Center for Life Resources

POLICY AND PROCEDURE MANUAL

SECTION: ADMINISTRATION
SUBJECT: Individual Rights
TOPIC: Health and Insurance Portability and Accountability Act (HIPAA) Compliance

POLICY:

The Center for Life Resources (Center) will establish procedures to ensure the confidentiality of clinical records and compliance with the Health and Insurance Portability and Accountability Act (HIPAA)

References: *42 Code of Federal Regulations (CFR), Part 2; 25 Texas Administrative Code (TAC), §1.501-§1.504; 773 Texas Health and Safety Code (THSC) §773.072; United States Health and Human Services (HHS) Office of Civil Rights (OCR) Privacy Brief*

Board Approval: _____ Date: 10/25/24
Shane Britton, Chairman

Effective Date: 10/25/2021
Replaces: 07/28/2014

PROCEDURES:

1. The Rights Protection Officer (RPO) is responsible for oversight and implementation of all Center privacy practices. The RPO phone number will be posted:
   A. In the waiting area of the Center clinical locations
   B. On the Center's website (www.cflr.us).
2. Clinical Records:
   A. Business Associates: Business associates are organizations (other than employees) that provide services to assist in the Center's clinical or business operations and require access to protected health information (PHI). Federal regulations require the Center to have a written agreement with each of its associates. The agreement requires at a minimum:
      (1) The associate to safeguard the PHI
      (2) The associate to restrict its use and disclosure
      (3) Termination of the business relationship for a breach of the privacy requirements
   B. Personnel Policies and Staff Training:
      (1) Clinical Information Systems (CIS) is responsible for ensuring the privacy and security of client charts, all related identifying data.
      (2) Center procedures require all employees to abide by Health and Insurance Portability and Accountability Act (HIPAA) and all Center procedures.
      (3) All employees will receive HIPAA and Center privacy procedures before accessing clinical records or any individual identifying data.
      (4) Management Information Systems (MIS) is responsible for the security of all electronic systems, including email and electronic health records (EHR).
      (5) All employees will receive electronic (data) security training before being granted access to Center data resources, including email, and at least annually after that. In addition, employees who require access to EHR will receive training specific to EHR before being granted access and periodically after that, as needed.
      (6) Violation of HIPAA or Center privacy and security (whether accidental or deliberate) will result in a personnel action up to and including termination with a do not rehire caveat.
   C. Storage of Records:
      (1) CIS is the sole repository for all written records.
      (2) Center staff shall not keep copies of psychotherapy treatment notes.
         a. Employees must enter all progress notes and clinical observations in the individual's EHR.
         b. Employees shall not keep field or working notes.

c. Employees must not store any form of PHI or maintain any working records in their work areas.

(3) Store written records in a locked file room or locked filing cabinets.

(4) Employees who access records (charts) must sign the record in and out of CIS.

(5) Employees must return all records to CIS no later than 4:00 p.m. the same day.

D. Clinical records and all other PHI (including any identifying data) created by the Center are property of the Center.

E. CIS will retain copies of all records, including all PHI and financial records that include identifying data for ten (10) years after the last date of service to an individual.

F. All records that include any form of PHI must be destroyed at the end of the required retention period.

(1) All paper records must be shredded or incinerated.

(2) All electronic records (includes hard drives, flash drives, CDs, and all other forms of electronic storage) must be thoroughly wiped using commercial grade mil-spec software:

a. At a minimum, the soft should complete seven (7) full passes.

b. MIS shall ensure no ghost images remain.

c. If wiping is not practical, the media should be physically destroyed (rendered unsalvageable).

3. Center Use of Protected Records:

A. Access to PHI:

(1) Center employees and independent contractors who perform services on the Center's behalf may access PHI strictly on an as-needed basis to perform their work.

(2) Employees and contractors must limit their requests for access to only essential information about individuals to whom they are directly providing services.

B. Use of Computer Systems: MIS will control access to PHI stored on Center data systems to ensure the employees or contractors can only access information relevant to their work (see MIS Procedures for information security and access).

C. The Center will use PHI only as necessary to deliver treatment, seek payment, pay claims for services, and operate Center programs.

(1) The Center will inform individuals that the Center will use their information for these purposes in its Notice of Privacy Practices.

(2) Individuals receiving Center service must be given (and sign) the Notice of Privacy Practices during Intake and annually after that.

(3) The Center does not need to obtain specific authorization for its use for these purposes.

D. Communications with Individuals in Services: The Center shall communicate with individuals as required about service to them.

(1) Communication may be by telephone, mail, electronic mail, or by text (based upon prior authorization only).

a. The Center shall respect reasonable requests for confidential communications.

b. All communication with individuals shall be delivered in plain white envelopes. The return address shall not include the Center's name or logo.

(2) The Center may contact an individual in services only to provide information about treatment alternatives, health-related services, or benefits specific to the individual.

(3) The Center shall not contact individuals for marketing purposes.

4. Disclosure of PHI to Third Parties:

A. The Center will only disclose the minimum PHI necessary to perform its function.

(1) Any concerns with a request shall be referred to the RPO.

(2) Minimum disclosure does not apply to:

a. Disclosures for treatment purposes

b. Disclosures to individuals who request their records

c. Disclosures to regulatory agencies such as the Texas Health and Human Services Commission (HHSC) or the Texas Medicaid and Healthcare Partnership (TMHP)

B. Disclosure to Arrange Treatment:

(1) The Center may disclose PHI to health care providers as required to arrange for the treatment of an individual.

(2) The Center shall obtain specific written consent from individuals Consent to Release) before releasing any PHI or identifying information.

C. Disclosure for Purposes of Payment for Services:

(1) The Center may disclose protected health information as needed to engage in billing and payment activities related to the Center's service to individuals, including:

a. Billing

b. Claims payment

c. Coordination of benefits

d. Credit card transactions.

e. Utilization reviews to determine the medical necessity of the service provided.

f. Payment transactions

g. Payment transactions of a health care provider or a health plan

(2) The Center will limit the information disclosed to the minimum necessary to accomplish the particular transaction.

(3) Written consent from the individual may be required before disclosing information for payment purposes (contact the RPO).

D. Disclosure for Health Care Operations:

(1) The Center may disclose protected health information as required to support its health care operations or the health care operations of another health care organization that has a relationship with that individual.

(2) The Center will disclose information to organizations that review our operations to determine if we meet national standards for quality of care. These reviews may be conducted at:

a. The Center's request

b. At the request of a health benefits plan that pays for service to an individual

c. Written consent from the individual may be required before disclosing information for health care operations purposes (contact the RPO).

DI. The Center may disclose protected health information as needed to enable health care providers and others to provide emergency care to an individual.

(1) An emergency is a situation in which there is an immediate and serious risk to the individual's physical or mental health

(2) The information requested must be needed to provide treatment.

(3) Written consent for the release of PHI in an emergency is not required (Texas Health & Safety Code, §773.092).

(4) The disclosure must be documented in the individual's record.

DII. The Center may disclose PHI to HHSC as required for:

(1) Audits to compliance with:

a. Federal law and rules for the privacy of health information

b. Compliance with the requirements of the Medicare and Medicaid programs

(2) The Center may also disclose information to State and local government agencies with legal authority to review Center operations.

a. Written consent is not required.

b. The disclosure must be noted in the individual record.

DIII. Disclosures to State Protective Agencies:

(1) The Center may disclose PHI to comply with State law requiring reports of suspected incidents of adult or child abuse or neglect.

(2) Written consent is not required.

(3) The disclosure must be noted in the individual record.

H. Other Disclosures: The Center will follow the provisions of 42 CFR Part 2 governing disclosure of protected health information.
   (1) Except for the circumstances described above, the Center may not disclose PHI to a third party without the individual's written consenter valid court order.
   (2) If a request for this type of disclosure is received, the individual who is the subject of a record will be asked if they are willing to authorize disclosure.
   (3) If the person refuses, or it is not feasible to contact the person, the Center shall not disclose any information without a valid court order.
   (4) All questions concerning disclosure must be referred to the CRO, who shall engage legal counsel, as required.

5. The Center will provide each person who presents themselves for services with a copy of the Center's Notice of Privacy Practices and annually after that.
   A. If there is a change in privacy policies, the Center will give individuals a copy of the revised notice.
   B. If an individual has difficulty reading or understanding a written notice, a staff member must explain it.
   C. Acknowledgment of Receipt of Notice of Privacy Practices:
      (1) Each person who receives a Notice of Privacy Practices will be asked to acknowledge receipt of the notice.
      (2) If the person refuses or cannot sign an acknowledgment, Center staff must note the person's record to confirm that the notice was provided.
   D. Center staff shall ask individuals to give written consent to use and disclose PHI for treatment purposes at the Center and other health care organizations that have an interest in their care at the beginning of treatment and annually after that.
   E. Center staff must ask the individual to authorize the disclosure of mental health PHI at the beginning of treatment and annually after that. Specific written consent must be given:
      (1) For the Center to use PHI for treatment purposes
      (2) For the disclosure of information about the individual to particular people or organizations.
   F. Alcohol and substance use treatment programs must obtain written consent each time an individual begins treatment.

Executive Director: _____ Date: 10/29/2021
Dion White