**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT OF BEHAVIORAL HEALTH**

# MHRS Bulletin

| | |
|---|---|
| Bulletin ID: | 93 |
| Issued Date | November 25, 2013 |
| Effective Date: | November 25, 2013 |
| Termination Date: | |

## ELECTRONIC HEALTH RECORDS AND THE RETENTION OF PAPER RECORDS:

The purpose of this bulletin is to provide guidance to Department of Behavioral Health (DBH) providers seeking to "image" paper records into electronic formats for accessibility and storage in Electronic Health Records (EHRs). This bulletin does not replace any applicable Federal and/or District of Columbia laws, rules, or policies.

### GENERAL CONSIDERATIONS

Providers must identify a process by which records converted from paper to an electronic format reproduce exactly the entire content of the medical record being imaged. Not only must each document be identical to the paper original, there must be a process in place for insuring that the record as a whole is intact. Further, providers must be able to affirmatively identify the official medical record for each consumer. Keep in mind that the need to reproduce historical versions of a medical record will frequently be related to billing compliance and/or legal requests.

### STAKEHOLDERS

There are several different stakeholders to whom providers should be responsive when imaging paper records:

- The Centers for Medicare and Medicaid Services (CMS) requires that electronic documents be identical to the paper original. In addition, the process of imaging must be clearly described, and must incorporate quality assurance methods for determining that the electronic image is identical.
- Liability insurers frequently have policies in place regarding record retention in the context of converting to EHRs. Failure to follow such policies might void insurance coverage.
- Title 22A, D.C. Municipal Regulation Chapter 3410.30 governs the required Records Retention policy for Mental Health Rehabilitation Services providers, and Title 29, D.C. Municipal Regulation Chapter 2355 governs the required Records Management procedures for Substance Abuse Treatment Facilities and Programs.

**GUIDANCE**

Providers have a duty to insure that their records are accurate, complete, responsive to all Federal and District regulations, and secure and accessible for the duration of all applicable record retention periods. Much of the following is information in the Medicare General Information, Eligibility and Entitlement Manual, Chapter 7, which can be found at www.cms.gov, and which provides good guidance about Federal expectations for program compliance.

1. Providers should establish written policies and procedures that govern the imaging, retention, storage, and destruction of medical record documents. Policies and procedures must also provide guidance on naming conventions, and insure searchablity and retrievability of imaged records.
2. Employees responsible for imaging medical record documents should be trained to operate the imaging system, and documentation of that training should be maintained.
3. Policies need to include a workflow that mandates the visual inspection of imaged documents to insure that they are identical to the original. This includes inspection of the completeness, clarity, and usability of the electronic document. At a minimum, providers need a sampling strategy for such inspection, and compliance with the policy, including any discoveries of "bad" copies, should be documented.
4. Providers need to consider how the integrity of the media storing the new electronic documents will be assured, as well as developing inspection procedures to insure that electronic documents stay readable and usable.
5. As with paper records, providers need to be able to validate access procedures and document modifications over time.

**DESTRUCTION OF PAPER RECORDS**

Providers may destroy a paper record if they are able to demonstrate that they possess an imaged version that is an exact copy of the paper document. Your agency must have a written record retention policy in place prior to the destruction of any documents, which should align with all applicable Federal and District regulations. Your agency's policy should also insure that the records of minors and any records involving an incident that could lead to, or is currently involved in, litigation are excepted from the general retention schedule. In addition, medical record destruction policies and agreements with independent record destruction contractors must insure patient confidentiality and meet all applicable Federal and District laws and regulations.

Agencies should retain a permanent patient index which includes basic information on destroyed records, including at least:

- Patient name, address, birth date, and identification numbers (e.g, social security and/or eCura numbers);
- Dates of admission and discharge;
- Record of diagnoses;
- Names of primary clinicians on the treatment team and their supervisors;
- Disposition or place to which patient was discharged or transferred; and,
- A certification attesting to the appropriate destruction of the record.

If you have questions please contact Sabriana Clark, the DBH Director of Health Information Management & Privacy Officer, at sabriana.clark@dc.gov or (202) 671-4088.