COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Provider Network Management**	**Chapter** **05**	**Section** **05**	**Subject** **07**
Subject **Consent and Coordination for Providers**	**Authorization** Melissa Hall		**Approved: 12/26/17** **Replaces: None**	

Name changed October 2022 (was "*Coordination, Communication, Consent to Share Information*" which was the same as another policy)

Reviewed/No Updates: December 2020; Updated: October 2022

I. PURPOSE: To establish standards and guidelines to ensure communication and service integration/coordination occurs (a) at the service-level between the Integrated Care Team members, primary care physicians, and associated providers; and (b) within NorthCare functional areas as necessary.

II. APPLICATION: Community Mental Health Authority (CMHA) providers employed directly, contracted, or subcontracted by CMHA.

III. DEFINITIONS:

A. Authorization: Synonymous with "Consent" and "Release of Information".

B. Consent: A written agreement executed by a recipient, a minor recipient's parent, or a recipient's legal representative with authority to execute a consent, or for mental health records a verbal agreement of a recipient that is witnessed and documented by an individual other than the individual providing treatment.

C. Behavioral Health Services: A general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders (SAMHSA).

D. Coordination of Care: A set of activities to ensure needed, appropriate and cost-effective care for beneficiaries. As a component of overall care management care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:

- Outreach and contacts/communication to support patient engagement,
- Conducting screening, record review and documentation as part of Evaluation and Assessment,
- Tracking and facilitating follow-up on lab tests and referrals,
- Care Planning
- Managing transitions of care activities to support continuity of care,
- Address social supports and making linkages to services addressing social determinants of health, and
- Monitoring, Reporting and Documentation.

E. Direct Administrative Control: 42 CFR Part 2 permits program staff to disclose information to other staff within the program – or to "an entity having direct administrative control over that program" – if the recipient needs the information in

connection with duties that arise out of the provision of substance use disorder diagnosis, treatment or referral for treatment. Minimum necessary and need to know standards apply. (Legal opinion from October 2019 includes communication between an entity who has direct administrative control over a Part 2 Program.)

F. Integrated Care Organization (ICO): A Health Insuring Corporation (HIC) contracted with Michigan Department of Health and Human Services and Center for Medicare and Medicaid Services to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the enrollee. The Upper Peninsula has one ICO which is the Upper Peninsula Health Plan (UPHP).

G. Mental Health (SAMHSA): A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

H. Payment: Activities undertaken by (1) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (2) A health care provider or health plan to provide reimbursement for the provision of health care.

I. Psychotherapy Notes: 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 (45 CFR 164.501).

J. Substance Use Disorder (MDHHS Contract): The taking of alcohol or other drugs as dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

K. Treatment: 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 referral of a patient for health care from one health care provider to another.

IV. POLICY: CMHA utilizes a variety of means to assure compliance with applicable requirements. Remedial action and possible sanctions, including intermediate sanctions as described in 42 CFR 438.700, as needed to resolve outstanding contract violations and performance concerns will be imposed. The use of remedies and sanctions typically follows a progressive approach; however, CMHA reserves the right to deviate from the

progression, as needed, to seek correction of serious, repeated, or patterns of substantial non-compliance or performance problems. The application of remedies and sanctions shall be a matter of public record.

V. PROCEDURE:

A. MINIMUM NECESSARY

1. A key protection of the HIPAA Privacy Rule, is derived from confidentiality codes and practices in common use today. It is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information. The Privacy Rule's requirements for minimum necessary are designed to be sufficiently flexible to accommodate the various circumstances of any covered entity. Minimum necessary does not apply to the following (Note: It is always best to check the regulations in these circumstances):

- **a)** Disclosures to or requests by a health care provider for treatment. NOTE: It is recommended to verify exactly what the provider is asking for before sending an "entire" record.
- **b)** Uses or disclosures made to the individual.
- **c)** Uses or disclosures made pursuant to an authorization under 45 CFR 164.508. **d)** Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160.
- **d)** Uses or disclosures that are required by law, as described by 45 CFR 164.512(a); and from a business associate that is a subcontractor.
- **e)** Uses or disclosures that are required for compliance with applicable requirements of 45 CFR.

B. NEED TO KNOW

Protected Health Information is only to be released to individuals who need to have access to the information to perform their job function.

C. RE-DISCLOSURES

1. When information is disclosed through consent, the information may only be re-disclosed under the following circumstances:

- **a) Mental Health Records:** The Michigan Mental Health Code requires that an individual who receives mental health records shall disclose the records to others "only to the extent consistent with the authorized purpose for which the information was obtained". (MCL 333.1748)

- **b) Substance Use Disorder Records:** Federal law generally prohibits the re-disclosure of substance use disorder information unless the re-disclosure is expressly permitted by written consent. Federal law requires that a specific notice regarding re-disclosure accompany any disclosure of substance use disorder information that is shared with the individual's written consent. (42 CFR, Part 2.32) Required re-disclosure statement is: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further

disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

D. REVOCATION OF CONSENT

1. An individual may withdraw his/her consent verbally or in writing. A copy of the withdrawal must be kept in the individual's records and a copy provided to the individual if withdrawal is in writing. It is the individual's responsibility to notify all providers and organizations listed on the form that consent has been withdrawn and mental health providers are encouraged to assist the individual with this notification.

2. If an individual withdraws consent verbally, the entity must document the time, place and manner of the withdrawal in the individual's record. A verbal withdrawal can be made only by the individual and not an individual's guardian.

3. If an individual wants to revoke the consent for one or more parties to the consent, but not all parties, the entire consent should be revoked, and a new consent be completed.

E. COORDINATING CARE

1. Coordination of care is appropriate for all individuals receiving specialty services and supports. It is essential to coordinate the care for individuals with their authorization under the following circumstances:

- **a)** when there are identified health conditions,
- **b)** those who are receiving medications, and/or
- **c)** when there are co-morbid conditions that could complicate treatment.

2. Coordination with the Primary and Other Health Care Providers

- **a)** Providers ask for the individual's primary care physician's name, phone, and address at the time of intake and document this in the clinical record. If no primary care physician is identified, the primary clinician shall make efforts to help the individual obtain one, and document accordingly. If the individual is Medicaid eligible, they must have either selected a primary care physician or the MHP (Medicaid Health Plan) has or will assign one to them. Primary Care Physician information for Medicaid beneficiaries may be obtained from the MHP.

- **b)** Individuals are encouraged to include their primary care physician and any other health care providers they deem appropriate in their person-centered planning process.

- **c)** Individuals will be asked to sign a consent to share information with other health care providers, their health plan, and/or ICO, and any other individual or provider/provider entity they choose.

d) When specialty services or supports are no longer medically necessary, as determined through the person-centered planning process, and with proper consent/authorization from the individual or their legal representative, a copy of the discharge summary may be provided to the individual's primary care physician and/or medical health plan.

F. COMMUNICATION

1. Information must only be shared in accordance with applicable laws, which include Michigan's Mental Health Code (Public Act 258 of 1974 as amended), 42 CFR part 2, Confidentiality of Alcohol & Drug Abuse Patient Records, 42 USC Section 290 dd – 2 Confidentiality of Records 2, and HIPAA Privacy Standards (45 CFR parts 160 and 164 subparts A and E) to the extent that they are applicable; keeping disclosures to a minimum amount of information necessary and only on a "need to know" basis, with proper authorization/consent as required.

2. Sharing Information with Signed Consent: Consent is needed to share information regarding mental health services, referrals and treatment for substance use disorders, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus to help diagnose, treat, manage and obtain payment for your health needs. Primary clinicians/care coordinators make ongoing efforts to secure informed consent authorizing information to be shared among primary and other health care providers as appropriate.

3. Consent Forms – Consent to share or release information to multiple providers and/or individual providers is voluntary for the individual/guardian.

a) The MDHHS Consent to Share Behavioral Health Information form (MDHHS-5515) is used to secure authorization/consent to share behavioral health information among multiple providers for purposes of care coordination. This allows for informed real time team consultations with medical, behavioral health, and other providers as chosen by the individual/guardian. This Standard Consent allows individuals to either consent to share all of their behavioral health information as noted on the consent or all of the behavioral health information with stated exceptions. This consent form does not act as a general HIPAA authorization.

b) Other approved consent forms (CMHA Consent to Share Behavioral Health Information Form) may be used when sharing of information is for a one-to-one relationship (i.e., request from a past provider for most recent note(s) for the purpose of evaluating ongoing treatment needs, etc.).

c) A HIPAA compliant consent (CMHA Consent to Share Behavioral Health Information Form) must be used to share:

(1) psychotherapy notes in compliance with 45 CFR 164.508 (a)(2).
(2) marketing, with the exceptions noted in 45 CFR 164.508 (a)(3).

d) It is the responsibility of the primary care clinician and/or care coordinator who has first contact with the individual to secure the proper consent. This consent is then faxed to the other parties authorized or if a MI Health Link Enrollee (MHL) uploaded into the Altruista Integrated Care Bridge.

e) If two or more like consents are received for the same individual, the most recent one will be honored and the older shall be considered to have expired.

f) If two Standard Consents are secured consenting to share with different providers listed or different health information, the primary Provider/Care Coordinator must contact consumer/guardian to reconcile by getting a new consent and voiding those no longer valid per consumer/guardian.

4. Sharing Information with the Medicaid Health Plan (MHP)/Integrated Care Organization (ICO)

a) Without Signed Consent – For individuals enrolled in the MHP/ICO and receiving *mental* health services within the NorthCare Network, information may be disclosed as necessary in order for the individual/recipient to apply for or receive benefits. This information may include demographic information, guardianship, and case manager/primary clinician name. This **does not** apply to individuals receiving substance use disorder services as a signed consent is required. (PA 258 of 1974, Michigan Mental Health Code and 42 CFR, Part 2).

b) With a Signed Consent – The Standard Consent form is used for all individuals enrolled in the UPHP Medicaid Health Plan and receiving services from a NorthCare Network provider. Upon receipt of a properly completed Standard Consent by UPHP or NorthCare, the following information will be sent as noted:

(1) For individuals *new to the (MI Health Link) MHL program*, UPHP will provide NorthCare Network Access Department a copy of the completed Level I Assessment.

(2) For individuals *enrolled in the MHL program and receiving SMI or I/DD services*, CMHA provider will send to UPHP assigned Care Coordinator:

- Current IPOS
- IPOS Amendments and Periodic Reviews as they occur
- Level II Assessment

(3) All other information may be sent, with proper consent, upon request.

G. DOCUMENTATION IN THE CLINICAL RECORD: Documentation in the individual's health record must include, but not be limited to, the following:

1. Name and contact information for the primary care physician, other health care providers and any individual health care supports.

2. A plan for how care will be coordinated shall be documented in the IPOS (Individual Plan of Service)/Treatment Plan.

3. The provider will document any refusal by the individual to coordinate care.

4. Each attempt to address coordination of care activities as well as actual coordination of care activities.

H. MORE STRINGENT REQUIREMENTS: Certain programs are subject to more stringent confidentiality requirements than those required under the Mental Health Code or 42 CFR Part 2. For example, programs that receive funding from the Violence Against Women Act (VAWA) or the Family Violence Prevention and Services Act (FVPSA) have additional confidentiality restrictions.

VI. REFERENCES AND LEGAL AUTHORITY: MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract, Section 7.9.3; Michigan Mental Health Code, PA 258- Section 330.1141a; HIPAA Privacy and Security Standards; 42 CFR, Part 2; Violence Against Women Act (VAWA); Violence Prevention and Services Act (FVPSA); Information regarding MDHHS Standard Consent Form can be found at: www. http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686--,00.html; Code of Federal Regulation – Title 45 - Section 164.501; Northcare Network's Consent to Share Information Policy

VII. EXHIBITS: None