicts the concern she expressed, repeatedly, throughout her brief about providers “unilaterally, self-selecting” what to include in the record. Once patient-related data is stored in some manner, it would meet plaintiff’s definition of the medical record, and a provider who failed to keep the record could be liable for punitive damages under the decision in *Moskovitz v. Mt. Sinai*, 69 Ohio St.3d 638, 635 N.E.2d 331 (1994), at paragraph one of the syllabus.³ Modified on other grounds by R.C. 2505.02. See *Cobb v. Shipman*, Trumbull App. No. 2011-T-0048, 2012-Ohio-1676, at ¶34.

B. The medical record is not determined by where information is stored.

The proposition of law Appellant has presented urges the Court not to “permit [a hospital] to withhold portions of a patient’s medical record by unilaterally selecting and storing those medical records in a department other than its medical records department.”

Setting aside the tone of contempt Appellant uses in this wording, and her unexplained hope that the Court will approach her issue with some disdain for the business integrity of Ohio hospitals, the proposition of law mischaracterizes the judgment below. The appellate court did not hold that the question of what constitutes a medical record depends on where that record is physically located within the hospital. It held, reasonably and correctly, that the medical record consists of the data and information that a provider has selected to include as part of the patient’s medical record.

³ In the medical negligence case she brought against Aultman Hospital, appellant included a claim for spoliation and punitive damages based on the alleged willful destruction of cardiac monitor data.

At paragraph 22, the court quoted from the argument presented by Aultman's counsel at the summary judgment hearing that when R.C. 3701.74 conditions the medical record to be information "maintained" by the provider, it necessarily means the record is "...that which a hospital determines to be maintained by a health care provider in the process of a patient's health." The court agreed, and held:

Thus, the medical record consists of what was maintained by the medical records department and information that the provider decides not to maintain is not part of the medical record.

In other words, the provider's selection of the information makes it part of the record and, therefore, it becomes the responsibility of the hospital to maintain.

In her attempt to discredit the appellate court's judgment, Appellant tries to cast it as a mechanical and senseless test that considers only the physical location of the record. That is not the court's holding.

Appellant attempts to connect her point with the circumstances of this case by discussing the cardiac monitor printout that Aultman's risk management employee made after the death of her decedent. The printout was not made on the decision of a physician for inclusion into the medical record and, accordingly, was not included in the record.

C. The designated record set is not the medical record.

Appellant's argues that the medical record is no different from the designated record set that is described in 45 CFR 164.501, and which includes billing and insurance claim records. At page 17 of her brief, Appellant writes that Aultman's director of the medical records department "testified that Aultman does not distinguish between 'medical record' as defined by R.C. 3701.74(A)(8) and 'designated record set' as defined by 45 CFR 164.501."

The question to the director on this point did not refer to the CFR in reference to the designated record set, but suggested the term was synonymous with the medical record:

- Q. Are you familiar in what defines a medical record? Are you familiar with the term “designated record sets?”
- A. Yes.
- Q. And what does that mean?
- A. What we consider to be the legal medical record.
(Supp. p.8; Depo., p.104)

Appellant did not reference the CFR in her question, but used the term as a suggested definition of the medical record.

Appellant’s suggestion that the designated record set is somehow identical with a patient’s medical record is inconsistent with the definition of the designated record as stated in 45 CFR 164.501, which says it means:

- (1) A group of records maintained by or for a covered entity that is:
- (i) the medical records and billing records about individuals maintained by or for a covered health care provider;
 - (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
 - (iii) used, in whole or in part, by or for the covered entity to make decisions about individuals. (App. 23.)

Under the CFR, the patient’s medical record is a subset of patient-specific records within the designated records set. By definition, the two are not the same thing.

Significantly, in defining the designated record set to include patient-related information in addition to the medical record, the definition undercuts Appellant’s proposal that all patient-related information, without any limitation, should be considered the medical record.

D. The medical records statute does not authorize physicians or hospitals to hide inculpatory records.

Throughout her brief, Appellant suggests a need to protect against medical providers who would hide inculpatory records by not including them as part of the medical record.⁴ She argues that the Fifth District's decision somehow authorizes such conduct.

Any provider who concealed inculpatory evidence through any means would be liable for fraud. Fraudulent concealment is shown where there is concealment of a material fact, made knowingly, with the intent of inducing the other's reliance. *Williams v. Aetna Finance Co.*, 83 Ohio St.3d 464, 475, 700 N.E.2d 859 (1998).

A physician fraudulently concealing medical records would be liable for compensatory and punitive damages.

The Fifth District's decision does not authorize fraud.

PROPOSITION OF LAW NO. 2

AN APPELLATE COURT HAS NO JURISDICTION TO REVIEW MATTERS THAT DO NOT INVOLVE AN ACTUAL CONTROVERSY.

In this appeal, Appellant asks the Court to reverse the summary judgment motion. The effect of that relief would be a remand to return the matter to the trial court to continue Appellant's action for production of the medical record.

Nowhere in Appellant's brief does she explain how a favorable ruling would be of any value to her. Rather, she discusses the import of the case only in abstract terms, either in reference to the supposed need to guard against fraud or the value to patients seeking "to

⁴ See, e.g., p.1 ("Judge Delaney's dissent recognizes that allowing the definition of a medical record to be changed based upon the location of the department to which those records are sent would permit the concealment and sanitization of medical records that the medical provider does not want to disclose to its patient."); p. 28 ("With the Fifth District's decision in *Griffith*, hospitals are now given the seal of approval to hide incriminating evidence by storing it in any part of the hospital other than the medical records department."); p.31 ("In turn, medical providers should not be given the seal of approval to store inculpatory records in a department other than the medical records department to prevent them from having to disclose such records to their patients..... The Fifth District's decision ... authorizes medical providers to provide an incomplete, sanitized medical record to its patients.")

determine the truth regarding their medical diagnosis, prognosis, and care or treatment.”
(Brief, p.31.)

Appellant has settled her medical negligence case. The Court has, in the record, a copy of the release and settlement agreement concluding that case. An order remanding this case for further discovery in the hope of finding more of Mr. Griffith’s medical record would have no effect on the plaintiff. It would be a waste of time.

Aultman has moved to dismiss this appeal as improvidently granted. In response, Appellant argues her right to litigate this case simply because the statute, R.C. 3701.74, gives her the right, i.e., “...Appellant has not received the relief she is entitled to and that is still to be granted.” (Memo opposing motion to dismiss, p.6.)

That argument does not meet the test. Appellant must show that the outcome of the appeal would redress an injury. The Court has no authority to decide cases in the absence of a controversy. As this Court has held, “[a]ppeal lies only on behalf of a party aggrieved by the final order appealed from. Appeals are not allowed for purposes of settling abstract questions, but only to correct errors injuriously affecting the appellant.” *Ohio Contract Carriers Assn. v. Pub. Util. Comm.*, 140 Ohio St. 160, 42 N.E.2d 758 (1942), at syllabus. See also, *Ohio Domestic Violence Network v. Pub. Util. Comm.*, 65 Ohio St.3d 438, 439, 605 N.E.2d 13, 14 (1992); *State ex rel. Gabriel v. Youngstown*, 75 Ohio St.3d 618, 619, 665 N.E.2d 209 (1996).

Appellant wrote in her response brief that she might “possibly want” to pursue litigation in this medical records case after remand to explore “what happened or did not happened [sic] with respect to her father’s medical care, her family medical history, amending incorrect information, discovering whether fraud occurred in the wrongful death case, and inquiring as to billing/lien disputes.” None of those matters concern any controversy that would support this litigation. Moreover, Appellant is bringing this action

as fiduciary of her decedent's estate, and the suggested rationales she has offered for continuing the litigation are personal to her.

Appellant made clear the purpose for this litigation in her merit brief at the conclusion where she wrote, "Parties should have a right to access all medical information that satisfies R.C. 3701.74(A)(8) and 45 C.F.R. 164.501...." The purpose of the litigation is to change the law affecting medical records, not for any benefit to Appellant, but to serve a perceived need in the society. The Court has no authority to decide questions in the absence of a real controversy affecting the parties.

Appellant wrote in her response brief that the Court could hear the appeal even though there is no controversy because the matter involves great public or general interest. In support, she cites *Danis Clarkco Landfill Co. v. Clark Cty. Solid Waste Mgt. Dist.*, 73 Ohio St.3d 590, 598, 1995-Ohio-301, 653 N.E.2d 646, 653 (1995). In *Danis*, however, the court noted that "... a real, justiciable controversy exists between the parties which is neither merely academic nor abstract." *Id.*

Appellant also cites to *Franchise Developers, Inc. v. Cincinnati*, 30 Ohio St.3d 28, 505 N.E.2d 966, as authority for her argument that the Court may decide cases involving abstract questions where there is no real controversy. In *Franchise Developers*, the court addressed a case that was not necessarily moot as to all litigants and that involved a constitutional question. Here, the controversy is resolved as to all the parties, and no constitutional question is involved. While Appellant argues that it presents a matter of great and general public interest, she has cited to no other decision in this state or in any other jurisdiction that has addressed her issue.

Appellant argues that the case qualifies for an exception to the mootness doctrine because, she claims, it is "capable of repetition yet evading review." She writes that an action to compel production of a medical record "may very well" extend beyond the one-year

statute of limitations governing medical negligence cases under R.C. 2305.113. This very case contradicts plaintiff's argument. Appellant filed her complaint to obtain the medical record and timely commenced an action for medical negligence. The only reason the question of mootness arose is that plaintiff, a fiduciary litigating an action to obtain the medical records of a deceased individual, settled the medical negligence/wrongful death case.

Finally, the case is barred by res judicata. As this Court has held:

A valid final judgment rendered upon the merits bars all subsequent actions based upon any claim arising out of the same transaction or occurrence that was the subject matter of the previous action.

Grava v. Parkman Twp., 73 Ohio St.3d 379, 1995-Ohio-331, 653 N.E.2d 226 (1995), at paragraph one of the syllabus.

A "transaction" is defined as a "common nucleus of operative facts." *Grava*, 73 Ohio St.3d 382; Restatement of the Law 2d, Judgments (1982) 198-99. As explained in the Restatement:

When a valid and final judgment rendered in an action extinguishes the plaintiff's claim pursuant to the rules of merger or bar ***, the claim extinguished includes all rights of the plaintiff to remedies against the defendant with respect to all or any part of the transaction, or series of connected transactions, out of which the action arose.

Section 24(1) of the Restatement of Judgments, supra, at 196. See, also, 46 American Jurisprudence 2d, Sections 516 and 533; *Gwen v. Reg'l Transit Auth.*, Cuyahoga App. No. 82920, 2004-Ohio-628, 2004 Ohio App. LEXIS 617.

Appellant's medical-records case and her medical negligence/wrongful death case arose out of the same nucleus of operative facts, i.e., the care given to Howard Griffith at Aultman Hospital. Appellant settled the medical negligence case, and that settlement extinguishes this case under the rules of merger.

In response, Appellant argued that the cases did not arise out of the same operative facts because the records case was an action seeking the decedent's medical record and the medical negligence case sought damages for alleged negligence in his care. An "operative

fact” is defined as “a fact that affects an existing legal relation, esp. a legal claim” or “a fact that constitutes the transaction or event on which a claim is based.” Black’s Law Dictionary 670 (9th Ed.) See also Restatement of Agency, § 284a (defining operative facts as “[t]hose facts which constitute the transaction or event upon which a cause of action or defense is based.”)

Both the negligence case and the records case arose out of the care that was rendered to plaintiff’s decedent; the care given to the decedent affected the legal relation between the parties and gave rise to both the claim for the medical record and for the alleged medical negligence.

Appellant’s claim is barred by the doctrine of res judicata and for mootness. There is no controversy between the parties. The underlying lawsuit between them has been settled, and the outcome of this case will not affect the parties. The Court should dismiss the appeal.

III. CONCLUSION

The appellate court held, correctly, that a patient’s medical record consists of those records that a provider has selected for inclusion. It is not, as suggested by Appellant, the entire universe of all patient information. The interpretation suggested by Appellant would impose an unmanageable burden on hospitals, and would degrade patient care.

Most importantly, Appellant’s interpretation does not fit the statutory wording. R.C. 3701.74 defines a medical record to consist of records that are “maintained” by the provider, which means they are managed as such. Appellant’s reading of the statute effectively removes the qualifying word “maintained” from the statute.

Finally, the Court should deny this appeal because there is no controversy. The parties have settled the underlying medical negligence case, and the outcome of this appeal will have no effect on the parties.

Appellee, Aultman Hospital, requests that the Court deny this appeal and affirm the judgment below.

Respectfully submitted,

MILLIGAN PUSATERI CO., LPA

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CERTIFICATE OF SERVICE

A copy of the foregoing *Merit Brief of Appellee Aultman Hospital* was sent by regular U.S. mail this 17th day of February, 2015 to the following:

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Document: Gene'a Griffith v. Aultman Hosp., 2014-Ohio-1218

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Gene'a Griffith v. Aultman Hosp., 2014-Ohio-1218

Copy Citation

Court of Appeals of Ohio, Fifth Appellate District, Stark County

March 25, 2014, Date of Judgment

Case No. 2013CA00142

Reporter

2014-Ohio-1218 | [2014 Ohio App. LEXIS 1147](#) | [2014 WL 1342988](#)

GENE'A **GRIFFITH**, EXECUTRIX FOR THE ESTATE OF HOWARD E. **GRIFFITH**, DECEASED, Plaintiff - Appellant -vs- **AULTMAN HOSPITAL**, Defendant - Appellee

Subsequent History: Discretionary appeal not allowed by [Griffith v. Aultman Hosp., 2014-Ohio-4414](#), 2014 Ohio LEXIS 2529 (Ohio, Oct. 8, 2014)

Prior History: CHARACTER OF PROCEEDING: Appeal from the Stark County Court of Common Pleas, Case No. 2013CV00487.

Disposition: Affirmed.

Core Terms

medical records, patient's, healthcare provider, trial court, summary judgment motion, appellee's, provider, discovery, records, additional discovery, summary judgment, strips, risk management, deposition, genuine

APP. 001

Case Summary

Overview

HOLDINGS: [1]-There was no genuine issue of material fact as to whether defendant had produced a decedent's entire medical record under R.C. 3701.74, as information that a provider decided not to maintain was not part of the medical record and nothing indicated that the statute was intended to be used as a broad discovery device; [2]-The trial court properly denied plaintiff additional time to conduct discovery under Civ.R. 56(F), as the information sought either did not fall within the definition of a medical record and/or had already been provided by defendant.

Outcome

Judgment affirmed.

▼ LexisNexis® Headnotes

Civil Procedure > ... > [Summary Judgment](#) ▼ > [Entitlement as Matter of Law](#) ▼
> [General Overview](#) ▼

HN1 See Civ.R. 56(C). [Shepardize - Narrow by this Headnote](#)

Civil Procedure > ... > [Summary Judgment](#) ▼ > [Burdens of Proof](#) ▼
> [Movant Persuasion & Proof](#) ▼

Civil Procedure > ... > [Summary Judgment](#) ▼ > [Burdens of Proof](#) ▼
> [Nonmovant Persuasion & Proof](#) ▼

HN2 The moving party bears the initial responsibility of informing the trial court of the basis for the motion for summary judgment, and identifying those portions of the record before the trial court, which demonstrate the absence of a genuine issue of fact on a material element of the nonmoving party's claim. The nonmoving party then has a reciprocal burden of specificity

APP. 002

and cannot rest on the allegations or denials in the pleadings, but must set forth specific facts by the means listed in [Civ.R. 56\(C\)](#) showing that a triable issue of fact exists. [Shepardize - Narrow by this Headnote](#)

Civil Procedure > ... > [Summary Judgment](#) ▼ > [Entitlement as Matter of Law](#) ▼
> [General Overview](#) ▼

HN3 A trial court may not enter summary judgment if it appears a material fact is genuinely disputed. [Shepardize - Narrow by this Headnote](#)

Healthcare Law > [Business Administration & Organization](#) ▼ > [General Overview](#) ▼

HN4 See [R.C. 3701.74](#). [Shepardize - Narrow by this Headnote](#)

Healthcare Law > [Business Administration & Organization](#) ▼ > [General Overview](#) ▼

HN5 [R.C. 3701.74\(A\)\(8\)](#) defines a "medical record" as meaning "data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment." [Shepardize - Narrow by this Headnote](#)

Healthcare Law > [Business Administration & Organization](#) ▼ > [General Overview](#) ▼

HN6 The critical word in [R.C. 3701.74\(A\)\(8\)](#) is "maintained," and the only meaning that can be attached to it is that the hospital record is to be that which the hospital maintains, not that which a plaintiff in a legal malpractice case -- or in a medical malpractice case -- thinks should be maintained, not everything having to do with the patient, but that which a hospital determines needs to be maintained by a health care provider in the process of a patient's health care. Thus, the medical record consists of what was maintained by the medical records department, and information that the provider decides not to maintain is not part of the medical record. [Shepardize - Narrow by this Headnote](#)

Civil Procedure > [Discovery & Disclosure](#) ▼ > [General Overview](#) ▼

Healthcare Law > [Business Administration & Organization](#) ▼ > [General Overview](#) ▼

HN7 The purpose of [R.C. 3701.74](#) is to enable a patient to obtain his or her file in order, for example, to obtain a second opinion or transfer to another medical provider. There is nothing in the statute indicating that the statute was intended to be used as a broad discovery device. [R.C. 3701.74](#) is contained in Title 37 of the Revised Code, which is titled "Health-Safety-Morals." More specifically, [R.C. 3701.74](#) is a miscellaneous provision contained in Chapter 3701, which is titled "Department of Health." The civil rules do not contain a similar provision. [Shepardize - Narrow by this Headnote](#)

Civil Procedure > ... > [Summary Judgment](#) ▼ > [Opposing Materials](#) ▼
> [Motions for Additional Discovery](#) ▼

HN8 See [Civ.R. 56\(F\)](#). [Shepardize - Narrow by this Headnote](#)

Civil Procedure > [Judicial Officers](#) ▼ > [Judges](#) ▼ > [Discretionary Powers](#) ▼

Civil Procedure > [Appeals](#) ▼ > [Summary Judgment Review](#) ▼ > [Standards of Review](#) ▼

Civil Procedure > ... > [Summary Judgment](#) ▼ > [Opposing Materials](#) ▼
> [Motions for Additional Discovery](#) ▼

HN9 The decision of whether to grant or deny a [Civ.R. 56\(F\)](#) continuance is within the sound discretion of the trial court. In order to find an abuse of discretion, an appellate court must determine the trial court's decision was unreasonable, arbitrary or unconscionable and not merely an error of law or judgment. [Shepardize - Narrow by this Headnote](#)

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For Defendant-Appellee: RICHARD S. MILLIGAN, Milligan Pusateri Co., LPA, Canton, OH.

Judges: Hon. John W. Wise ▼, P.J., Hon. Patricia A. Delaney ▼, J., Hon. Craig R. Baldwin ▼, J.
Wise ▼, P.J. concur. Delaney ▼, J. dissents.

Opinion by: Craig R. Baldwin ▼

Opinion

Baldwin ▼, J.

[P1] Plaintiff-appellant Gene'a **Griffith**, Executrix for the Estate of Howard E. **Griffith**, Deceased, appeals from the June 28, 2013 Judgment Entry of the Stark County Court of Common Pleas granting the Motion for Summary Judgment filed by defendant-appellee **Aultman** Hospital.

STATEMENT OF THE FACTS AND CASE

[P2] Howard E. **Griffith** was a patient at appellee **Aultman** Hospital from May 2, 2012 until his death on May 8, 2012. **Griffith** had surgery on May 2, 2012 and, after developing a heart arrhythmia, was placed on a cardiac monitor on May 4, 2012. On May 6, 2012, he was found unresponsive with the leads to his cardiac monitor detached from his chest. He was taken off of life support on May 8, 2012 and died on such date. Appellant is his daughter and the Executrix of his estate.

[P3] After her attempts to obtain a complete copy of her father's medical records were unsuccessful, appellant, who had received some medical records from appellee, filed an action on February 12, 2013 against appellee pursuant to R.C. 3701.74 to compel production of her father's complete medical record from his admission on May 2, 2012 until his death on May 8, 2012. Appellant, in her complaint, alleged, in part, that appellee had failed to produce any monitoring strips for her father's vital signs from the early morning of May 6, 2012, among other times, and any nurses' records from the morning of May 6, 2012, among other times. Appellee, on March 8, 2013, filed an answer to appellant's complaint. Appellee, in its answer, alleged that it had provided appellant with her father's complete medical record on February 28, 2013.

[P4] Appellant, on March 11, 2013, deposed Jennifer Reagan-Nichols, appellee's Director of Medical Records. Reagan-Nichols testified that a medical record consisted of a patient's chart minus any type of document that did not belong as part of the patient's permanent medical record. She further testified that appellee decided what was part of a patient's medical record and that appellee's definition of what was a medical record was the same definition as set forth in R.C. 3701.74. Reagan-Nichols further testified that Bates Numbers 655 to 707, which appellee produced

in response to Request for Production No. 1, were not part of the medical record because "those documents are [EKG] rhythm strips that do not print out of other systems that we don't get...." Reagan-Nichols Dep. Vol. I at 42. She testified that the nursing staff did not print out the same and send them to the medical records department and that the medical records department did not have access to the rhythm strips. She was unable to say where the rhythm strips were maintained and testified that she did not know if they met the definition of a medical record.

[P5] Appellee, on March 14, 2013, filed a Motion for Summary Judgment supported by the sworn interrogatory answers of Reagan-Nichols. Reagan-Nichols, in her answers, indicated that a complete copy of Howard **Griffith's** medical chart had been provided to appellant. On March 28, 2013, appellant filed a memorandum in opposition to appellee's Motion for Summary Judgment and a Motion to Conduct Additional Discovery pursuant to Civ.R. 56(F).

[P6] After Reagan-Nichols submitted an errata sheet that changed her testimony, the trial court permitted appellant to take a second deposition of Reagan-Nichols. During the May 24, 2013 deposition, Reagan-Nichols testified that the reason Bates Numbers 655 to 707 were not considered part of Howard **Griffith's** medical record was because they were never provided to the medical records department. Reagan-Nichols testified that they had been printed at the direction of appellee's Risk Management Department and stored by such department. She further testified that if a record or document is not given to the medical records department, it is not made part of the patient's medical record even if another part of the hospital may have a copy. Reagan-Nichols, when asked, testified that she meant to change her testimony to state that Bates Numbers 655 to 707 did not meet the legal definition of a medical record. When asked if she agreed that they were medical records of a patient, she stated that she did. According to Reagan-Nichols, "if they provide it to us [the medical records department], then we make it part of the medical record. Reagan-Nichols Dep. Vol. II at 103. She agreed that the only distinction as to what was part of a patient's medical record was what the medical providers gave to the medical records department and that it was within the provider's discretion as to what to provide to the medical records department.

[P7] During her deposition, Reagan-Nichols testified that she did not know if the Risk Management Department had any other records for Howard Griffiths that had not been provided to appellant.

[P8] After Reagan-Nichol's second deposition, both parties filed supplemental briefs. Appellant, in her June 7, 2013 supplemental brief, asked, in the alternative, to be permitted to conduct additional discovery pursuant to Civ.R. 56(F) "to determine where and why another page from Mr. **Griffith's** medical record suddenly appeared, what other departments including risk management have other medical records regarding Mr. **Griffith** that have not been produced, and to obtain the

additional monitoring equipment information regarding Mr. **Griffith** that has not been produced." Attached to the brief was a letter from defense counsel dated May 31, 2013 supplementing the prior discovery responses with Bates Number 708.

[P9] On June 28, 2013, an oral hearing was held on appellee's Motion for Summary Judgment. Pursuant to a Judgment Entry filed on the same day, the trial court granted appellee's motion, finding that appellee had produced **Griffith's** medical record as defined by R.C. 3701.74(A)(8).

[P10] Appellant now raises the following assignments of error on appeal:

[P11] "I. THERE IS A GENUINE ISSUE OF MATERIAL FACT AS TO WHETHER **AULTMAN** HAS PRODUCED MR. **GRIFFITH'S** ENTIRE MEDICAL RECORD FROM HIS MAY 2, 2012 ADMISSION BECAUSE 1) **AULTMAN'S** DEFINITION OF "MEDICAL RECORD" IS INCONSISTANT WITH STATE AND FEDERAL LAW AND, AS SUCH, ANY CERTIFICATIONS OR ASSERTIONS BY **AULTMAN** THAT IT HAS PRODUCED MR. **GRIFFITH'S** ENTIRE MEDICAL RECORD ARE MEANINGLESS, 2) JENNIFER REAGAN-NICHOLS WHO CERTIFIED SUCH RECORDS TESTIFIED THAT SHE DOES NOT KNOW IF OTHER **AULTMAN** DEPARTMENTS HAVE MEDICAL RECORDS REGARDING MR. **GRIFFITH**, AND 3) BASED ON JENNIFER REAGAN-NICHOL'S TESTIMONY, ADDITIONAL RECORDS OF MR. **GRIFFITH** SHOULD EXIST THAT HAVE NOT BEEN PRODUCED."

[P12] "II. THE TRIAL COURT ABUSED ITS DISCRETION WHEN IT DENIED GENE'A **GRIFFITH** ADDITIONAL TIME TO CONDUCT DISCOVERY BEFORE RULING ON **AULTMAN'S** MOTION FOR SUMMARY JUDGMENT FOR REASONS INCLUDING THAT FACT THAT **AULTMAN** HOSPITAL'S MOTION FOR SUMMARY JUDGMENT WAS FILED ONLY A MONTH AFTER THE COMPLAINT WAS FILED AND THERE A (SIC) SUFFICIENT BASIS TO BELIEVE THAT **AULTMAN** IS IN POSSESSION OF ADDITIONAL MEDICAL RECORDS NOT PRODUCED."

Standard of Review

[P13] We refer to Civ.R. 56(C) in reviewing a motion for summary judgment which provides, in pertinent part:

[P14] **HN1** Summary judgment shall be rendered forthwith if the pleading, depositions, answers to interrogatories, written admissions, affidavits, transcripts of evidence in the pending case and written stipulations of fact, if any, timely filed in the action, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. * * * A summary judgment shall not be rendered unless it appears from such evidence or stipulation and only from the evidence or stipulation, that reasonable minds can come to but one conclusion

and that conclusion is adverse to the party against whom the motion for summary judgment is made, such party being entitled to have the evidence or stipulation construed most strongly in the party's favor.

[P15] HN2 The moving party bears the initial responsibility of informing the trial court of the basis for the motion, and identifying those portions of the record before the trial court, which demonstrate the absence of a genuine issue of fact on a material element of the nonmoving party's claim. Dresher v. Burt, 75 Ohio St.3d 280, 292, 1996-Ohio-107, 662 N.E.2d 264. The nonmoving party then has a reciprocal burden of specificity and cannot rest on the allegations or denials in the pleadings, but must set forth "specific facts" by the means listed in Civ.R. 56(C) showing that a "triable issue of fact" exists. Mitseff v. Wheeler, 38 Ohio St.3d 112, 115, 526 N.E.2d 798, 801 (1988).

[P16] Pursuant to the above rule, **HN3** a trial court may not enter summary judgment if it appears a material fact is genuinely disputed. Vahila v. Hall, 77 Ohio St.3d 421, 429, 1997-Ohio-259, 674 N.E.2d 1164, citing Dresher, supra.

I

[P17] Appellant, in her first assignment of error, argues that the trial court erred in granting appellee's Motion for Summary Judgment because there is a genuine issue of material fact as to whether appellee had produced **Griffith's** entire medical record from his May 2, 2012 admission.

[P18] As is stated above, appellant filed her complaint seeking the medical records pursuant to R.C. 3701.74. R.C. 3701.74 states, in relevant part, as follows:

[P19] HN4 "(B) A patient, a patient's personal representative or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than one year before the date on which it is submitted. The request shall indicate whether the copy is to be sent to the requestor, physician or chiropractor, or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient,

the health care provider shall provide the record to a physician or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

[P20] "(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record."

[P21] **HN5** R.C. 3701.74(A)(8) defines a "medical record" as meaning " data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment."

[P22] At the June 28, 2013 hearing before the trial court on appellee's Motion for Summary Judgment, appellee argued that that **HN6** the critical word in the above statute was "maintained" and that "the only meaning that can attached to it, is that the hospital record is to be that which the hospital maintains, not that which a Plaintiff in a legal malpractice case - - or in a medical malpractice case thinks should be maintained, not everything having to do with the patient, but that which a hospital determines needs to be maintained by a health care provider in the process of a patient's health care." Transcript at 6-7. We agree. As is stated above, Jennifer Reagan-Nichols, the Director of Medical Records who maintained the medical records, testified that the medical record consisted of what the medical provider gave to her. Thus, the medical record consists of what was maintained by the medical records department and information that the provider decides not to maintain is not part of the medical record. Appellee certified that it had produced the medical records at issue in this case. On such basis, we find that the trial court did not err in granting summary judgment in favor of appellee.

[P23] It is apparent that **HN7** the purpose of R.C. 3701.74 is to enable a patient to obtain his or her file in order, for example, to obtain a second opinion or transfer to another medical provider. There is nothing in the statute indicating that the statute was intended to be used as a broad discovery device. We note that R.C. 3701.74 is contained in Title 37 of the Revised Code, which is titled "Health-Safety-Morals." More specifically, R.C. 3701.74 is a miscellaneous provision contained in Chapter 3701, which is titled "Department of Health." The civil rules do not contain a similar provision.

[P24] Appellant's first assignment of error is, therefore, overruled.

[P25] Appellant, in her second assignment of error, argues that the trial court abused its discretion when it denied her additional time to conduct discovery pursuant to Civ.R. 56(F) before ruling on appellee's Motion for Summary Judgment.

[P26] Civ.R. 56(F) provides:

[P27] HNS "(F) When affidavits unavailable.

[P28] "Should it appear from the affidavits of a party opposing the motion for summary judgment that the party cannot for sufficient reasons stated present by affidavit facts essential to justify the party's opposition, the court may refuse the application for judgment or may order a continuance to permit affidavits to be obtained or discovery to be had or may make such other order as is just."

[P29] HNS The decision of whether to grant or deny a Civ.R. 56(F) continuance is within the sound discretion of the trial court. Beegle v. Amin, 156 Ohio App.3d 533, 2004-Ohio-1579, 806 N.E.2d 1045 (7th Dist. Jefferson). In order to find an abuse of discretion, we must determine the trial court's decision was unreasonable, arbitrary or unconscionable and not merely an error of law or judgment. Blakemore v. Blakemore, 5 Ohio St.3d 217, 5 Ohio B. 481, 450 N.E.2d 1140 (1983).

[P30] In the case sub judice, appellant, in her motion for additional discovery, argued, in part, that she should be permitted to conduct additional discovery regarding Bates Number 708. A letter from defense counsel dated May 31, 2013 had supplemented the prior discovery responses with Bates 708 (EKG rhythm strips). However, Reagan-Nichols testified that such strips did not meet the legal definition of medical records. While appellant also alleged that she was entitled to additional discovery to determine whether any department other than the medical records department, including Risk Management, had medical records regarding her father that were not produced, as is stated above, such documents do not meet the definition of a medical record because they were not "maintained" by the medical records department. We find that the information that appellant sought through additional discovery either did not fall within the definition of a medical record and/or was already provided by appellee. We further find, therefore, that the trial court did not abuse its discretion in not allowing appellee additional time for discovery before ruling on appellant's Motion for summary Judgment.

[P31] Appellant's second assignment of error is, therefore, overruled.

[P32] Accordingly, the judgment of the Stark County Court of Common Pleas is affirmed.

By: Baldwin ▼, J.

and Wise ▼, P.J. concur.

and Delaney ▼, J. dissents.

Dissent by: [Patricia A. Delaney](#) ▼

Dissent

Delaney ▼, J., dissenting.

[P33] I respectfully dissent from the majority opinion.

[P34] Any claim for malpractice is governed by [Civ.R. 10\(D\)](#) which requires the filing of an affidavit of merit with the complaint for any medical claim, dental claim, optometric claim or chiropractic claim. In order to meet this evidentiary requirement, it is imperative that sufficient medical records available for review are provided to a patient for an expert to opine whether the standard of care has been violated.

[P35] [R.C. 3701.74](#) permits a patient to file a civil action against a health care provider to enforce the patient's right of access to a copy of part or all of the patient's medical record that is "generated and maintained by a health care provider in the process of the patient's health care treatment." [R.C. 3701.74\(A\)\(8\)](#).

[P36] The majority improperly limits a patient's ability to access all of the patient's medical records to those records given to a medical record department, even though the health care provider's other departments, such as Risk Management in this case, also has or may have medical records of the patient. I find such a limitation is not found in the plain language of the statute, nor is [R.C. 3701.74](#) limited in any way to the patient's need for his or her medical records (e.g., to obtain a second opinion or file a malpractice action).

[P37] Health care providers have a responsibility to maintain up-to-date, accurate and complete patient records. This is for the benefit of both the patient and the health care provider. I am concerned the majority's opinion could lead to the concealment, even though unintended, of medical records if a health care provider can self-define the statutory definition of "maintain" to only include those records it determines to send to its medical records department.

[P38] Based upon the record before us, I would sustain the first and second assignments of error and remand this matter to the trial court for further proceedings.

Jump To ▼



APP. 011



**IN THE COURT OF COMMON PLEAS
STARK COUNTY, OHIO**

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Gene'A Griffith, Executrix for)	Case No. 2013CV00487
the Estate of Howard E.)	
Griffith, Deceased,)	
)	
Plaintiff,)	Judge Kristin G. Farmer
)	
vs.)	
)	JUDGMENT ENTRY
Aultman Hospital,)	
)	
Defendant.)	

This matter came before the Court upon the motion of the defendant, Aultman Hospital, for summary judgment. The plaintiff filed a response to said motion, to which the defendant has replied. Additionally, after the Court allowed a second limited deposition of Jennifer Reagan-Nichols, the parties submitted supplemental briefing. On June 28, 2013, the Court held an oral hearing on the motion for summary judgment.

Summary judgment is appropriate where no genuine issues of material fact exist and the undisputed facts entitle the moving party to judgment as a matter of law. *Ohio Civil Rule 56(C); Harless v. Willis Day Warehousing, Co., Inc. (1978), 54 Ohio St.2d 64, 375 N.E.2d 46.* The Ohio Supreme Court, in *Dresher v. Burt (1996), 75 Ohio St. 3d 280, 662 N.E.2d 264,* outlined more specifically the duties of the parties in summary judgment proceedings as follows:

Accordingly, we hold that a party seeking summary judgment, on the ground that the nonmoving party cannot prove its case, bears the initial burden of informing the trial court of the basis for the motion, *and identifying those portions of the record that demonstrate the absence of a genuine issue of material fact on the essential element(s) of the nonmoving party's claims. The moving party cannot discharge its initial burden under Civ.R. 56 simply by making a conclusory assertion that the nonmoving party has*

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no evidence to prove its case. Rather, the moving party must be able to specifically point to some evidence of the type listed in Civ.R. 56(C) which affirmatively demonstrates that the nonmoving party has no evidence to support the nonmoving party's claims. If the moving party fails to satisfy its initial burden, the motion for summary judgment must be denied. However, if the moving party has satisfied its initial burden, the nonmoving party then has a reciprocal burden outlined in Civ.R. 56(E) to set forth specific facts showing that there is a genuine issue for trial and, if the nonmovant does not so respond, summary judgment, if appropriate, shall be entered against the nonmoving party. (Emphasis added.)

See also, Vahila v. Hall (1997), 77 Ohio St3d 421, 429, 674 N.E.2d 1164 (citing Dresher v. Burt (1966) 75 Ohio St.3d 280, 662 N.E.2d 264.

The plaintiff filed this action pursuant to R.C. 3701.74(c) to enforce her right to obtain the medical record at issue. R.C. 3701.74(A)(8) defines a "medical record" as the "data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment."

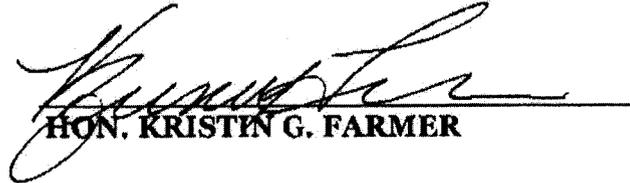
Upon review of the evidence present in conjunction with the motion for summary judgment, as well as the arguments presented by counsel at the hearing on June 28, 2013, the Court finds that the defendant has produced the "medical record" of Howard E. Griffith as defined by R.C. 3701.74(A)(8). Accordingly, this Court finds that no genuine issue of material fact remains in this case and that the defendant is entitled to judgment as a matter of law. The Court, hereby, **SUSTAINS** the defendant's motion for summary judgment. Judgment is, hereby, granted in favor of the defendant and against the plaintiff.

IT IS SO ORDERED.


HON. KRISTIN G. FARMER

**NOTICE TO THE CLERK:
FINAL APPEALABLE ORDER
Case No. 2013CV00487**

IT IS HEREBY ORDERED that notice and a copy of the foregoing judgment entry shall be served on all parties of record within three (3) days after docketing of this Entry and the service shall be noted on the docket.


HON. KRISTIN G. FARMER

IN THE COURT OF COMMON PLEAS, STARK COUNTY, OHIO

**STARK COUNTY CLERK OF COURTS
NOTICE OF JUDGMENT**

2013CV00487

GENE GRIFFITH VS AULTMAN HOSPITAL

INDIVIDUALS LISTED BELOW WERE NOTIFIED THAT AN ENTRY WHICH MAY BE A FINAL APPEALABLE ORDER HAS BEEN FILED WITH THE CLERK OF THE COMMON PLEAS COURT ON Jun 28 2013.

Name	Address
JAMES MICHAEL MCHUGH	220 MARKET AVE SOUTH EIGHT FLOOR CANTON, OH 44702
PAUL J PUSATERI	4684 DOUGLAS CIRCLE NW P O BOX 35459 CANTON, OH 44735
MEGAN J FRANTZ OLDMAN	220 MARKET AVENUE S EIGHTH FLOOR CANTON, OH 44702
LEONIDAS EVANGELOS PLAKAS	220 MARKET AVE SOUTH EIGHTH FLOOR CANTON, OH 44702
COLLIN S WISE	220 MARKET AVE S EIGHTH FLOOR CANTON, OH 44702
RICHARD SCOT MILLIGAN	4684 DOUGLAS CIRCLE NW PO BOX 35459 CANTON, OH 44735

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July 01, 2013

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Current through Legislation passed by the 130th General Assembly and filed with the Secretary of State through File 140 (SB 143)

Page's Ohio Revised Code Annotated **Title 37: Health – Safety – Morals** **Chapter 3701: Department of Health** **Miscellaneous**

§ 3701.74 Patient, personal representative or authorized person may request access to medical record.

(A) As used in this section and section 3701.741 of the Revised Code:

- (1)** "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice.
- (2)** "Chiropractor" means an individual licensed under Chapter 4734. of the Revised Code to practice chiropractic.
- (3)** "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.
- (4)** "Health care practitioner" means all of the following:
- (a)** A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;
 - (b)** A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;
 - (c)** An optometrist licensed under Chapter 4725. of the Revised Code;
 - (d)** A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;
 - (e)** A pharmacist licensed under Chapter 4729. of the Revised Code;
 - (f)** A physician;
 - (g)** A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;
 - (h)** A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;
 - (i)** A psychologist licensed under Chapter 4732. of the Revised Code;
 - (j)** A chiropractor;
 - (k)** A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;
 - (l)** A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;
 - (m)** An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;
 - (n)** A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

- (o)** A licensed professional clinical counselor, licensed professional counselor, social worker, independent social worker, independent marriage and family therapist, or marriage and family therapist licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;
- (p)** A dietitian licensed under Chapter 4759. of the Revised Code;
- (q)** A respiratory care professional licensed under Chapter 4761. of the Revised Code;
- (r)** An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.
- (5)** "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.
- (6)** "Hospital" has the same meaning as in section 3727.01 of the Revised Code.
- (7)** "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults; a nursing facility, as defined in section 5165.01 of the Revised Code; a skilled nursing facility, as defined in section 5165.01 of the Revised Code; and an intermediate care facility for individuals with intellectual disabilities, as defined in section 5124.01 of the Revised Code.
- (8)** "Medical record" means data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment.
- (9)** "Medical records company" means a person who stores, locates, or copies medical records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative.
- (10)** "Patient" means either of the following:
 - (a)** An individual who received health care treatment from a health care provider;
 - (b)** A guardian, as defined in section 1337.11 of the Revised Code, of an individual described in division (A)(10)(a) of this section.
- (11)** "Patient's personal representative" means a minor patient's parent or other person acting in loco parentis, a court-appointed guardian, or a person with durable power of attorney for health care for a patient, the executor or administrator of the patient's estate, or the person responsible for the patient's estate if it is not to be probated. "Patient's personal representative" does not include an insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state, a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code, or any other person not named in this division.
- (12)** "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

(13) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(14) "Authorized person" means a person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical record.

(B) A patient, a patient's personal representative, or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than one year before the date on which it is submitted. The request shall indicate whether the copy is to be sent to the requestor, physician or chiropractor, or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician, psychologist, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the health care provider shall provide the record to a physician, psychologist, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record.

(D)

(1) This section does not apply to medical records whose release is covered by section 173.20 or 3721.13 of the Revised Code, by Chapter 1347., 5119., or 5122. of the Revised Code, by 42 C.F.R. part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," or by 42 C.F.R. 483.10.

(2) Nothing in this section is intended to supersede the confidentiality provisions of sections 2305.24, 2305.25, 2305.251, and 2305.252 of the Revised Code.

History

140 v H 433 (Eff 3-28-85); 148 v H 508 (Eff 3-22-2001); 148 v H 506 (Eff 4-10-2001); 149 v S 179. Eff 4-9-2003; 150 v H 331, § 1, eff. 12-21-04; 152 v H 119, § 101.01, eff. 9-29-07; 2011 HB 153, § 101.01, eff. July 1, 2011; 2012 HB 487, § 101.01, eff. Sept. 10, 2012; 2013 HB 59, § 101.01, eff. Sept. 29, 2013; 2014 HB 232, § 1, eff. July 10, 2014; 2014 HB 483, § 101.01, eff. Sept. 15, 2014.

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Code of Federal Regulations **TITLE 45-- PUBLIC WELFARE** **SUBTITLE A--**
DEPARTMENT OF HEALTH AND HUMAN SERVICES **SUBCHAPTER C-- ADMINISTRATIVE**
DATA STANDARDS AND RELATED REQUIREMENTS **PART 164-- SECURITY AND**
PRIVACY **SUBPART E-- PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH**
INFORMATION

§ 164.501 Definitions.

As used in this subpart, the following terms have the following meanings:

Correctional institution means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes

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juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

Data aggregation means, with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

Designated record set means:

- (1)** A group of records maintained by or for a covered entity that is:
 - (i)** The medical records and billing records about individuals maintained by or for a covered health care provider;
 - (ii)** The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
 - (iii)** Used, in whole or in part, by or for the covered entity to make decisions about individuals.
- (2)** For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Direct treatment relationship means a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

- (1)** Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
- (2)** Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

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- (3)** Except as prohibited under § 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;
- (4)** Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- (5)** Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
- (6)** Business management and general administrative activities of the entity, including, but not limited to:
- (i)** Management activities relating to implementation of and compliance with the requirements of this subchapter;
- (ii)** Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.
- (iii)** Resolution of internal grievances;
- (iv)** The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- (v)** Consistent with the applicable requirements of § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

Indirect treatment relationship means a relationship between an individual and a health care provider in which:

- (1)** The health care provider delivers health care to the individual based on the orders of another health care provider; and

(2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Inmate means a person incarcerated in or otherwise confined to a correctional institution.

Marketing: (1) Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

(2) Marketing does not include a communication made:

(i) To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication.

(ii) For the following treatment and health care operations purposes, except where the covered entity receives financial remuneration in exchange for making the communication:

(A) For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual;

(B) To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or

(C) For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.

(3) Financial remuneration means direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any payment for treatment of an individual.

Payment means:

(1) The activities undertaken by:

(i) Except as prohibited under § 164.502(a)(5)(i), a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

- (ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and
- (2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:
- (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - (ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
 - (iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
 - (v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
 - (vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:
 - (A) Name and address;
 - (B) Date of birth;
 - (C) Social security number;
 - (D) Payment history;
 - (E) Account number; and
 - (F) Name and address of the health care provider and/or health plan.

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Statutory Authority

AUTHORITY NOTE APPLICABLE TO ENTIRE SUBPART:

42 U.S.C. 1320d-2, 1320d-4, and 1320d-9; sec. 264 of Pub. L. 104-191, 110 Stat. 2033-2034 (42 U.S.C. 1320d-2(note)); and secs. 13400-13424, Pub. L. 111-5, 123 Stat. 258-279.

History

[65 FR 82462, 82803, Dec. 28, 2000; 66 FR 12434, Feb. 26, 2001; 67 FR 53182, 53266, Aug. 14, 2002; 68 FR 8334, 8381, Feb. 20, 2003; 74 FR 42740, 42769, Aug. 24, 2009; 78 FR 5566, 5695, Jan. 25, 2013]

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