Title: MEDICAL RECORDS	**Policy #: 0024 Dept: QI/Operations**
	Reviewed/Approved By: Quality & Compliance Committee
Adopted: 4/6/1996	**Last Revision: 2/2015**
Revision Dates: 3/18/1997; 3/27/2001; 2/2005; 7/2008; 7/2010; 10/2013	**Review Frequency:** Every two years
Sources: 438.100 (b)(2)(vi)	

POLICY:

OHMS/PrimaryHealth providers shall ensure that member medical records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR). This means they will be kept for a minimum of 7 years. Member medical records shall include the complete clinical records that document the care that is received by members including primary care and referral care.

PROCEDURES:

OHMS/PrimaryHealth:

- Providers and/or OHMS/PrimaryHealth shall not release or disclose any information concerning an member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the member;
- Except in emergency, providers shall obtain a written consent from the member or the legal guardian of the member before releasing information. The written consent shall specify the type of information to be released and the recipient of the information, and shall be placed in the member's medical record. In an emergency, release of services information shall be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the member; and
- Members age 14 and older are competent to authorize or prevent disclosure of mental health and alcohol and drug treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the member's clinical treatment requirements.

OHMS/PrimaryHealth and its contracting providers will also:

- Release health services information requested by a provider involved in the care of an member within ten working days of receiving a signed release;

- Facilitate the process of the CCO assuring that directly operated and subcontracted service components, as well as other cooperating health service provider, have access to the applicable contents of a member's mental health record when necessary for use in the diagnosis or treatment of the member. Such access is permitted under ORS 179.505 (6); and
- Provide for member access to clinical records. Providers upon request shall provide the member access to his/her own clinical records and provide copies within ten days unless the member has need of them sooner.
- If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526. This rule states:
    - Members have the right of access except as otherwise provided in paragraph (a)(2) or (a)(3) of this section. An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, except for: Psychotherapy notes; Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and Protected health information maintained by a covered entity that is subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law.

The following Information will be documented in the patient's medical record ***whenever possible.***

1. Baseline Data:
    a. Personal and biographical data - including name, address, phone number (home and work), insurance coverage, occupation/employer, marital status, etc.
    b. Past medical history including serious accidents, operations, illnesses and symptoms. Information on habits, use of tobacco, alcohol, and substance abuse.
    c. Physical exam including age, weight, health, vital signs, and pertinent health findings.
    d. Periodic screening appropriate for age.
    e. Current medications and drug allergies listed on problem list.
    f. Complete immunization records or notation that immunizations are up to date.
    g. Documentation of any Advance Directive.

2. Visit Data:
    a. Entries dated and person making entry identified with title.
    b. Purpose of visit recorded.
    c. Pertinent history and physical findings.
    d. Differential and/or working diagnoses including signs, symptoms, or clinical impressions.
    e. Appropriate follow-up recorded including specific time to return in weeks, months, or whenever necessary.
    f. Unresolved problems from previous visits addressed when appropriate.
    g. Health education provided and/or member social services provided.
    h. Member phone calls.
    i. Appointments missed and follow-up efforts made.

3. Referral and Ancillary Services:
    a. Hospital records have review indicated and are put into the medical records.
    b. Referrals are indicated and the results of the referrals are documented.
    c. Pertinent lab, x-ray and diagnostic tests are kept in the medical record, if available.
    d. Results of therapeutic services ordered by the physician are kept in the record.

E. CONFIDENTIALITY - HIV, MH, A&D

1. It is the policy of OHMS/PrimaryHealth that all information and medical records pertaining to a person's HIV status, mental health issues, and/or chemical dependency treatment be maintained in a strictly confidential manner. This information is not to be copied from the medical records or transferred to any other person or institution under any circumstances without the express written consent of the individual who this information pertains to or his/her legal representative.

The federal laws listed below are followed and incorporated into our confidentiality procedures:

2. **ALCOHOL AND DRUG ABUSE TREATMENT CONFIDENTIALITY**
    42 USC Section 290 dd-3
    42 USC Section 290 ee-3 (Alcohol and Drugs)
    42 CFR Part 2

Federal law imposes special restrictions on the disclosure and use of alcohol and drug abuse patient records in connection with the operation of any federally assisted alcohol and drug abuse program. The term "federally assisted alcohol and drug abuse program" has been broadly interpreted and may include any alcohol or drug program that receives any federal assistance or any non-profit alcohol or drug program because such a program benefits from federal tax exempt status.

These rules generally provide that which information can be disclosed with and without the patient's consent. The consent must be in writing and must include:

- Specific name or general designation of the program or person permitted to make the disclosure.
- Name or title of the individual or the name of the organization to which disclosure is to be made.
- Name of the patient
- Purpose of the disclosure
- How much and what kind of information is to be disclosed
- The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.
- Date the consent is signed
- Statement that consent may be revoked at any time
- Date, event or condition on which the consent will expire if not revoked before.

Under federal law, a court may order disclosure of confidential communications under certain circumstances, such as to protect against an "existing threat to life or of serious bodily injury" including suspected child abuse; for investigation or prosecution of an "extremely serious crime" such as those listed in the statute, and where the patient offers testimony in an administrative or litigation proceeding [42 CFR § 2.63(a)].

Federal law requires that the patient be advised of these confidentiality rights when admitted into a drug or alcohol program. Patients must also be given a copy of the federal laws and regulations [42 CFR § 2.22(a)].

When served with a subpoena requiring production of drug or alcohol treatment records, the provider must attempt to protect those records to avoid civil liability; however, the health care provider must properly respond to the subpoena to avoid being held in contempt. Legal advice is strongly recommended in these situations. It is important to note that under federal law, a subpoena is not sufficient; a court order is urged for disclosure of drug or alcohol treatment records [42 CFR § 2.61].

MONITORING:

1. PrimaryHealth will create and implement a Medical Records audit process for delegates and providers.
2. On a scheduled basis, PrimaryHealth will review all contracted provider's documentation of requested medical records and/or requests for amendment/correction for timeliness.
3. On a scheduled basis, PrimaryHealth will ask for attestations attesting to the contracted provider assuring that their delegated entities monitor for timeliness to members requests for medical records and/or amendments/corrections to their record.

RESPONSIBILITY:

The operational process of monitoring compliance to this policy will fall upon the PrimaryHealth/Oregon Health Management Services Quality Improvement Department. Outcomes will be reported to the Quality and Compliance Committee and any concerns shall be reported to the Board of Directors.