LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 10/22/2012
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CHAPTER Information Management	**CHAPTER** 07	**SECTION** 002	**SUBJECT** 10
SECTION Data Management	**DESCRIPTION** Integrity of Electronic Data: OASIS		
WRITTEN BY Lauren Emmons, ACSW COO	**REVISED BY** Sandy Koyl, BHSA IT and Data Management Supervisor	**AUTHORIZED BY** Brooke Sankiewicz, LMSW, CADC, CEO	

APPLICATION:

☒CMH Staff	☐Board Members	☐Provider Network	☒Employment Services Providers
☐Employment Services Provider Agencies	☒Independent Contractors	☒Students	☒Interns
☒Volunteers	☐Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) ensures data in Optimal Alliance Software Information System (OASIS) is accurate, entered in a timely manner, and documented in compliance with regional, state, and federal requirements. Best practice procedures are employed to ensure the safety, integrity, and quality of information in OASIS.

STANDARDS:

A. All responses to the Freedom of Information ACT, Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, confidentiality and any other applicable policies and procedures apply to the data and files associated with OASIS.

B. The accuracy, comprehensiveness, and timeliness of data in OASIS shall meet the requirements of the Michigan Department of Health and Human Services (MDHHS), Michigan Medicaid Provider Manual, Michigan Mental Health Code, Region 10 Prepaid Inpatient Health Plan (PIHP), External Quality Review (EQR), Commission on Accreditation of Rehabilitation Facilities (CARF) and any other necessary regulatory or accrediting organizations.

C. LCCMH data staff monitor the accuracy, completeness, and timeliness of the data in OASIS.

D. Service Activity Logs (SALs) for direct operated programs are signed in accordance with LCCMH clinical documentation requirements (LCCMH Form #339) and are reviewed by supervisors for accuracy as needed and by billing personnel through auditing and error reports.

E. Claims are entered or imported as denoted by LCCMH designated process and will pass through system edits as part of the claims processing cycle.

F. All data entries are dated by month, day, and year. Many entries in the individual chart contain the author's identification by name and credentials. The author identification can be a handwritten signature (if document is scanned) or a unique electronic identifier/signature. It is expected all documentation will be signed by the author at the time of completion.

G. All data entries in OASIS involving authorized services requiring specific times indicate actual beginning and ending times of the service provided. Exceptions can include per diem services or equipment, etc.

H. Individual Plans of Service (IPOS) are not effective (valid) until the individual/guardian has provided a signature. Therefore, documentation must be completed prior to effective date.

I. Delayed entries are acceptable within a reasonable time period after the service, for the purposes of clarification, error correction, addition of information not initially available, on holidays or weekends, or if certain unusual circumstances prevented the generation of the document at the time of service.

J. A document is considered valid in OASIS once it is signed by the staff documenting the provision of the service. Signing a document serves as authentication and adds the document as official documentation in the electronic health record.

K. Signed documents cannot be deleted from the record by the primary case holder. Staff must submit a request in OASIS to delete a signed document.

L. No changes can be made to a signed electronic document without going through the change signed document request and approval process. A historical original document without changes is kept in the person served's chart in OASIS.

M. Documents created before 10/01/12 in a paper format but scanned into OASIS can contain corrections made by ink including a line drawn through the portion changed with the word "error" or "correction" beside the deleted section. The correction must include the date and signature of the staff who made the correction. The corrected statement can be rewritten or typed.

N. All staff who create, handle, view or modify personal health information as part of the clinical record have a responsibility to ensure the information is as accurate as possible and belongs in the record. Any staff suspecting a certain document or piece of information does not belong in the record notifies their supervisor. In addition, if documents or information appear to be missing, it is the responsibility of the primary case holder to attempt to obtain this information or provide documentation of its absence.

PROCEDURES:

Clinical Staff/Supervisors

A. Enter information and data into OASIS following and/or during interaction with the individual or non-face-to-face activity.

B. Are granted authorization to perform system tasks in OASIS based on their department alignment and agency job duties.

C. Use OASIS as the primary means to access, retrieve information and capture data. Clinical staff are informed of documentation due dates by alerts and notices within OASIS, access to "how-to" documents in the help menu of OASIS, and by trainings provided by data staff, supervisor, and Chief Clinical Officer.

Data Staff

A. Maintains list of acceptable procedure codes and location codes for staff use.

B. Reviews data to ensure accuracy, completeness, and timeliness.

C. Follows up with staff as needed with data errors or questions.

D. Submits encounter data to the PIHP.

E. Submits Behavioral Health Treatment Episode Data Set (BH-TEDS) data to the PIHP.

F. Reviews SAL change requests daily.

G. Requests for deletion of documents are reviewed and if the rationale of deletion is not defined clearly, data staff must deny the request and ask for further clarification. If the rationale is clear, the document is approved for deletion.

DEFINITIONS:

Behavioral Health Treatment Episode Data Set (BH-TEDS): Data record collected per episode of care and reported to the Michigan Department of Health and Human Services on an on-going basis.

Corrections in the Electronic Health Record: A typographical error or any incorrectly documented material in the electronic case records that has been corrected.

Information System: The network of computers, hardware and software used to categorize, store, retrieve, copy, protect, analyze, and manipulate data, including OASIS modules of clinical and administrative operations.

Integrity of Data: A condition of OASIS and related data which is compiled, utilized, and analyzed by the Information System that is believed to be accurate, valid and is a result of processes employed through the Data Management Department to protect the accuracy, security, comprehensiveness and standardization of the data and electronic information.

Optimal Alliance Software Information System (OASIS): The certified electronic health record utilized by the LCCMH and contract providers.

Protected Health Information (PHI): Individually identifiable health information (1)(i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media; or (iii) transmitted or maintained in any other form or medium. (2) Excludes individually identifiable health information in (2)(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).

User: Individual having access to OASIS as staff, contractor, temporary employee, or other person given some level of access to OASIS information.

REFERENCES:

HIPAA Privacy Rule, 45 CFR Part 164 (164.501), Part 160 (160.130)
Mental Health Code, Act 258 org 1974, 330.114 (section 141)
LCCMH Form #339 Documentation Requirements

SK:rb