NorthCare Network Directive

NorthCare Network Directives are developed through a collaborative interpretation of rules, regulations, and/or policy. They are provided as a standard for those working within our Network to assist in achieving compliance and consistency in our work.

Title: **Designated Record Set Directive**	**Functional Area(s):** ELMER	**Section(s):** Electronic Health Record - ELMER
Directive Supersedes: N/A	**Lead Author(s):** Cheryl Palmer	**Per NorthCare Directives Policy Authorized by:** Claudia Johnson, Interim COO -
Sent for 14-day Review On: March 12, 2010	**Effective Date:** May 1, 2010	**Review/Revised Date:**
Applies To: ☒CMHSP ☒CMHSP Sub-Contractors ☐NorthCare CA	☐CA Sub-Contractors ☐Other:____________________ ☐Excluding: ____________________	

PURPOSE

To establish guidelines for the definition and content of the Designated Record Set (DRS) and to facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, Medicare/Medicaid Conditions of Participation, Accreditation requirements, and all Federal and State laws related to an individual's Protected Health Information (PHI).

DEFINITIONS

1. ***Protected Health Information*** (PHI) is individually identifiable health information maintained in or transmitted by electronic media (Internet, extranet, leased lines, dial-up line, private networks, magnetic tape, disks, compact disk media, or maintained on any other media).
   Specific EXCLUSIONS: Education and Employment Records.

2. ***Record*** is considered any item, collection, or grouping of information that includes protected health information (PHI) and is maintained, collected, used, or disseminated by or for a facility, no matter what media it is maintained on.

3. ***Designated Record Set*** (DRS) is a group of records maintained by or for a covered entity which includes:
   - The legal medical and billing records about individuals maintained by or for a covered healthcare provider.
   - The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan
   - Information used in whole or in part by or for the covered entity to make decisions about an individual.
   - Records held by a business associate that meet the definition of the DRS.
   - The legal medical record maintained by or for a covered entity.

   Specific EXCLUSIONS: Information systems used for Quality Control and/or for Peer Review analyses.

4. ***Legal Medical Record*** is any clinical/medical documents created and/or used to determine and/or monitor the clinical/medical treatment plan of an individual.

5. ***Episode of Care*** is healthcare services provided for a specific illness during a set time period.

6. ***Service Provider*** is any employee of a CMHSP, a contracted individual or entity, and/or private healthcare provider that provides a service which is associated with the clinical/medical treatment plan of an individual.

DIRECTIVE(S)

1. Each CMHSP must maintain the consumer's paper and/or electronic record based on the HIPAA DRS definition. The designated record set will include, at a minimum, the following items:
    - Face sheet
    - Consent to Treat
    - Rights Verification
    - Insurance and Billing records including the content of the consumer's account file and coding summary
    - Enrollment, payment, claims adjudication and case or medical management records maintained by or for a health plan
    - All clinical documentation created by a NorthCare Network service provider (including contracted service providers) during a consumer's episode of care including but not limited to: BPS, IPOS, Progress notes, Specialty Assessments (OT, PT, ST, Dietary), Psychological Assessments, Behavior Management Assessments and progress documents, Emergency Service screenings/Crisis Intervention notes, Discharge Summary
    - All medical documentation created by a NorthCare Network service provider (including contracted service providers) during a consumer's episode of care including but not limited to: Psychiatric Assessments, Medication Review, Physician Progress notes, Physician Orders, Nursing Progress notes, Nursing Assessments, Health History Forms including identified allergies, Current Medication list, Medication Administration Record, Medication Consents, physical health test results ordered by the CMHSP's physician (eg. Labs, xray, EKG)
    - All legal paperwork pertaining to a consumer's status during the episode of care including but not limited to: Guardianship letters/orders, Child Custody papers, Consent for Treatment and Medication administration, and all documents pertaining to the mental commitment process (Petitions and Clinical Certificates for treatment, Court Notices and Orders, Consumer Notices, and Authorization(s) for Release of Information

2. The DRS will be retained in accessible form (original paper, electronic documents or exact reproductions, including those achieved through miniaturization or digitization) according to State Retention Statutes, at minimum of 7 years post discharge for non-medical data to a maximum of 20 years post discharge for Identifying and Summary Data (final face sheet, final discharge summary, and diagnosis)

3. The following is <u>NOT CONSIDERED PART OF THE DRS</u>:
    - Psychotherapy notes as defined by the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, sect.164.501)
    - Peer Review Information
    - Quality Improvement/Management Information
    - Incident Reports

- Administrative, Attorney-Client privileged information
- Recipient Rights records and reports
- NorthCare Centralized Access Information Only screening call notes
- Emergency Services Inquiry Call notes

4. Each CMHSP will have an identified person (Medical Records or Health Information Manager) or department who will act as the custodian of the medical record, is responsible for storing the original paper medical record, is responsible for overseeing the processing of the medical record in electronic form (i.e. the electronic health record), who will regularly monitor for the existence of any other records or repositories containing protected health information (hand written notes, copies of documents, or other information being held by clinicians, nurses, and/or physicians) to determine if the information is a duplication of designated record set content or information necessary to carry out the operations of the organization, and to maintain privacy practices related to HIPAA Privacy Standards and other regulatory guidelines.

5. There is no other officially sanctioned record or repository for receipt or creation of original content of the designated record set. If any duplicate designated record set content is identified, its existence will be reported to the identified person/department for appropriate disposition.

6. Each CMHSP will have an identified person or department (such as a patient accounts manager or business office manager) who is custodian of the billing record, is responsible for storing the original paper billing record, is responsible for overseeing the processing of the electronic billing record, and maintaining privacy practices related to HIPAA Privacy Standards and other regulatory guidelines.

7. All protected health information in the DRS will be stored in a manner that ensures the records' accessibility, completeness, and logical arrangement or ability to be retrieved in a logical manner. Storage of protected health information safeguards against loss, defacement, and tampering as well as unauthorized use or disclosure.

8. The components of the DRS are not necessarily filed in one location or in one medium. Individuals may be directed to obtain components of their DRS at the various locations in which they are maintained (eg. contracted residential/vocational settings).

METHOD OF MONITORING

Documentation reviews.

REFERENCES

- Protected Health Information, 45 CFR Part 160 (160.13)
- HIPAA Privacy Rule, 45 CFR Part 164 (164.501)
- Mental Health Code, Act 258 of 1974, 330.1141(sec. 141)
- MDCH, General Schedule #20, Retention and Disposal Schedule, approved 5/1/07
- Hughes, Gwen. "Defining the Designated Record Set (AHIMA Practice Brief)." *Journal of AHIMA 74, no. 1 (2003): 64A-D.*
- NorthCare Designated Record Policy