Effective Date: April 14, 2003, Motion #03-013
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Review Date: 6/13/13

North Sound Mental Health Administration

Section 2500 – Privacy: Designated Record Set

Authorizing Source: RCW 70.02; 45 CFR 165 (HIPAA)
Cancels:
See Also:
Providers must have own "HIPAA & WAC compliant policy" | Approved by: Executive Director | Date: 7/17/2013
Responsible Staff: Privacy Officer | Signature:

POLICY #2504.00

SUBJECT: DESIGNATED RECORD SET

PURPOSE

The North Sound Mental Health Administration (NSMHA), in compliance with the Privacy Rules of Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions and the requirements of the Health Information Technology for Economic and Clinical Health (HITECH) Act, sets out, in this policy, the elements of the designated record set and the creation and maintenance of data sources that contain Protected Health Information (PHI). This policy mandates that NSMHA maintains accurate and complete records for each of our consumers, so that they can exercise their rights to access, review, and amend their PHI maintained in a designated record set as required under HIPAA.

POLICY

NSMHA shall identify categories of records maintained, collected, used, or disseminated by the agency that contain Individually Identifiable Health Information, including enrollment, payment, claims adjudication and case or medical management records maintained by or for NSMHA. Such records shall be termed "Designated Record Sets," and shall be considered the only personal health information records to which our consumers have a right to request access, amendment and copies.

A designated record set is a description of health and/or business information that can be maintained in one or many areas within the agency. The term "record" means any item, collection, or grouping of information that includes information (including Individually Identifiable Health Information) and is maintained, collected, used, or disseminated by or for NSMHA.

Records created and/or maintained by our Business Associates in the rendering of services to NSMHA must be considered when evaluating documentation for Designated Record Sets. It is the responsibility of NSMHA to ensure that a Business Associate Agreement (BAA) is in place when required. Health information specifically created and/or maintained by Business Associates, when acting on behalf of NSMHA, is subject to the client rights provision to request access or amendment of such information in accordance with the BAA. Copies of information that are also maintained by a health care provider or health plan should not be included in the Business Associate's Designated Record Set.

The documentation maintained by NSMHA will be evaluated to determine those groups of records that should be categorized as designated record sets. The defined process should ensure that the following information is gathered about the evaluated records:

1. Documentation type;
2. Basic content;
3. Location of the documentation;
4. Contact person;

5. Paper/electronic documentation;
6. Documentation contains Individually Identifiable Health Information; and
7. Documentation is used to make decisions about the client.

NSMHA will maintain the following items in its designated record set:

1. Any records generated by, or correspondence between, NSMHA staff and the consumer or others involved in the consumer's care related to any complaint, grievance or Fair Hearing;
2. Authorizations for Medicaid Personal Care funding;
3. Applications for Children's Long-Term Inpatient Program services;
4. Inpatient reconciliation of billing;
5. Authorizations for other services or other written acknowledgements of consumer eligibility for services;
6. 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;
7. Any other records or PHI used in whole or in part to make decisions about publicly-funded Medicaid-eligible consumers, including enrollment, payment, claims adjudication and case or medical management records maintained by or for NSMHA.

The designated record set will ***not*** include:

1. Education records governed by the Family Educational Rights Privacy Act (FERPA) and exempt from HIPAA;
2. Psychotherapy notes;
3. PHI exempted by the Clinical Lab Improvements Act (CLIA);
4. Information involved in civil, criminal or administrative actions or records assembled in anticipation of a legal action;
5. Information created as part of a research study to which the patient has temporarily waived right to access;
6. Health information that is not used to make decisions about the client;
7. Quality improvement records;
8. Risk management records including incident reports; and
9. Employment records held by NSMHA in its role as employer.

PHI is kept in many forms throughout NSMHA. Each of the existing repositories of PHI have been identified, documented, and approved for usage. It is NSMHA's policy that any new need for creation of an additional repository of PHI must follow the same process. Unsanctioned maintenance of PHI in any form will lead to disciplinary action.

Documentation retention requirements include:

Policies and procedures for medical records and PHI

Other policies and procedures to review that are related to this policy:

1. Individual rights to access, amendment, and accounting
2. Administrative requirements – documentation retention

ATTACHMENTS

2504.01 – Procedure: 2504 A