

NORTHCARE NETWORK

POLICY TITLE: Legal Health Record	CATEGORY: Information Management	
EFFECTIVE DATE: 6/25/13 (previously Legal Medical Record & Designated Record Set policy)	BOARD APPROVAL DATE: 2/10/16	
REVIEWED DATE: 6/22/23	REVISION(S) TO POLICY STATEMENT: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	OTHER REVISION(S): <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RESPONSIBLE PARTY: Chief Information Officer	CEO APPROVAL DATE: 7/11/23 Megan Rooney, Interim CEO	

APPLIES To

NorthCare Network Personnel
Member CMHSPs
Network Providers

POLICY

It is the policy of NorthCare Network to establish the Legal Health Record by defining specific information or records that constitute the Legal Health Record for each individual receiving services from Network Providers. Service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided are maintained in a legible manner, via hard copy or electronic storage/imaging.

PURPOSE

To identify the Legal Health Record to ensure the integrity of the health record is maintained so that it can support business and legal needs and for purposes of responding to formal requests for information for legal and legally permissible purposes.

DEFINITIONS

1. **Designated Record Set** (DRS) is a group of records maintained by or for a covered entity which includes the legal medical and billing, enrollment, payment, claims adjudication, and clinical 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 services provided to an individual.
2. **ELMER Case Status/Consumer Status** – refers to the status of a caller/consumers/client record in the ELMER system. Values and definitions include:
 - Not Yet Open/Registered: A MCOID has been assigned to an individual and no Admission to a Provider has been established.
 - Open: The consumer has an assigned provider or is actively (within last 90 days or currently) receiving services.
 - Recipient/Active Consumer: Has received at least one face-to-face service (Recipient as defined in the Mental Health Code).
 - Closed: The consumer's record has a discharge or closure date in the most recent episode of care; not currently receiving services.

3. **ELMER** – NorthCare Network’s clinical practice management system name; acronym derived from “ElectronicMedicalRecord”.
4. **Electronic Health Record Companion Modules** - administrative modules operating within with clinical practice management system that are not considered part of the Designated Record Set or Legal Health Record. The Companion modules include: Recipient Rights; Incident Reports; Customer Service/Grievances; Centralized Access – “Information Only” screening call notes which are not part of a specific consumers record; and Emergency Services Inquiry call notes which are not part of a specific consumers record.
5. **Episode of Care** - All services provided to an individual within a specific period of time across a continuum of care in an integrated health care system.
6. **Legal Health Record (LHR)** is the official record of healthcare service which includes components of the clinical record that pertain to the documentation of services and supports provided, health status, coordination of activities, progress toward goals, etc.
7. **Hybrid Medical Record** – records that exist in a variety of formats including an EHR, paper, microfiche, scanned image, etc.
8. **Peer Review** is the evaluation of work by one or more people of similar competence which serves as a form of self-regulation by qualified members of a profession. Peer review methods are employed to maintain standards of quality, improve performance, and provide credibility, includes but is not limited to: documentation reviews, service verification, etc.
9. **Protected Health Information (PHI)** is individually identifiable protected 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 in any other form or medium).
10. **Record** is considered any item, collection, or grouping of information that includes protected health information (PHI) and is created, maintained, collected, used, or disseminated by or for a facility, no matter what media it is maintained on.

REFERENCES

- HIPAA Privacy Rule, 45 CFR Parts 160 & 164
- Medicare/Medicaid Conditions of Participation (COP)
- Michigan Medicaid Provider Manual
- MDHHS Administrative Rules
- Mental Health Code, Public Act 258 of 1974
- 42 CFR Part 2
- Uniform Business Records as Evidence Act, MCL 450.831 et seq.
- MDHHS/PIHP Contract
- MDHHS, General Schedule #20, Retention and Disposal Schedule, approved 5/1/07
- AHIMA. "Fundamentals of the Legal Health Record and Designated Record Set." *Journal of AHIMA* 82, no.2 (February 2011)
- Accreditation Standards

- NorthCare Records Retention and Disposal Schedule Policy
- ELMER E-Filing Guideline

HISTORY

REVISION DATE: 8/24/17, 10/30/21

REVIEW DATE: 6/19/13, 6/14/14, 6/1/15, 11/23/15, 9/27/16, 8/24/17, 6/15/18, 4/22/19, 2/19/20, 12/27/20, 10/30/21, 8/29/22, 6/22/23

CEO APPROVAL DATE: 6/19/13, 6/14/14, 6/2/15, 1/11/16, 10/4/16, 9/12/17, 7/3/18, 5/6/19, 2/26/20, 1/5/21, 11/2/21, 9/6/22, 7/11/23

BOARD APPROVAL DATE: 6/25/13, 2/10/16

PROCEDURES

This policy applies to all uses and disclosures of the health record for administrative, business, or evidentiary purposes. It encompasses records that may be kept in a variety of media including, but not limited to, electronic, paper, digital images, video, and audio. In determining whether a document is considered part of the Legal Health Record one must consider how the information is used and whether it is reasonable to expect the information to be routinely released when a request for a complete health record is received. Routine disclosures will only include information needed to fulfill the intent of the request.

The Legal Health Record serves to support the decisions made in an individual's care, support the revenue sought from payers, document the services provided as legal testimony regarding the individual's presenting problem, response to treatment and provider decisions, and to serve as the organization's business and legal record.

1. The Legal Health Record includes:

- All clinical documentation used to make decisions about an individual, including but not limited to, assessments, treatment plans, progress notes, labs, orders, consultations, authorizations and consents;
- External records and reports used to make decisions about an individual;

2. The Legal Health Record excludes:

- Administrative data, which is patient-identifiable and used for administrative, regulatory, or other healthcare operations, such as event history, audit trails, data used in quality assurance or utilization management, or prepared in anticipation of legal action;
- Derived data stored in aggregate or summarized which is not patient-identifiable, such as data used for accreditation reports, research data, statistical reports, best practice guidelines;
- Psychotherapy notes maintained separate from the legal medical record as defined by the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, sect.164.501);
- Records that have been destroyed because they have exceeded their required retention period or because they have been rendered unusable due to fire, flood, or other circumstances;
- Supporting documentation for Continuing Stay Reviews conducted;
- Information that is subject to legal privilege such as peer review or attorney/client privilege.