MCCMH MCO Policy 10-320

(was Administrative Policy 9-09-030)

Chapter: **DIRECTLY-OPERATED PROGRAM MANAGEMENT**
Title: **DESIGNATED RECORD SET**

Prior Approval Date: 12/06/07
Current Approval Date: 2/24/11

Approved by: _____ 02/24/11
Executive Director Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health Board (MCCMH) for compliance with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by establishing the elements of the designated record set and the creation and maintenance of data sources that contain personal health information.

II. Application

This policy shall apply to the MCCMH administrative offices and to all directly-operated network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board to maintain accurate and complete clinical and billing records for each of its consumers so that they can exercise their rights to access, review, and amend their personal health information maintained in a designated record set as required under HIPAA.

IV. Definitions

A. Designated Record Set

All of the information in the clinical record and billing record of each MCCMH consumer that is used to make decisions about the individual.

V. Standards

A. MCCMH shall maintain the following items in its designated record set:

1. The Clinical Record, including applicable items listed below and any other records of care that would be appropriate:

    a. Clinical diagnostic assessments;
    b. Psychiatric diagnostic assessments;
    c. Treatment plans;
    d. Consents for treatment;
    e. Reports from external treatment providers;
    f. Functional status assessments;
    g. Medication profiles;
    h. Progress notes and documentation of care provided (for both treatment and reimbursement purposes);
    i. Content of any consultation with internal or external individuals regarding the consumer's care;
    j. Nursing assessments;
    k. Orders for diagnostic tests and diagnostic study results;
    l. Records of physical history and examinations;
    m. Respiratory therapy, physical therapy, speech therapy, occupational therapy records, and any other records of services provided by specialty providers;
    n. Telephone consultation records;
    o. Telephone orders;
    p. Discharge instructions;
    q. Discharge summaries;
    r. Legal documents and correspondence between the agency and the consumer or others involved in the consumer's care; and
    s. Utilization review forms that are used to determine or review level of care decisions including admission, continuing stay, and discharge.

2. The Billing Record

    a. Signature on file;
    b. Copies of any insurance cards and other data on insurance coverage;
    c. Fee Agreements;
    d. Requests for prior authorization of services;
    e. Authorizations for services or other written acknowledgments of consumer eligibility for services; and

f. Billing records including dates, services provided, provider, billing and payment records, and other information used to bill or to record and report encounters or services.

3. Documents that have been archived and deleted from a consumer's active FOCUS electronic medical record system according to the standards and procedures of MCCMH MCO Policy 2-018, "Correction, Supplementation, or Deletion of Information From Electronic Medical Record," are considered a part of that consumer's designated record set.

B. The responsibility for maintaining the billing record is shared within MCCMH, including the Account Clerks who often receive information from consumers about changes in insurance or financial status and are responsible for completing certain documents in the billing record.

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VI. Procedures

A. A MCCMH staff member should contact his/her Supervisor, the Privacy Officer, or the Corporate Compliance Officer for direction on how to proceed when he/she:

1. Is not sure if a certain document or piece of information belongs in the designated record set; or

2. Believes that there are documents in a consumer's designated record set that do not belong there.

B. Clinical Records

1. MCCMH staff members who create or handle the personal health information that will become a part of the clinical record or who have access to the clinical record shall:

a. Ensure that the personal health information complies with MCCMH policies and regulation on content, dating and appropriate signatures;

b. Complete all personal health information as soon as possible and within the time frames designated by MCCMH policies;

c. With regard to any personal health information that must be filed in the clinical record, file it on a timely basis, in date order and in the appropriate section of the clinical record; and

d. With regard to any personal health information obtained from a third party, review it for relevant content and file it in the clinical record as soon as possible.

C. Billing Records

1. Each employee or contractor who is responsible for obtaining or maintaining any of the billing records shall ensure that the information is:

a. Complete, communicated to the appropriate person, and filed (or entered into the billing database) in a timely manner; and

b. Appropriately secured according to MCCMH policies.

2. No MCCMH staff member should maintain any of the information contained in the billing record in a separate file or outside of the locations designated in MCCMH policies.

3. In certain circumstances a staff member may be asked to bring billing information to a community location or at a satellite site. In these cases, the information should be secured until it can be given or communicated to the appropriate person.

VI. References / Legal Authority

A. Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191

B. 45 CFR § 164.501

VIII. Exhibits

A. None.