

CHAPTER V: REPORTING FROM HEALTH RECORDS

Disclaimer: The information contained in this chapter is not intended to be used as legal advice. Please refer to the most current specific state statutes and your own legal counsel when warranted. Some statutes may be referred to throughout this chapter

Health care providers are required by law to report certain events and conditions to government agencies. Reporting requirements are constantly changing, and this chapter should not be viewed as an all-inclusive list. The following table gives page references for the requirements covered in this manual.

EVENT / DIAGNOSIS TO BE REPORTED	SECTION OR CHAPTER
Abortion, induced	Chapter 5, section 4
Abuse, child	Chapter 5, section 6
Abuse, adult	Chapter 5, section 7
Arson, burn inflicted during commission of	Chapter 5, section 11
Birth, live	Chapter 5, section 1
Cancer	Chapter 12
Death	Chapter 5, section 5
Death, fetal	Chapter 5, section 2
Disease, notifiable (reportable)	Chapter 5, section 8
Disease, occupational	Chapter 5, section 9
Driver, impaired	Chapter 5, section 12
Driver, involved in motor vehicle accident while under the influence	Chapter 5, section 12
Food and Drug Administration	Chapter 5, section 17
HIV disease	Chapter 11
Injury, head	Chapter 5, section 13
Injury, work-related	Chapter 1, page 6
Maine Health Data Organization (MHDO) Reporting	Chapter 5, section 15
Miscarriage reporting	Chapter 5, section 3
New England Organ Bank (NEOB)	Chapter 5, section 16
Screening, newborn	Chapter 5, section 14
Wound, gunshot	Chapter 5, section 10

VITAL STATISTICS

Health care providers have a responsibility under Maine state law to report live births, fetal deaths, miscarriages, induced abortions, and deaths. All hospitals should have as references the "Hospital Vital Statistics Handbook" and "Vital Statistics Registration in Maine," both published by the Office of Data, Research, and Vital Statistics (ODRVS) of the Maine Department of Health and Human Services. Questions about reporting requirements should be directed to ODRVS at 207-287-3181.

SECTION 1. LIVE BIRTHS

BIRTH CERTIFICATES

In accordance with 22 MRSA §2761, a certificate of each live birth occurring in Maine must be filed within a reasonable period of time with the clerk of the municipality in which the birth occurred. A live birth is defined as "the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached." (22 MRSA § 1595). When signs of life are only momentary and the infant then expires, both a birth and a death certificate must be filed.

All Maine hospitals which offer obstetrical services are required to submit a certificate of live birth via Electronic Birth Certificate (EBC) computer system. All certificates must be electronically transmitted to the Office of Vital Statistics within 2 business days (excludes weekends and holidays) of the birth. Birth information is filed on paper certificates only in the case of births outside hospitals or at hospitals which do not offer obstetrical services. Guidelines concerning legitimacy, paternity, and naming of infants are applicable regardless of which type of birth certificate (paper or electronic) is used.

RESPONSIBILITIES

Hospital personnel are responsible for collecting the information required for the birth certificate. The hospital is supplied with birth worksheets (2 pages, one Medical Worksheet for the Birth Certificate and one Parent Worksheet for the birth certificate) to:

- Collect demographic and medical information required for the certificate.
- Prepare a complete and error-free certificate.

The steps for completion include:

- Obtaining the signature of the informant (usually the mother or father of the infant) on the birth certificate worksheet.
- Assisting the parents of the infant, when necessary, with completion of the paternity affidavit.
- Assisting Vital Records and the parents with correction of any errors on the certificate.
- Providing parents with information about how they can obtain a Social Security number for their infant through the birth registration process.

The delivering practitioner is responsible for providing or reviewing, depending upon the facility's policies, the medical portion of the form. (A physician worksheet may be used to collect the medical data.) The delivering practitioner is required to sign the medical worksheet within twenty-four (24) hours of the birth.

LEGITIMACY

In accordance with 22 MRSA §2761, subsection 4, if the mother was married at the time of conception *or* at the time of birth *or* at any time in between, her husband is the child's legal father, and his name must be entered as father on the birth certificate. This applies even when the mother is divorced at the time of the birth, unless the final divorce decree was issued more than nine months prior to the date of birth. If a woman who was married (at the time of conception, at the time of birth, or at any time in between) wishes to have the name of a man other than her husband listed as the child's father on the birth certificate, she must obtain a determination of paternity from a court of competent jurisdiction. If the mother refuses to give information about her husband, or if she refuses to sign the certificate with her husband's name on it, hospital personnel should enclose a note to this effect when filing the certificate with the town clerk.

PUTATIVE FATHER

When the mother was not married at the time of conception or at the time of birth or at any time in between, the name of the putative father may be entered on the birth certificate, provided that both parents have signed an Acknowledgement of Paternity. The parents are not required to sign at the same time, but both signatures must be notarized. If the Acknowledgement of Paternity is completed before the mother leaves the hospital, hospital personnel will enter the putative father's name and other required information on the birth certificate; otherwise, the name of the father will be left blank, but the parents can complete the Acknowledgement at a later date at any municipal clerk's office or at the Vital Records Office, and the father's name will then be added to the certificate.

In 1999, in accordance with Federal Regulations, the State of Maine implemented the Maine Acknowledgement of Paternity Project. 22 MRSA 2761-B requires that all hospitals and birthing centers provide unmarried parents the opportunity to voluntarily acknowledge paternity. "A complete training guide regarding acknowledgement of paternity" is available through the Maine Office of Vital Statistics by calling (207) 287-3181.

INFANT'S NAME

In Maine there are no legal limitations on the parents' choice of a surname for their infant. The child of a married woman may be given the woman's husband's surname, her own surname, a combination of the two, or any other surname the parents choose. Similarly, the child of an unwed mother may be given the mother's surname, the father's surname, or any other surname the mother chooses. The unwed mother does not need the permission of the baby's father to name the child after him. However, giving the child the father's surname has no legal implications for paternity, which must be established by a properly executed Acknowledgement of Paternity.

BIRTHS OUTSIDE THE HOSPITAL

Births of infants born outside the hospital but transferred to the hospital after birth should be certified by the physician or other person in attendance at the delivery or immediately thereafter. A paper birth certificate should be filed by hospital personnel. If the infant is born in a moving conveyance (car, bus, airplane, etc.), the place of birth is listed as the place at which the baby was first removed from the conveyance.

SOCIAL SECURITY NUMBER

Parents may, by their signature on the birth certificate or on an approved birth certificate worksheet, give permission for Vital Records to provide information about their child to the Social Security

Administration so that a Social Security number can be issued. The SSA will then mail the infant's Social Security card to the parents after processing. The program is voluntary, and parents are under no obligation to consent. A number cannot be issued, and hospital personnel must check "No" in **field 32** of the certificate, if the child is being put up for adoption; if the child is not expected to live; if the child has not been given a first name; or if neither parent has signed the certificate or the worksheet.

Parents who are on or applying for MaineCare will need proof that they have applied for a Social Security Number for their child. Hospital personnel should supply them with form SSA-2853 OP3, "Message from Social Security", which confirms that the number has been applied for. If the parents need to receive the child's actual Social Security number immediately, they can file an application at their local Social Security office as well as applying through the birth certificate process. The baby will receive only one number, although two cards will be issued. If parents have questions about their baby's Social Security number, they should be referred to their local Social Security office. Vital Records does not issue the numbers and cannot provide information on the status of applications.

As of March 1, 2000 all parents wishing to obtain a social security number for their infant through the creation of the birth certificate must supply social security numbers for both the mother and the father (if one is named) and these numbers must match what is on file at the Social Security Administration. If the social security numbers and parents names do not match what is on file at the Social Security Administration, the parents will not receive a social security number for their child. They will receive a notice from Social Security Administration requesting that they provide the correct information before a social security number will be assigned.

VITAL STATISTICS PAMPHLETS

The Department of Health and Human Services (DHHS) publishes several informative pamphlets which hospitals may issue to parents or other persons and they can be ordered from the DHHS stockroom or by calling (207) 287-3181 for the listing available. However, the following pamphlets are required if filing acknowledgement of paternity papers:

- "The Power of Two" which is accompanied by a video
- "Genetic Testing for Paternity Establishment"
"Signing a Voluntary Acknowledgement of Paternity at Locations other than the Hospital or Birthing Center"
- "Maine's Law for Parental Names on Birth Certificates for Out-of-Wedlock Children"

COPIES OF BIRTH CERTIFICATES

A copy of the child's birth certificate is not automatically sent to the parents. Parents can obtain a copy of their child's birth certificate from the following sources:

- The municipal clerk in the town where they were residing at the time the child was born;
- The municipal clerk in the town where the child was born; or
- The Vital Records Office in Augusta.

There is usually a charge for any official documents. The hospital *may not* release copies of any birth certificates or birth certificate worksheets in its possession. Anyone requesting such copies should be referred to one of the sources listed above.

CHANGES AND CORRECTIONS TO BIRTH CERTIFICATE

After the municipal clerk has accepted the birth certificate for filing, any changes must be made by completing form VS-7A, "Application for Correcting or Completing a Certificate of Birth/Marriage/Death," at a municipal clerk's office or at Vital Records. Most corrections made during the child's first year will not result in the certificate being marked as amended. If a change is required to correct a hospital error, Vital Records will ask the hospital for a statement in support of this. Corrections of hospital errors will not result in an amended certificate regardless of when they are made. There is a substantial fee for corrections or completions made subsequent to the child's first birthday.

LEGITIMATION

If an unwed mother who was not married at the time her baby was conceived later marries the father of the baby, a new birth certificate showing the father's name can be substituted for the original certificate without any indication that the file has been amended. Parents must make application for legitimation of their child to Vital Records by filing form VS-8 along with a certified copy of the marriage certificate and a completed Acknowledgment of Paternity.

SECTION 2. FETAL DEATHS

A fetal death certificate must be filed when a delivery results in a fetus of 20 or more weeks' gestation that shows no evidence of life (e.g., heartbeat, respiration, voluntary muscle movement, etc.) after it is entirely outside the mother. The certificate must be signed by the attending physician within five days, and the completed certificate filed within 14 days. The top three copies are submitted to the clerk of the municipality where the delivery occurred, and the bottom copy is submitted to Vital Records. Completion of the name field at the top of the form is optional, depending upon whether the parents have chosen to name the fetus.

DISPOSAL OF FETAL REMAINS

Following a fetal death (20 or more weeks' gestation), the parents may choose to engage a funeral director to have the hospital dispose of the fetal remains, or to arrange disposition of the remains themselves.

- If the hospital is to dispose of the remains, it may do so without a disposition permit. The facility is responsible for filing the fetal death certificate with the municipal clerk. The facility may wish to have the parents sign a consent form authorizing disposal of the remains.
- If the remains are to be removed from the hospital by a licensed funeral director, the remains may be released without a disposition permit. The funeral director will file the fetal death certificate with the municipal clerk.
- If disposition is to be handled by the parents or some other authorized person, the hospital should present the fetal death certificate to the parents or other person to file with the municipal clerk in order to obtain a disposition permit. The hospital may not release the remains to anyone other than a funeral director until the disposition permit is obtained.

SECTION 3. MISCARRIAGE

Health care providers are required to submit a minimal data set to Vital Records on each miscarriage

(spontaneous abortion at less than 20 weeks) which they treat. Every miscarriage treated by the same physician over the course of a month is listed on the "Monthly Miscarriage Report Register" (VS-48a). The form is then signed by the physician and submitted to Vital Records within 10 days after the end of the month during which the miscarriage occurs. The VS-48a form is a log sheet which contains only those data required to track incidence and causes of miscarriage. It does not identify patients by name and is used only for epidemiological purposes. Procedures for handling fetal remains following a miscarriage are the same as in the case of an induced abortion (see below).

SECTION 4. ABORTIONS.

A report of induced abortion must be completed for every abortion performed, regardless of the length of gestation, and be submitted to the Office of Vital Statistics. The report shall not identify the patient by name or otherwise. Abortion is defined as "the intentional interruption of a pregnancy by the application of external agents, whether chemical or physical, or the ingestion of chemical agents with an intention other than to produce a live birth or to remove a dead fetus" (22 MRSA §1596). The report is a single copy which is submitted directly to Vital Records within 10 days following the end of the month in which the abortion occurred.

If the parents wish the facility to dispose of the fetal remains, no further paperwork is required. The facility may wish to have the parents sign a consent form authorizing disposal of the remains.

Should the parents wish to have the remains disposed of outside the facility, the health care provider must complete the report of induced abortion and also generate a letter on facility letterhead, addressed to the municipal clerk. The letter must state that the parents have chosen to dispose of the remains outside the facility and must include the name *and signature* of the person who will handle the disposition (e.g., the parent, a funeral director, a relative, etc.). A sample format for such a letter is as follows:

This letter concerns the remains of a dead fetus or product of induced abortion delivered on [date]. The parents have expressed their wish to remove the remains for disposition outside this facility and have designated [name of person responsible for disposition] for this purpose. This letter is notification to you that the required miscarriage or induced abortion report has been filed with the Office of Vital Records and a disposition permit may be issued.

Should an induced abortion result in a live birth, the report of induced abortion is not filed. The health care provider should complete a certificate of live birth, and, if applicable, a death certificate.

SECTION 5. DEATHS

DEATH CERTIFICATES

A death certificate must be filed for every death occurring within the state. Two types of certificates are used: Form VS3 (Standard Form) and form VS3-ME (Medical Examiner Form). Form VS3 is signed by the attending physician in the case of death from natural causes. The physician must have treated the patient prior to death, although not necessarily for the condition which caused the death, provided that the cause of death is reasonable and consistent with the general state of health of the patient and circumstances surrounding death.

Death from natural causes may be certified by a physician other than the attending when that physician is

associated with or covering for the attending, is designated by the attending to certify death, or is the chief medical officer of the hospital in which death occurred or was pronounced, provided that the physician has access to the patient's recent medical history. In the case of the death of a nursing home resident, the certifying physician must examine the body prior to completing the certificate unless the patient had been examined within 48 hours prior to death (or, in the case of a terminally ill patient, within two weeks prior to death) by the attending physician or another physician designated by the attending.

PROCESSING OF CERTIFICATE

Death certificate forms are provided by Vital Statistics to funeral directors, hospitals, and physicians. Funeral directors may also generate certificates using software approved by Vital Statistics. The certificate is signed by the physician or medical examiner in black ink, printed or typed (certificates signed in other colors will not be accepted for filing) and is turned over to the funeral director for filing. The funeral director makes three photocopies and checks off the appropriate box on the top of each form ("Original--State," "Copy--Place of Death," "Copy--Place of Residence," and "Copy-Place Permit Issued"). The original, place of death copy, and place of residence copy are submitted by the funeral director to the town clerk at the place of death. The town clerk reviews the certificate for accuracy and completeness, and then signs the original and copies. The town clerk sends the original to Vital Statistics, files the "Place of Death" copy, and sends the "Place of Residence" copy to the town of residence. The copy marked "Place Permit Issued" is submitted by the funeral director to the town clerk in the town where the disposition permit is being issued.

When the death certificate is filed by an authorized person rather than by a funeral director, either that person or the town clerk will make the photocopies. Multi-copy forms are also available for use in such cases.

INCOMPLETE CERTIFICATES

If the physician is unable to determine the cause of death until autopsy results, laboratory studies, or additional records are available, the certificate may be submitted with the words "pending autopsy," "pending laboratory studies," etc., in the cause of death section. When the missing information becomes available, the physician must submit a supplemental cause of death report. If this is not received within a reasonable time, a blank form will be sent to the physician by Vital Statistics. The supplemental cause of death report may also be submitted for any case in which the cause of death as originally certified is found to be inaccurate.

MEDICAL EXAMINER CASES

Form VS3-ME must be signed by a medical examiner in the case of:

- Death by violence or poisoning;
- Sudden death when the person is in apparent good health;
- Death during medical procedures under circumstances indicating gross negligence or when clearly due to trauma or poisoning unrelated to the ordinary risks of those procedures;
- Death in a jail, other correctional facility, or residential facility, unless clearly due to natural cause;
- Death suspected of being a threat to public health;
- Sudden infant death syndrome deaths and all other deaths of children under the age of 18, unless clearly due to natural causes; and

- Fetal death of 20 or more weeks' gestation occurring without medical attendance at or after the delivery.

Under 22 MRSA §3022, information concerning a medical examiner's case, including copies of the deceased's medical records, may be released to the medical examiner's office without authorization from the next of kin.

DISCLOSURE TO MEDICAL EXAMINER

Disclosure to the Medical Examiner is an authorized disclosure which does not require written or verbal authorization. A request from the ME's office should be in writing. As with any disclosure that includes substance abuse issues, the information cannot be disclosed absent a court order.

RELEASE OF BODY

The remains of a person who died in hospital or was declared dead on arrival may be released to a Maine-licensed funeral director without a disposition permit or other documentation. Hospital personnel should verify the identity and record the license number of the person picking up the body, unless that person is known to them as holding a Maine funeral director's license or employed by a Maine-licensed funeral director. Release of a body to an unauthorized individual may be subject to penalty under Maine law (22 MRSA §2708-2709).

Any other person, including a funeral director licensed in another state, must present a completed disposition permit before the hospital can legally release the body. (10-146 CMR 1) With the proper permit, the body may be released to a member of the immediate family of the deceased, or to a person authorized in writing by a member of the immediate family (22 MRSA §2846). The disposition permit is issued by the clerk of the municipality in which the hospital is located. A completed death certificate must be presented before the clerk can issue the permit, and the certificate must indicate that the physician or medical examiner has personally examined the body after death. If the person applying for the disposition permit is not a member of the deceased's immediate family, written authorization from the family must be presented. If the body is to be cremated or transported out of state, a medical examiner's release must also be presented to the municipal clerk in order to obtain the disposition permit.

SECTION 6. CHILD ABUSE

Under 22 MRSA §4005-4023 , health care providers are required to report suspected child abuse or neglect to the Department of Health and Human Services (DHHS). The report is to be made by telephone with a written report to follow within 48 hours if requested by DHHS. Consent of the child's parent or guardian is not required. Health care professionals practicing in a health care facility or agency are to make their report through the "person in charge of the institution, agency or facility or his designated agent"--that is, report should be made to the health care professional's superior or other person designated to handle such reports. The report is non-discloseable and if written, should not be filed in the designated record set. A disclosure of information without authorization form may be used. Hospitals are required to make reasonable efforts to take color photographs of any trauma visible on the child. This does not require consent of the parent or guardian. The law provides immunity from civil liability for persons making a report in good faith, and this includes the taking of photographs or x-rays. This protection does not extend, however, to the release of the child's actual health records. Copies of records should not be released to DHHS or any law enforcement agency without either the consent of the parent or guardian, or an investigative subpoena or court order. If the information requested contains

substance abuse diagnosis or treatment records, a patient authorization or court order is required.

GUARDIAN AD LITEM

In cases of suspected abuse or neglect, the court may appoint a guardian ad litem for the child. This person has the right under the law to have access to all reports and records relevant to the case, including all records of any examination or treatment of the child, unless the records contain information regarding substance abuse diagnosis or treatment or if the court documentation states differently. Carefully review the guardian ad litem document prior to the disclosure of any information. Also, it is important to note that the guardian ad litem does not have the authority to access information or permit disclosure of information without a court order.

SHORT-TERM EMERGENCY SERVICES

The Department of Health and Human Services may provide short-term emergency protective services, including medical treatment, to a child who appears to be threatened with serious harm, a runaway, or without any person responsible for him or her. These services may be provided for no longer than 72 hours from the time DHHS assumes responsibility for the child. The DHHS has the right to consent to medical treatment for a child receiving short-term emergency services, and health care providers are protected from liability for providing services without the consent of the parent or guardian. If a parent or guardian objects to medical treatment, it must be discontinued by DHHS within six hours of receiving the objection.

SECTION 7. ADULT/ELDER ABUSE

Under 22 MRSA §3470-3492, health care providers are required to report to DHHS any suspected abuse or neglect of an incapacitated adult. An incapacitated adult is defined as a person impaired by mental or physical illness, mental deficiency, or disability, to the extent that the person cannot make or communicate responsible decisions or effectively manage his or her own affairs. The manner of reporting is as described above for cases of suspected child abuse or neglect. Reporting is not required when the health care provider has learned of the situation through providing treatment, for a problem related to the abuse or neglect, to the person suspected of causing the abuse or neglect, *provided that the abused or neglected adult's life and health are not immediately threatened*. If the information requested contains substance abuse diagnosis or treatment records, a patient authorization or court order is required.

MEDICAL EXAMINER

Any death of an adult which is suspected to have been caused by abuse or neglect must be reported to the medical examiner.

SECTION 8: NOTIFIABLE DISEASES

Please see DHHS Rule 10-144, chapter 258 which speaks to this section. The following website provides a Notifiable Conditions List and tells which diseases to report, who must report, what to report and how to report: <http://mainegov-images.informe.org/dhhs/boh/REPORTABLE%20DISEASES%20IN%20MAINE.pdf>

These diseases most likely will NOT be reported by HIM professionals, but rather by clinical staff.

SECTION 9. OCCUPATIONAL DISEASES

In 1989 the state of Maine established an occupational disease reporting program aimed at identifying the prevalence and causes of work-related disease conditions. (See 22 MRSA Chapter 259-A.) All physicians and hospitals are required to report to the Bureau of Health, within 30 days of the diagnosis or the patient's discharge, any person diagnosed with an occupational disease. The report is to be made on a DHHS abstract form and must include any factor suspected of being contributory to the disease. Reportable conditions include asbestosis, byssinosis, carpal tunnel syndrome, heavy metal poisoning, hypersensitivity pneumonitis, mesothelioma, occupational asthma, pesticide poisoning, silicosis, solvent toxicity, and toxic gas poisoning. Detailed reporting requirements are available from the Bureau of Health, 207-287-5378.

SECTION 10. GUNSHOT WOUNDS/VIOLENCE

Health care providers must report gunshot wounds to a law enforcement agency within 24 hours. (See 17A MRSA §512.) Failure to report treatment of a gunshot wound is a Class E crime. Also, any health care provider who is aware of a death involving violence, or in which violence is suspected, must immediately notify an appropriate law enforcement agency. (22 MRSA §3026).

SECTION 11. BURNS DUE TO ARSON

Under 25 MRSA §2415, if a health care provider treating a burn patient suspects that the burns may have been sustained while the patient was committing arson, the provider *may* make a report to the State Fire Marshall's office. The report may include the patient's name and address, the reasons for the provider's suspicions, and any other information which the provider feels may aid in the investigation. Note that this reporting is optional rather than required. The statute provides immunity for providers acting in good faith.

SECTION 12. IMPAIRED DRIVERS

A physician *may* report to the Secretary of State's office a patient who, because of physical, mental, or emotional impairment, appears to present an imminent threat to driving safety. This is an optional report. The statute provides limited immunity to the reporting party. (See 29-A MRSA §1258.)

A physician may also report to a law enforcement agency any patient who is treated following a motor vehicle accident when the physician suspects that the patient was operating the motor vehicle under the influence of liquor or drugs. (See 29-A MRSA §2405.) This also is optional reporting. The statute provides limited immunity.

SECTION 13. HEAD INJURIES

Hospitals, physicians, and neuropsychologists are *encouraged* to report to the Bureau of Rehabilitation all persons diagnosed with a head injury. This is not mandatory reporting. The report should be submitted within seven days of diagnosis and should contain information such as the name of the patient (if done with patient consent), age and residence of patient, and the date and cause of injury. (See 22 MRSA §3087.)

SECTION 14. NEWBORN SCREENING

Under 22 MRSA §1532, the DHHS has the right to require hospitals and birthing facilities to test newborn infants for metabolic disorders which may cause mental deficiencies, including phenylketonuria. Infants may be exempted from testing if the testing conflicts with the parents' religious beliefs. DHHS regulations require:

- Health care providers will obtain and submit to DHHS blood specimens from every infant born in Maine or moving into Maine within three months of birth.
- The person who actually obtains the sample will document that fact in the infant's chart.
- The person who "assembles the discharge papers" will check that a specimen has been obtained and is documented in the record. The discharge instructions must include the fact that a specimen has been obtained.
- DHHS will send each facility a list of specimens received, and the facility must check this list against the list of discharged newborns. If an infant is not listed as having had a specimen submitted, the facility must notify the physician within 24 hours and DHHS within five working days.
- If the infant is transferred during the first 48 hours of life, the specimen is to be taken at the second facility. The first facility will document the need for testing in the infant's transfer documents.
- Results of screening tests must be recorded in the newborn's record.
- The facility must review 10% of newborn records within six weeks after discharge to ensure that screening information is recorded.
- For infants born outside of Maine, the first primary care physician to examine the infant in Maine must determine whether testing was done and, if not, must take a specimen.
- A Maine primary care physician who examines a child for the first time in the first three months of life will determine whether the child has been screened. If not, the physician will obtain a specimen within five working days.
- For term infants, the specimen is to be taken by the third day of life. If the hospital stay is less than three days, the specimen is to be taken as close to discharge as possible.
- If the infant is discharged within 24 hours of birth, a first specimen is taken as close to discharge as possible and a second specimen as close to the third day as possible and not later than the seventh day. The facility must notify the parents of what they need to do to complete the second test and must notify the physician of the early discharge and the need for retesting. These notifications must be documented in the record.
- Specimens will be obtained from pre-term or sick infants and infants in intensive care on the third day of life and again at two weeks or at discharge, whichever is earlier.
- Specimens will be obtained prior to blood transfusion, regardless of age, and again within three to seven days post transfusion.
- If parents object to testing on religious grounds, they must refuse in writing. The written refusal will be made a part of the medical record. The facility will notify DHHS of the refusal within 14 days of the infant's birth.

| Failure to comply with regulations is punishable by civil and criminal penalties.

SECTION 15: REPORTING TO MAINE HEALTH DATA ORGANIZATION

The Maine Health Data Organization (MHDO) was established by the Maine Legislature in 1996 as an independent executive agency to collect clinical and financial health care information and to exercise responsible stewardship in making this information accessible to the public. Each hospital must file a completed hospital inpatient data set and a completed hospital outpatient data set for every service provided to each patient, including data from provider based practices considered departments of the hospital. The listing of all submission requirements is detailed in 90-590 Chapter 241: Uniform Reporting System for Hospital Inpatient Data Sets and Hospital Outpatient Data Sets.

SECTION 16: NEW ENGLAND ORGAN BANK

Under Medicare's Condition of Participation rule §482.45, Organ Procurement Responsibilities, hospitals are required to notify an organ procurement organization (New England Organ Bank-NEOB) of all deaths that occur in the hospital and imminent deaths. This ensures that organ procurement organizations have the opportunity to determine the suitability of every potential organ donor, thus increasing opportunities to contact families and request organ donation. Consent by surviving family members for organ donation is requested even in cases where the individual had signed an organ donation card. HIM professionals are often called upon to send a monthly list of hospital deaths to a contact at the NEOB who then verifies that all deaths for that month were reported.

SECTION 17: FOOD AND DRUG ADMINISTRATION

Health care facilities report equipment failure/malfunction, defective equipment, etc., to the Food and Drug Administration.