

NORTHCARE NETWORK

POLICY TITLE: Designated Record Set Policy	CATEGORY: Information Management	
EFFECTIVE DATE: 6/25/13 (previously included with Legal Medical Record & Designated record set policy)	BOARD APPROVAL DATE: 2/10/16	
REVIEWED DATE: 7/20/22	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: 8/2/22 Dr. Tim Kangas, CEO	

APPLIES To

NorthCare Network Personnel
Member CMHSPs
Network Providers

POLICY

It is the policy of NorthCare Network to establish the Designated Record Set by defining the specific information or records that individual's may access and amend under the Health Insurance Portability and Assurance Act (HIPAA) of 1996 and state privacy laws. Individuals have the right to inspect and obtain a copy and request amendment of clinical information used to make decisions about their care and billing information.

PURPOSE

To establish guidelines for the definition and content of NorthCare Network's Designated Record Set and to ensure compliance with HIPAA rules.

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. ***Individually Identifiable Health Information*** means any information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual; or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.
3. ***Protected Health Information*** (PHI) is individually identifiable health information transmitted or maintained in any form or medium by a Covered Entity or its Business Associate.

REFERENCES

- HIPAA Privacy Rule, 45 CFR Parts 160 & 164
- Medicare/Medicaid Conditions of Participation (COP)
- Michigan Medicaid Provider Manual
- Michigan Department of Health and Human Services 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, 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: N/A

REVIEW DATE: 6/19/13, 6/14/14, 6/1/15, 11/23/15, 9/27/16, 7/10/17, 5/18/18, 3/21/19, 12/28/19, 10/29/20, 8/26/21, 7/20/22

CEO APPROVAL DATE: 6/19/13, 6/14/14, 6/2/15, 1/11/16, 10/4/16, 7/13/17, 6/5/18, 4/1/19, 1/7/20, 11/3/20, 9/7/21, 8/2/22

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

PROCEDURES

This policy applies to all uses and disclosures of the health record and 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 designated 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 from the individual to inspect, copy or request an amendment.

1. The Designated Record Set includes:

- enrollment records;
- billing records;
- claims adjudication;
- clinical or medical management record systems maintained by or for a health plan;
- outside facility or provider records used in whole or in part by the provider organization or NorthCare to make decisions about individuals;
- Individual submitted documentation and referral letters;
- other individual-specific information such as consents and referral letters;
- information used in whole or in part by or for the covered entity to make decisions about services provided to an individual;
- Legal Health Record as identified in the Legal Health Record Policy.

2. The Designated Record Set excludes:

- a. health records that are not official business records of a healthcare provider
- b. psychotherapy notes maintained separate from the individual's health record;
- c. information subject to legal privilege such as peer review or attorney/client privilege;

- d. administrative data, which is patient-identifiable and used for administrative, regulatory, or other healthcare operations, such as event history/audit trails, data used for quality assurance or utilization management, data prepared in anticipation of legal action, etc.
3. Individuals maintain the right to access, amend and receive an accounting of disclosures of their protected health information (PHI) in accordance with HIPAA rules.

¹ “Fundamentals of the Legal Health Record and Designated Record Set.” *Journal of AHIMA* 82, no.2 (February 12011); expanded online version.