KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE POLICY & PROCEDURE 36.01

Subject: Records of Individuals Served	**Section:** Records of Individuals Served
Applies To: ☒ KCMHSAS Staff ☒ KCMHSAS Contract Providers	**Page:** 1 of 4
Approved: (Jeff Patton, Chief Executive Officer)	

Revised:	**Supersedes:**	**First Effective:**
09/08/2017	05/20/2015	04/22/2008

PURPOSE

To establish practices on records of individuals served which support the clinical process and for meeting documentation standards and requirements.

DEFINITIONS

Authenticate
To verify that an entry is complete, accurate and final through signature. The signature may be written or an approved electronically produced signature. Staff responsible for scanning original documentation into the Streamline Electronic Health Records (EHR) acknowledge verification that the original document was scanned in its entirety without alterations.

Record of a Person Served
The clinical, medical and billing records, including protected health information that is maintained for the purpose of enrollment, treatment and decision making, payment and claims adjudication. KCMHSAS defines the record of a person served to include both electronic and paper records. **Clinical documentation** within the record refers to documentation that individuals receiving services, direct care and/or clinical staff must complete throughout the provision of service.

POLICY

A complete, up-to-date and accurate record shall be developed and maintained to ensure that all appropriate individuals have access to relevant clinical and other information regarding the services of each person served.

STANDARDS

I. Records of persons served must:

A. Be maintained in a confidential manner and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other relevant requirements, such as the Mental Health Code (MHC) for mental health records and 42 CFR, part 2 for federally funded substance abuse services.

B. Comply with all other applicable contract, accreditation and regulatory requirements.

C. Clearly document all information pertinent to services that are rendered to beneficiaries.

D. Include documentation to substantiate the need for the authorized service(s) in order to demonstrate medical necessity of the person served and appropriately document rationale regarding level of care.

E. Ensure that all entries into the clinical record are limited to individuals who are authorized and qualified with the proper credentials to make an entry. All entries must be legible and authenticated by the individual.

F. Be organized in a uniform manner so that similar information will be found in the same place from case record to case record.

II. KCMHSAS has established clinical documentation standards for many of the primary areas for documenting the services to individuals. The clinical documentation standards have been designed to meet Federal, State and KCMHSAS contract requirements.

III. Providers are expected to be in compliance with the KCMHSAS clinical documentation standards. The means for achieving this include utilization of one of the following options:

A. The KCMHSAS standardized clinical documentation templates (exhibit A).

B. The EHR software that incorporates the KCMHSAS clinical documentation standards.

C. Another EHR system that incorporates all of the KCMHSAS clinical documentation standards. The EHR may look or print different than the standardized paper template as long as the necessary elements are present.

IV. Exceptions to the above identified standardized clinical documentation templates or forms needs to be approved through an organizational process to ensure consistency and

meeting of all Federal, State, and Accreditation body standards as applicable. Requests for changes to clinical documentation templates for KCMHSAS direct run services must be approved by the Director of Quality Management and Contract Services (QM & CS) and the Kalamazoo Quality Improvement Committee (KQIC) through the submission of a Quality Improvement Idea. Exceptions will not be approved when it is apparent that KCMHSAS contract and/or regulatory requirements will be sacrificed through an alternative means.

V. The KQIC or a delegated workgroup is charged with developing, maintaining and updating the KCMHSAS standardized clinical documentation set and templates. Representatives of those utilizing the standardized clinical documents are to have input in the development and/or revisions. The following criteria will be used in maintaining the standardized clinical documentation system.

A. Clinically relevant

B. Non-duplicative entry of information

C. Person/Family-Centered/friendly/easy-to-understand and complete

D. Organized and good flow of information

E. Brief and concise

VI. All providers must conduct internal audits/peer reviews of records of individuals served to insure compliance with regulations and their accreditation standards. Each provider must conduct at least one review annually on a representative sample of active cases. A written report detailing the review and findings are to be made available at the time of the Quality Monitoring Review (QMR) of the provider when requested.

VII. On-site records of persons served are subject to review by appropriate KCMHSAS or Michigan Department of Health and Human Services (MDHHS) staff at any time for clinical and/or monitoring purposes.

PROCEDURES

I. OPENING A RECORD AND ENTRIES

A. A program service record must be opened for each individual receiving clinical services provided or funded by KCMHSAS within 24 hours of the initial contact with an individual.

B. All entries into the clinical record are limited to individuals who are authorized and qualified with the proper credentials to make an entry (for KCMHSAS staff, refer to procedures 36.01_01 [Record Access] and 36.01_02 [Record Entries]).

C. Complete and updated diagnosis and demographic information on each individual served must be maintained (refer to procedure 36.01_03 [Maintaining Demographics and Diagnosis of Individuals Served]).

II. RECORD ORGANIZATION, STORAGE AND SECURITY

A. All clinical records must be secured and protected in a manner that safeguards against loss, destruction, tampering, and unauthorized access or use.

B. Records must be organized in a consistent manner so that information can be found quickly and easily, with the most current information appearing first.

C. Records must include all items required by MDHHS policy, Medicaid Guidelines and any relevant accreditation standards to the organization (for KCMHSAS staff, refer to procedure 36.01_04 [Record Organization, Storage and Security]).

III. RELEASE OF INFORMATION

Information may only be released under the conditions established in KCMHSAS policy 24.05 (Confidentiality and Disclosure) and 26.02 (Confidentiality and Disclosure of Substance Abuse Information).

IV. RECORD RETENTION, THINNING AND CLOSURE

Records must be retained according to the specifications in Federal and MDHHS rules, guidelines, and contracts (refer to policy 07.04 [Records Retention and Disposal]; for KCMHSAS staff, also refer to procedure 36.01_06 [Record Thinning and Closure]).

REFERENCES

- MDHHS Medicaid Provider Manual
- Health Insurance Portability and Accountability (HIPAA)
- Michigan Mental Health Code (Public Act 258 of 1974 supplemented through Act 152 of 1996; sections 746, 748, 749)
- 42 CFR, part 2

EXHIBITS

A. Clinical Documentation Forms List