PATHWAYS CMH

<table>
<tr><td colspan="1">POLICY TITLE:
Definitions – Privacy Practices</td><td colspan="2">CATEGORY:
Recipient Rights</td></tr>
<tr><td>EFFECTIVE DATE:
April 14, 2003</td><td colspan="2">BOARD APPROVAL DATE:
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<tr><td>RESPONSIBLE PARTY:
Recipient Rights Supervisor or Designee/Mary J. Swift, CEO</td><td colspan="2"></td></tr>
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PURPOSE

To define terms referenced in the Pathways Privacy Practices.

DEFINITIONS

Consumer with co-occurring disorders means a consumer who is diagnosed with a serious mental illness and /or a developmental disability AND a substance use disorder. A consumer with co-occurring disorders is designated in the demographic reporting data on disabilities as both MI (DD) and SUD regardless of whether the substance use disorder is in remission or a focus of current treatment. The entire chart of the consumer shall be protected by the rules in 42CFR Part 2. Exceptions: Commitment, ATOs and Adolescents.

Correctional institution means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. *Other persons held in lawful custody* includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

Covered functions means those functions of a covered entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

Data aggregation means, with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

1. **Designated record set** means: **Designated Record Set** (DRS) is a group of records maintained by or for a covered entity which includes:
    - The legal medical and billing records about individuals maintained by or for a covered healthcare provider.
    - The enrollment, payment, claims adjudication, and case 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 an individual.
- Records held by a business associate that meet the definition of the DRS.
- The legal medical record maintained by or for a covered entity.

Specific EXCLUSIONS: Information systems used for Quality Control and/or for Peer Review analyses.

Substance Abuse/CDR

Assessment and Narrative - AccuCare Software resides on a Pathways' server as a client server application requiring authentication.

Releases and Demographic information - These paper documents are scanned and reside in a Lotus Notes database on a Pathways' server as a client server application requiring authentication and the use of Domino Access Control Lists (ACLs).
Admit, Discharge, Financial, Insurance, Clinical Notes, and DEG information - Resides within the Adia application accessed via a web browser running SSL and requiring authentication. Adia is an application service provider for substance abuse providers and CAs in Michigan.

NorthCare Network

Inpatient Review - These documents are direct data entered into a Lotus Notes database on a Pathways' server as a web application requiring authentication, SSA, and the use of Domino Access Control Lists (ACLs). The function of this database is to provide a regional repository for continuing stay reviews, pre admission screenings, and authorizations for service. Old records of this nature that are not electronic are kept in binders under the control of NorthCare's Inpatient Specialist.

Inpatient billing and enrollment/registration - The MCO system runs within CMHC software on a Pathways' server as a client server application requiring authentication.

UM - All information reviewed or collected by the U.M. Department is considered peer review and does not contain IIHI or PHI.

Pathways

Medical Record - The primary record is a paper record stored in one of four designated medical records rooms at each of Pathways' Locations. This paper medical record follows an indexing protocol for the filing of documents within the record.

Archived Medical Records - The records of recipients who have closed cases or are deceased are stored in two formats. Microfilm is on file and was the original way of archiving paper records. The new format is scanning the paper documents where they reside in a Lotus Notes database on a Pathways' server as a client server application requiring authentication and the use of Domino Access Control Lists (ACLs).

Billing Records - These insurance and eligibility records are stored in one of two designated billing offices at Pathways' Marquette and Delta County Offices.

Demographic and Financial Information - Resides within the CMHC application accessed via a telnet session requiring authentication.

Classes of persons requiring access to the designated medical record set.

Direct Service Therapists, including outpatient, supports coordination, and case management. These persons have case assignments and must follow the standards of minimum necessary and need to know. They are discouraged from looking at case records of persons not directly under their care.

Auxiliary Therapists, including on-call, nurses, doctors, and specialty disciplines - There persons do not have specific case assignment and must follow the standards of minimum necessary and need to know. While they may have access to an ever changing case load, they are discouraged from looking at case records of persons not under their immediate care.

Billing Staff - They have access to all the financial information of recipients. They are discouraged from looking at demographic or financial information that is not required to carry out their job duties as outlined in their job description.

Records Staff - They have access to all the electronic and paper medical records in their respective counties. They are discouraged from looking at the content of the medical record except when required to carry out their job duties as outlined in their job description.

Incidental Contact Staff - Information Technology, Receptionists, Data Entry, Intake, Transcriptionists, Accounts Payable, Payroll/Personnel, Accounting, and Scanners/Prep Persons will have incidental contact with information which will become part of the designated record set. They are discouraged from looking at data and information except as required to carry out their job duties as outlined in their job description.

Recipient Rights Staff - They have access to any medical record information. They are discouraged from accessing these records except as required to carry out their job duties as outlined in their job description.

Employees who have a right to request a record (as a recipient, parent of a minor, guardian or power of attorney) must access that record in accordance with Pathways Privacy Practices, Appendix #2.

Direct treatment relationship means a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Health care operations mean any of the following activities of the covered entity to the extent that the activities are related to covered functions, and any of the following activities of an organized health care arrangement in which the covered entity participates:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;

(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

(iii) Resolution of internal grievances;

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and

(v) Consistent with the applicable requirements of § 164.514, creating de- identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required as described in § 164.514(e)(2).

Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

Indirect treatment relationship means a relationship between an individual and a health care provider in which:

(1) The health care provider delivers health care to the individual based on the orders of another health care provider; and

(2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Individual means the person who is the subject of protected health information.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) 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

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Inmate means a person incarcerated in or otherwise confined to a correctional institution.

Law enforcement official means an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

(1) Investigate or conduct an official inquiry into a potential violation of law; or

(2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Marketing means to make a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product or service.

(1) *Marketing* does not include communications that meet the requirements of paragraph (2) of this definition and that are made by a covered entity:

(i) For the purpose of describing the entities participating in a health care provider network or health plan network, or for the purpose of describing if and the extent to which a product or service (or payment for such product or service) is provided by a covered entity or included in a plan of benefits; or

(ii) That are tailored to the circumstances of a particular individual and the communications are:

(A) Made by a health care provider to an individual as part of the treatment of the individual, and for the purpose of furthering the treatment of that individual; or

(B) Made by a health care provider or health plan to an individual in the course of managing the treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

(2) A communication described in paragraph (1) of this definition is not included in marketing if:

(i) The communication is made orally; or

(ii) The communication is in writing and the covered entity does not receive direct or indirect remuneration from a third party for making the communication.

Organized health care arrangement means:

(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

(3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

(4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

(5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

Payment means:

(1) The activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

(ii) A covered health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(v) Utilization review activities, including pre certification and preauthorization of services, concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;

(B) Date of birth;

(C) Social security number;

(D) Payment history;

(E) Account number; and

(F) Name and address of the health care provider and/or health plan.

Plan sponsor is defined as defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

Protected health information means individually identifiable health information:

(1) Except as provided in paragraph (2) of this definition, that is:

(i) Transmitted by electronic media;

(ii) Maintained in any medium described in the definition of *electronic media* at § 162.103 of this subchapter; or

(iii) Transmitted or maintained in any other form or medium.

(2) *Protected health information* excludes individually identifiable health information in:

(i) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and

(ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Required by law means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. *Required by law* includes, but is not limited to, court orders and court- ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

<u>Use:</u> means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.