940 – Medical Records and Communication of Clinical Information

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I. Purpose

This Policy applies to ~~AHCCCS Complete Care (~~ACC~~)~~, ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors; Fee-For-Service (FFS) Programs ~~as delineated within this Policy~~ including: American Indian Health Program (AIHP); Tribal ALTCS, TRBHA, and all FFS populations~~, excluding Federal Emergency Services (FES)~~[3]. ~~(For FES, see AMPM Chapter 1100)~~[4]~~.~~ This Policy establishes requirements for protection of member information and documentation requirements for member physical and behavioral health records and outlines record review requirements including the use of ~~e~~Electronic ~~h~~Health R~~r~~ecords (EHR) and external health information systems.

II. Definitions

Arizona Association Of Health Plans (AzAHP)

For purposes of this Policy, AzAHP is an organization dedicated to working with elected officials, AHCCCS Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans. AzAHP is involved in administration of the chart audit process for physical health plan sites and they collaborate with the Contractors with regard to the behavioral health chart audit process.

Designated Record Set (DRS)[5]

A group of records maintained by the provider. The DRS may include the following:

1. Medical and billing records maintained by a provider,
2. Case/medical management records, or
3. Any other records used by the provider to make medical decisions about the member.

[1] Date changes are effective Date presented at APC Meeting or without APC review, the date Policy is published
[2] Date presented at APC Meeting or without APC review, the date Policy is published
[3] Removed exclusion of FES because protection of their medical information and medical requirements will also apply
[4] POST APC CHANGE: removed; not needed
[5] Adding applicable language that was previously found in AMPM Policies 550 and 630

HEALTH INFORMATION EXCHANGE (HIE)	The secure sharing of patient health information among authorized providers. It is a process or action that can be facilitated by an HIO. Health information exchange can also include the secure sharing of patient health information directly between providers (Healthcare Information and Management System Society[6]).[7]
HEALTH INFORMATION ORGANIZATION (HIO)	An entity that facilitates the secure exchange of electronic patient health information between participating providers (Healthcare Information and Management System Society)[8].
MEDICAL RECORDS	A chronological written account of a patient's examination and treatment that includes the patient's medical history and complaints, the provider's physical findings, behavioral health findings, the results of diagnostic tests and procedures, medications and therapeutic procedures, referrals and treatment plans.[9] ~~For purposes of this Policy, all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including medical records that are prepared by a health care provider or by other providers as specified in A.A.C. R9-12-2291.~~
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)[10]	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

III. POLICY

Providers are required to maintain comprehensive documentation related to care and services provided to ~~AHCCCS~~ members. Contractors and FFS providers[11] shall ensure via regular monitoring activities that documentation completed and maintained by the providers,[12] meets the requirements ~~outlined~~ specified in this Policy.

[6] Added reference for definition
[7] Added as new definition to align with process of HIE within this policy
[8] Added reference for definition
[9] Revised to align with Contract definition
[10] Added to align with Contract definition
[11] Specific to FFS
[12] Added for clarification

Throughout this Policy, all references to CFTs or ARTs pertain to Contractors and not to FFS Programs or FFS populations. A CFT or ART is not required in order for FFS [13]

A. PHYSICAL AND BEHAVIORAL HEALTH MEDICAL RECORD ~~FORMATS~~REQUIREMENTS

1. Medical Record requirements are applicable to both paper and electronic medical records. Records may be documented on paper or in an electronic format and shall include the following:
   a. Documentation shall be completed as close to the actual event as possible,
   b. Up-to-date, well organized and comprehensive documentation, with sufficient detail to promote effective member care and ease of quality review,
   ~~a.~~c. Documentation of identifying demographics, including:
      i. The member's name,
      ii. Address,
      iii. Telephone number,
      iv. AHCCCS identification number,
      v. Gender,
      vi. Age,
      ~~ii.~~vii. Date of birth,
      ~~iii.~~viii. Marital status,
      ~~iv.~~ix. Next of kin, and
      x. Parent/guardian/Healthcare Decision Maker, if applicable .[14]
   ~~b.~~d. Member identification information on each page of the Medical Record including:
      i. Member name, and
      ii. Member AHCCCS ID~~-~~, or
      iii. Member DOB.[15]
   e. Past medical history, including, but not limited to:
      i. Disabilities,
      ii. Any previous illness or injuries,
      iii. Smoking,
      iv. Alcohol/substance use,
      v. Allergies,
      vi. Adverse reactions to medications,
      vii. Hospitalizations,
      viii. Surgeries,
      ix. Emergent/urgent care received, and~~.~~
      x. Immunization records (required for children, recommended for adult members if available).
   f. Medical records documented on paper shall be written legibly in blue or black ink, signed, and dated by the rendering[16] provider for each entry. Electronic

[13] POST APC CHANGE: Added for clarification regarding requirement of CFTs/ARTs
[14] Changed to Healthcare Decision Maker from previous term of designated representative.
[15] Added "and member AHCCCS ID or DOB'
[16] Added for clarity

format Medical Records shall also include the name of the provider who made the entry and the date for each entry,

If revisions to information are made, a system shall be in place to track when, and by whom they are made. In addition, a back-up system shall be maintained that tracks initial and revised information,[17]

g. If a Medical Record is physically altered:
   i. The stricken information shall be identified as a correction and initialed by the rendering provider altering the record, along with the date when the change was made; correction fluid or tape is not allowed.
   ii. If Medical Records are kept in an electronic file, the provider shall establish a method for indicating the author, date and time of added and/or revised information, and
   iii. Ensure that information is not inadvertently altered.
h. Medical Records shall identify the treating or consulting provider. A member may have more than one Medical Record kept by various health care providers that have rendered services to the member,
i. Providers in multi-provider offices shall have the treating provider sign his or her treatment notes after each appointment and/or procedure. Provider signature shall occur as close to the actual entry of treatment notes as possible, and based on either professional standards of care and/or requirements outlined within A.A.C. R9-10,
j. Medical Records shall contain documentation of referrals to other providers,
k. Documentation that reflects transmission of the diagnostic, treatment and disposition information related to a specific member to the requesting provider, as appropriate to promote continuity of care and quality management of the member's health care.,
l. Documentation to reflect review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances,[18]
m. Documentation of coordination of care activities including, but not limited to:
   i. Reports from referrals, consultations and specialists for behavioral and/or physical health, as applicable[19],
   ii. Emergency/urgent care reports,
   iii. Hospital discharge summaries,
   iv. Transfer of care to other providers, and
   i. Any notification when a member's health status changes or new medications are prescribed.

[17] Revised language from "including initial and revised information shall be maintained" to add clarification to requirement.
[18] Added to this section as it applies to both BH & PH; deleted from other section
[19] This changed from "l" – "Behavioral health referrals and services provided, as applicable.

n. Legal documentation that includes:[20]
   i. Documentation related to requests for release of information and subsequent releases,
   ii. Documentation of a Health Care Power of Attorney or documentation authorizing a Health Care Decision Maker,[21]
   iii. Copies of any Advance Directives or Mental Health Care Power of Attorney:
      1) Documentation that the adult member was provided the information on Advance Directives and whether an Advance Directive was executed (refer to AMPM Policy 640 for additional details),
      2) Documentation of general and informed consent to treatment,
      3) Authorization to disclose information,.

Refer to AMPM Policy 710 for Medical Record information regarding members who receive Medicaid direct services through their school system.[22]

2. Physical Health Medical Record Requirements: Primary Care Provider[23]
   a. Any provider delivering primary care services to a member and acting as their Primary Care Provider (PCP) shall maintain a comprehensive record that incorporates at least the following components:
      i. Initial history and comprehensive physical examination findings for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member, if known),
      ii. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a Medical Record, such information may be kept in an appropriately labeled file but shall be associated with the member's Medical Record as soon as one is established,
      iii. Documentation of any requests for forwarding of behavioral health Medical Record information,
      iv. Behavioral health history and information received from a AHCCCS Contractor, TRBHA, or other Provider involved with the member's behavioral health care or a provider, who is also treating the member for behavioral health needs,
      v. Documentation, initialed by the provider, to signify review of diagnostic information including:
         1) Laboratory tests and screenings,
         2) Radiology reports,
         3) Physical examination notes,

[20] Moved from progress note section to here for improved flow and clearly stated record components for PH & BH
[21] Changed language to reflect all possible legal representatives and proper legal relationship.
[22] Moved from previous location for flow.
[23] Moved for flow

4) Medications,
5) Last provider visit,
6) Recent hospitalizations, and
7) Other pertinent data.

~~i.~~vi. ~~-~~Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools,

vii. ~~-~~Current and complete EPSDT tracking forms (or an equivalent including, at minimum all data elements on the EPSDT tracking for) are required for:

1) All members age 0 through 20 years, and
2) Developmental screening tools for children ages nine, 18 and 24 months,
3) Dental history if available, and current dental needs and/or services,
4) Current problem list,
5) Current medications, and
6) Documentation to reflect review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances,

~~ii.~~viii. Evidence that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members. Refer to AMPM Policy 410.~~,~~ [24]

3. Behavioral Health Medical Record Requirements [25]

The following elements shall be included in all Behavioral Health Medical Records:

a. Initial behavioral health evaluation that includes:
   i. Documentation of the member's choice for receipt of the Member Handbook (either paper or electronic format),
   ii. Receipt of Notice of Privacy Practice, and
   iii. Contact information for the member's PCP.

   Financial documentation for Non-Title XIX/XXI– members receiving behavioral health services, as outlined in AMPM Policy 650. At minimum, include documentation of the results of a completed Title XIX/XXI screening at initial evaluation appointment, ~~-~~when the member has had a significant change in his/her income, and at least annually
   iv.
b. Behavioral health assessment documentation that includes:
   i. Documentation of all information collected in the behavioral health assessment and any applicable addenda and required demographic information. For additional requirements refer to AMPM Policy 320-O, AMPM Policy 320-U, AMPM Policy 580[26], and AHCCCS Technical Interface Guidelines,

[24] 'a' through 'e' above moved to section A, pg 2: Physical and Behavioral Health Medical Record Formats
[25] Moved for flow
[26] Added additional locations of reference

ii. Diagnostic information including psychiatric, psychological, and physical health evaluations,
iii. Evaluation of the need for reporting as required under A.R.S. §13-3620,
iv. Copies of documentation related to the need for Special Assistance, if applicable. Refer to AMPM Policy 320-R,
v. An English version of the behavioral health assessment and/or Service Plan if the documents are completed in any language other than English, and
~~i.~~vi. For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.

c. Service Plan documentation that includes:
i. The member's Service Plan,
ii. Child and Family Team (CFT) documentation, based on member's age (0 to 18 or up to 21 should member chose to continue with Child & Family team after turning 18),
iii. Adult Recovery Team (ART) documentation for adults 18 and beyond, and
~~i.~~iv. Progress reports or Service Plans from all other service providers. ~~,~~

d. Progress note documentation that includes:
i. Documentation of the type of services provided,
ii. The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a principal diagnosis is identified, the member may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable,
iii. The date the service was delivered,
iv. The date and time the progress note was signed,
v. The signature of the staff that provided the service, including the staff member's credentials,
vi. Duration of the service (time increments),
~~i.~~vii. A description of what occurred during the provision of the service related to the member's Service Plan. Any additional information added to progress notes shall be identified as a late entry and dated accordingly.
viii. In the event that more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services,
ix. The member's response to service, and
~~ii.~~x. For members receiving services via telemedicine, electronically recorded information of direct, consultative, or collateral clinical interviews,

~~c.~~e. Documentation (as applicable) for the processing of an appeal shall be documented in the case file; including the Notice of Extension (NOE) received from the MCO, that was sent to the member and his/her legal guardian or authorized representative.

Individuals that are Non-Title XIX/XXI may or may not have a PCP. For appropriate documentation that is required for completion and maintenance in the behavioral health record for Grants refer to AMPM Policy 320-T1[27] and associated Aattachments covering antidiscrimination and charitable choice.

~~A.~~B. POLICIES[28] AND PROCEDURES FOR ENSURING MEDICAL (PHYSICAL AND/OR BEHAVIORAL HEALTH) RECORD CONTENT~~:~~

1. Contractors shall implement and maintain Policies and Procedures to ensure that subcontracted providers have information required to monitor effective and continuous physical and/or behavioral health care for members through accurate Medical Record documentation regardless of whether records are paper or electronic via:
   a. Onsite quality review
   b. Initial and on-going monitoring of medical records[29]
   c. Review of health status, changes in health status, health care needs, and services provided,
   d. Review of coordination of care activities,
   e. Maintenance of a legible Medical Record for each member who has been seen for physical and/or behavioral health appointments and/or procedures,
   f. The Medical Record shall also contain clinical records from other providers who also provide care/services to the member, and~~.~~
   ~~a.~~g. Medical ~~-~~Record requirements for paper and electronic medical records.

2. Contractors shall have Policies and Procedures in place for use of Electronic Medical Records (physical and behavioral health) and for Health Information Exchange via the state's Health Information Organization and digital (electronic) signatures. Policies and procedures shall meet federal and state requirements including those related to security and privacy including but not limited to 45 CFR 160, 162, and 164; 45 CFR 431, and Medicaid Information Technology Architecture (MITA).[30] The following processes shall be included:
   a. Signer authentication
   b. Message authentication,
   c. Affirmative act (i.e. an approval function such as a signature which establishes the sense of having legally consummated a transaction),[31]
   ~~b.~~d. Efficiency, and
   ~~e.~~ Medical Record review~~.~~.[32]

[27] AMPM Policy 320-T is currently under development and will be separated into AMPM Policy 320-T1 (being specific to Grants) and AMPM Policy 320-T2 (specific to Non Titled XIX)
[28] Moved Policies and Procedures section for better flow (to reflect actual process)
[29] Changed order under #1 to more closely align with general processes
[30] Revised to include HIPPA and other Security/Privacy requirements for electronic records
[31] Expanded on explanation for clarity
[32] Moved for flow

3. Contractors shall implement Policies and Procedures that:
   a. Support members' rights to request and receive a copy of their Medical Record at no cost and to request that the Medical Record be amended or corrected [45 CFR Part 160 and 164, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi)],
   b. Ensure information from or copies of, Medical Records are released only to the member their Health Care Decision Maker[33]. Contractors shall implement a process to ensure that unauthorized individuals cannot gain access to, or alter Member Records~~.~~,
   ~~a.~~c. Medical Records are maintained in a secure manner that maintains the integrity, accuracy and confidentiality of member medical information.[34]

4. Contractors shall have written Policies and Procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and shall conduct reviews to verify that:
   a. A provider making a referral transmits necessary information to the provider receiving the referral,
   b. A provider furnishing a referral service reports appropriate information to the referring provider,
   c. Providers request information from other treating providers as necessary to provide appropriate and timely care,
   d. Information about services provided to a member by a non-network provider (e.g. emergency services) is transmitted to the member's provider
      i. Medical Records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP, or health home. The member's Medical Records or copies of Medical Records shall be forwarded to the new PCP or health home provider(s) or entity(ies) involved in the member's care, within 10 business days from receipt of the request for transfer of the medical records, and
      ~~i.~~ii. Member information is shared when a member enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care.

~~B.~~C. METHODOLOGY FOR CONDUCTING MEDICAL (PHYSICAL OR BEHAVIORAL HEALTH) RECORD REVIEW PROCESS

For purposes of this Policy, and as specified in Contract, the Medical Record audit process will include the Ambulatory Medical Record Review (AMRR)[35] and the Behavioral Health Clinical Chart Audit. Contractors may utilize Arizona Association of Health Plans (AzAHP) to conduct Medical Record review and other provider documentation review processes. AzAHP serves as an association of contracted

[33] Corrected language to Health Care Decision Maker to reflect proper legal relationship
[34] Added for additional clarification
[35] Added this term to align with historical process and terminology under previous AHCCCS contracts.

AHCCCS Managed Care Organizations organized to support attainment of member health outcomes as well as efficient and cost effective processes.[36]

1. Contractors shall ~~The follow~~utilize~~ing~~ the following methodology ~~shall be utilized~~ when conducting a Medical ~~Medical~~ Record review of~~for~~ provider~~s: types outlined below:~~
   a. ~~Medical~~[37] Medical ~~–~~Record reviews shall be conducted using a standardized tool that has been ~~reviewed~~ approved by AHCCCS~~.~~.
   b. Physical health records~~, The tool~~ shall include, but is not limited to:
      i. EPSDT,
      ii. ~~f~~Family planning, and
      iii. ~~m~~Maternity components not otherwise monitored for provider compliance by Contractors,
   c. For behavioral health Medical Records, the tool shall include:
      i. Elements that pertain to assessment,
      ~~–~~Service, and/or
      ii. Treatment planning, and~~.~~
      iii. As applicable, individual elements shall delineate which requirements pertain to:
         a) The unique needs of individual lines of business, and
         b) Special populations including:
            1) GMHSU,
            2) SMI,
            3) Special Health Care Needs,
            4) CMDP, or
            ~~1)~~5) Individuals receiving services under DDD.[38]
   d. Medical ~~Medical~~ Record reviews shall be conducted according to the following schedule:
      i. A~~a~~t a minimum of every three years for physical health charts (AMRR), and
      ~~i.~~ii. Yearly for behavioral health charts, according to methodology as outlined in Contract (Behavioral Clinical Chart Audit Methodology and Findings Summary Report),
   e. Use of a collaborative approach across Contractors ~~(i.e.~~including the ~~–~~use of an AHCCCS approved vendor ~~by~~ such as AzAHP~~)~~. The review process is acceptable, provided it will result in only one Medical ~~Medical~~ Record review process for each provider. Use of a vendor would be considered a delegated arrangement,
   f. The Medical (AMRR or Behavioral Health) Record reviews shall be conducted utilizing staff with the appropriate licensure and/or experience necessary for

[36] Removed no longer applicable.
[37] Deleted term "Medical" where appropriate to create an overall term of Record review that allows for either behavioral or AMRR audit process.
[38] Added to delineate specific requirements under either BH or PH

completion of either clinical charts for behavioral health services or physical health services:

i. For Behavioral Health Clinical Chart Audits, licensed Behavioral Health Professionals (BHPs) or Behavioral Health Technicians (BHTs) with a minimum of three years' experience as a BHT and under the supervision of a BHP, shall be utilized

ii. [39]For AMRR Audits, a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) with current Licensure under the Arizona State Board of Nursing. In the event that RNs or LPNs are unavailable to conduct an AMRR audit, MCOs may utilize their own staff (currently licensed RN's or MD's) for assistance and consultation to staff during the AMRR audit activities.[40]

~~b.~~g. Results of the ~~Medical~~ Record review shall be made available to all Contractors who utilize AzAHP for this process and ~~that~~ those that contract with the audited provider,

~~c.~~h. Deficiencies identified shall be shared with all health plans contracted with the provider,

~~d.~~i. If quality of care issues are identified during the Medical ~~Medical~~ Record review process, it is expected that all ~~health plans~~Contractors ~~that~~, which contract with that provider, be notified ~~promptly (i.e.~~ within 24 hours~~)~~ in order to conduct an independent onsite provider audit,

j. Contractors may request approval to discontinue conducting the AMRR and/or behavioral health Medical Record reviews. However, prior to receiving approval to discontinue the Medical Record review process, the Contractor shall:

i. Conduct a comprehensive review of its use of the Medical Record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT, family planning, maternity, and behavioral health services;

ii. Document what processes will be used in place of the Medical Record review process to ensure compliance with AHCCCS requirements, and

~~i.~~iii. Submit the process the Contractor will utilize to ensure provider compliance with AHCCCS Medical Record requirements to the AHCCCS/QM, Clinical Quality Management Administrator prior to discontinuing the Medical Record review process.[41]

2. Ambulatory Medical Record Review (AMRR)~~-~~ – Process

Providers to be included in the ~~Medical Record review~~AMRR[42] process shall include all PCPs that serve children (children defined as ~~under~~less than 21 years of age) and obstetricians/~~-~~gynecologists. The ~~Medical Record~~AMRR review process shall consist of reviewing eight charts per practitioner and include ~~the following, unless a different~~

[39] Added this content as it was not previously a requirement listed under this policy or under contract
[40] Added to allow for flexibility in AHCCCS requirement for RNs and LPNs (which may not always be available given staffing patterns)
[41] Moved content under "2" to be included under methodology
[42] Updated to acronym AMRR throughout Policy

~~methodology is reviewed and approved by AHCCCS:~~the requirements specified in Contract.[43]

~~a. If the score after eight charts is less than 90 percent, technical assistance shall be provided to the practitioner, and the practitioners shall also be audited the following year.~~
~~b. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be given to the practitioner.~~
~~c. For providers that do not treat children or pregnant members, the following process shall occur unless a different methodology is reviewed and approved by AHCCCS:~~
~~i. A random sample of 30 providers per Geographic Service Area (GSA) will be pulled for audit each year. Eight charts will be audited per provider;~~
~~ii. If the score after eight charts is less than 90 percent, technical assistance shall be given to the provider, and the provider shall also be re-audited the following year;~~
~~iii. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be given to the provider; and~~
~~If, after all the audits are completed and noted trends are identified around deficiencies or improvement opportunities, the entire network shall receive education and guidance on the issues identified.~~[44]

3. Behavioral Health Record Review Process[45]
   Providers to be included in the behavioral health Medical Record review process shall include Behavioral Health Outpatient Clinics;~~.~~ integrated Health Homes and FQHCs shall be included if they provide both behavioral health and physical health care.
   a. The Medical Review process for behavioral health records shall be followed as specified in Contract,
   ~~a.~~b. For changes in methodology or sampling, submit to AHCCCS in advance for approval as specified in Contract.

~~C.~~D. ~~-~~MULTI-SPECIALTY INTEGRATED CLINICS

1. Contractors shall implement written Policies and Procedures to ensure that Multi-Specialty Integrated Clinics (MSICs) have an Integrated Electronic Medical Record for each member that is served through the MSIC.

2. The Integrated Electronic Medical Record shall:
   a. Be available, electronically through the Health Information Exchange (HIE), for the multi-specialty treatment team and community providers,

[43] Revised to allow for moving audit process steps over to contract
[44] Deleted and moved to contract to maintain consistency for AMRR process
[45] Added reference for detailed Contract methodology.

b. Contain all information necessary to facilitate the coordination and quality of care delivered by multiple providers in multiple locations at varying times. For care coordination purposes, and
c. Medical Records shall be shared with other care providers, such as the multi-specialty interdisciplinary team.

~~D.~~E. COMMUNITY SERVICE AGENCY , THERAPEUTIC FOSTER CARE PROVIDER, AND HABILITATION PROVIDER REQUIREMENTS

For Community Service Agencies (CSAs), Therapeutic Foster Care (TFC) providers, and Habilitation providers Contractors shall require that the Medical Records conform to the following standards.

1. Each record entry shall be:
   a. Dated and signed with credentials noted,
   b. Legible text, written in blue or black ink, or typewritten, and
   c. Factual and correct.

2. If Medical Records are kept in more than one location, the agency/provider shall maintain documentation specifying the location of the Medical Records. Providers shall maintain a Medical Record of the services delivered to each member. The minimum written requirement for each member's record shall include:
   a. The service provided and the time increment,
   b. Signature and the date the service was provided,
   c. The name title and credentials of the member providing the service,
   d. The member's Date of Birth (DOB)[46] and AHCCCS identification number,
   e. Services are reflected in the member's Service Plan. Providers shall keep a copy of each member's Service Plan in the member's Medical Record, and
   f. Monthly summary of service documentation progress toward treatment goals. A summary of the information required in this section shall be transmitted from the Provider to the member's clinical team for inclusion in the comprehensive Medical Record.[47]

~~E.~~F. DESIGNATED RECORD SET ~~(DRS)~~

The following applies to the member's Designated Record Set (DRS).

1. The DRS is the property of the provider who generates the DRS. The DRS is a group of records maintained by the provider and may include the following:
   a. Medical and billing records maintained by a provider,
   b. Case/medical management records, or

[46] Deleted reference to CIS as it is no longer in use; replaced with DOB
[47] Added for clarity if records kept in more than one location

c. Any other records used by the provider to make behavioral and/or medical decisions about the member.[48]

~~1.~~2. A member may:
a. Review, request, and annually receive a copy, free of charge, of those portions of the DRS that were generated by the provider,
b. Request that specific provider information is amended or corrected, and
c. Not review, request, amend, correct, or receive a copy of the portions of the DRS that are prohibited from view under HIPAA.

~~2.~~3. AHCCCS is not required to obtain written approval from a member before requesting the member's DRS from a healthcare provider or any agency. For purposes relating to treatment, payment, or health care operations, AHCCCS may request sufficient copies of records necessary for administrative purposes, free of charge.

~~3.~~4. Written approval from the member is not required by the PCP when:
a. Transmitting Medical Records to a provider when services are rendered to the member through referral to a Contractor's subcontracted provider,
b. Sharing treatment or diagnostic information with the entity or entities responsible for or directly providing behavioral health services, or
c. Sharing Medical Records with the member's C~~c~~ontractor.

~~4.~~5. Medical Records or copies of Medical Record information related to a member shall be forwarded by any AHCCCS-registered provider to the member's PCP within 10 business days from receipt of a request from the member or the member's PCP.

6. AHCCCS shall have access to all Medical Records, whether electronic or paper, within at least 20 business days of receipt of a request.

~~5.~~7. Information related to fraud, waste, and/or abuse against the AHCCCS program may be released to authorized officials in compliance with Federal and State statutes and rules.

8. Evidence of professional and community standards and accepted and recognized evidence-based practice guidelines.

Refer to AMPM Chapter 500 for a discussion of member medical records regarding member transitions between Contractors and facilities. [49]

~~6.~~9. Ensure the Contractor has an implemented process to assess and improve the content, legibility, organization, and completeness of Medical Records when concerns are identified.

[48] Added applicable language that was previously found in AMPM 630
[49] Added reference to other applicable policies.

~~7.~~10. Require documentation in the Medical Record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

G. LEGAL REQUIREMENTS FOR RECORDS MAINTENANCE

Consistent with 9 A.A.C. 22, Article 5, Contractors and providers, including non-contracted providers, shall safeguard the privacy of Medical Records and information about members who request or receive services from AHCCCS or its Contractors.

1. The content of any Medical Record may be disclosed in accordance with the prior written consent of the member with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to 42 U. S. Code §290 dd-2 (confidentiality of records); 42 CFR Part 2, 2.1 – 2.67.

2. Original and/or copies of Medical Records shall be released only in accordance with Federal or State laws, and AHCCCS Policy and Contracts. Contractors shall comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

3. Medical Records retention processes shall align with AHCCCS Contract and TRBHA Intergovernmental Agreement (IGA) requirements. The maintenance and access to Medical Records shall survive the termination of a provider's contract regardless of the cause of termination.

4. Contractors and providers shall participate and cooperate in State of Arizona and AHCCCS activities related to the adoption and use[50] of EHR and integrated (bi-directional) clinical data sharing[51]. Non contracted providers are encouraged to cooperate and participate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated (bi-directional) clinical data sharing.[52]

[50] Changed to adoption and use to reflect more correct process
[51] Term "e-prescribing" replaced with "clinical data sharing" as process of "e-prescribing no longer administered in the same way.
[52] Added content related to non contracted providers to align with updated electronic medical record processes.

[53]940 - MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

EFFECTIVE DATES: 10/01/94, 01/25/19

APPROVAL DATES: 07/01/16, 10/01/15, 03/01/14, 10/01/13, 04/01/12, 02/01/11, 10/01/09, 10/01/08, 02/01/07, 04/01/05, 01/01/04, 08/13/03, 10/01/01, 10/01/97, 01/23/19

1. **Contractors shall have policies and procedures in place for use of electronic medical (physical and behavioral health) records and for use of an health information exchange (including electronic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking forms) and digital (electronic) signatures (when electronic documents are utilized) that include processes for:**
   a. **Signer authentication,**
   b. **Message authentication,**
   c. **Affirmative act,**
   d. **Efficiency, and**
   e. **Record review.**

2. **Contractors shall implement appropriate policies and procedures to ensure that the organization and its providers have information required for:**
   a. **Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member's health status, changes in health status, health care needs, and health care services provided,**
   b. **Quality review,**
   c. **Coordination of care, and**
   d. **An ongoing program to monitor compliance with those policies and procedures. If during the quality of care review process, or other processes, issues are identified with the quality or content of a provider's medical record, the Contractor shall conduct a focused review, implement corrective actions or other remedies until the provider's medical records process meets standards specified in the AMPM.**

3. **Contractors shall implement policies and procedures for initial and on-going monitoring of medical records.**

4. **Contractors may utilize Arizona Association of Health Plans (AzAHP) to conduct medical record reviews. AzAHP serves as an association of contracted AHCCCS health plans organizes to bring exemplary health care – at the lowest possible cost – to the 1.9 million Arizonans enrolled in the AHCCCS program.**

[53] AMPM 940 original version has been placed here for reference to the new changes in the policy above

5. The following methodology shall be utilized:
   a. Conduct Medical Record Reviews using a standardized tool that has been reviewed by AHCCCS. The tool shall include but is not limited to EPSDT, family planning and maternity components not otherwise monitored for provider compliance by Contractors,
   b. Conduct medical records reviews at a minimum of every three years,
   c. Utilize a collaborative approach (use of a vendor by AzAHP) is acceptable that will result in only one medical record review for each provider. Use of a vendor would be considered a delegated arrangement,
   d. Results of the medical record review will be made available to all Contractors who utilize AzAHP for this process and that contract with the audited provider,
   e. Deficiencies identified shall be shared with all health plans contracted with the provider,
   f. If quality of care issues are identified during the medical record review process, it is expected that all health plans that contract with that provider be notified promptly (within 24 hours) in order to conduct an independent on-site provider audit,
   g. Providers to be included in the medical record review process shall include all primary care providers that serve children (children defined as under 21 years of age) and obstetricians/gynecologists. The review process will include the following, unless a different methodology is reviewed and approved by AHCCCS:
      i. The review process shall consist of reviewing eight charts per practitioner,
      ii. If the score after eight charts is less than 90 percent, technical assistance shall be provided to the practitioner,
      iii. If the score after eight charts is less than 90 percent, the practitioner shall also be re-audited the following year, and
      iv. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be provided to the practitioner.
   h. For providers that do not treat children, the following process shall occur unless a different methodology is reviewed and approved by AHCCCS:
      i. A random sample of 30 providers per Geographic Service Area (GSA) will be pulled for audit each year. Eight charts will be audited per provider,
      ii. If the score after eight charts is less than 90 percent, technical assistance shall be provided to the provider,
      iii. If the score after eight charts is less than 90 percent, the provider shall also be re-audited the following year,
      iv. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be provided to the provider, and
      v. If, after all the audits are completed and noted trends are identified around deficiencies or improvement opportunities, the entire network shall receive education and guidance on the issues identified.

6. Each Contractor shall implement policies and procedures that address paper and electronic health records, and the methodologies to be used by the organization to:
   a. Ensure that contracted providers maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical or behavioral health appointments or procedures. The medical record shall also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member;
   b. Ensure providers, in multi-provider offices, have the treating provider sign his or her treatment notes after each appointment and/or procedure. Progress notes shall be documented on the date the event occurs. Any additional information added to progress notes shall be identified as a late entry and dated accordingly. Additionally, behavioral health provider signatures shall include the provider's credentials as part of the signature;
   c. Ensure the medical record contains documentation of referrals to other providers, coordination of care activities, and transfer of care to behavioral health and other providers;
   d. Make certain the medical record is legible, kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care, quality review, and identifies the treating or consulting provider. A member may have more than one medical record kept by various health care providers that have rendered services to the member. However, the PCP shall maintain a comprehensive record that incorporates at least the following components:
      i. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but shall be associated with the member's medical record as soon as one is established;
      ii. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number);
      iii. Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative;
      iv. Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member);
      v. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance use, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received;
      vi. Immunization records (required for children; recommended for adult members if available);
      vii. Dental history if available, and current dental needs and/or services;

viii. Current problem list,
ix. Current medications,
x. Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances,
xi. Current and complete EPSDT forms (required for all members age 0 through 20 years),
xii. Developmental screening tools for children ages nine, 18 and 24 months,
xiii. Documentation, initialed by the member's provider, to signify review of:
(a) Diagnostic information including:
(i) Laboratory tests and screenings,
(ii) Radiology reports,
(iii) Physical examination notes, and
(iv) Other pertinent data.
(b) Reports from referrals, consultations and specialists,
(c) Emergency/urgent care reports,
(d) Hospital discharge summaries,
(e) Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and
(f) Behavioral health history and behavioral health information received from a Regional Behavioral Health Authority (RBHA) or RBHA provider who is also treating the member.
xiv. Documentation as to whether or not an adult member has completed advance directives and the location of the document,
xv. Documentation that the provider responds to behavioral health provider information requests within 10 business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation shall also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member,
xvi. Documentation related to requests for release of information and subsequent releases, and
xvii. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.

d. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of

Obstetricians and Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines,

e. Ensure that PCPs utilized AHCCCS approved developmental screening tools,

f. Ensure each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation) maintains a record of the services provided to a member, including:

i. Physician or provider orders for the service,

ii. Applicable diagnostic or evaluation documentation,

iii. A plan of treatment,

iv. Periodic summary of the member's progress toward treatment goals,

v. The date and description of service modalities provided, and

vi. Signature/initials of the provider for each service.

g. Ensure that RBHA transportation services that utilize provider employees (e.g. facility vans, drivers, etc.) maintain documentation that supports each transport provided. The follow information shall be documented to verify transportation services:

i. Complete service provider's name and address,

ii. Signature and credentials of the driver who provided the service,

iii. Vehicle identification (car, van, wheelchair van, etc.),

iv. Members' AHCCCS identification number,

v. Date of service, including month day and year,

vi. Address of pick up site,

vii. Address of drop off destination,

viii. Odometer reading at pick up,

ix. Odometer reading at drop off,

x. Type of trip – round trip or one way,

xi. Escort (if any) shall be identified by name and relationship to the member being transported, and

xii. Signature of the member, parent and/or guardian/caregiver, verifying services were rendered including documentation by the driver of refusal by a member to sign.

h. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines,

i. Ensure the Contractor has an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and

j. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or para professionals provide services.

7. Medical records may be documented on paper or in an electronic format:

a. If records are documented on paper, they shall be written legibly in blue or black ink, signed, and dated for each entry. Electronic format records shall

also include the name of the provider who made the entry and the date for each entry,

b. If records are physically altered, the stricken information shall be identified as an error and initialed by the member altering the record along with the date when the change was made; correction fluid or tape is not allowed,

c. If kept in an electronic file, the provider shall establish a method of indicating the author, date, and time of added/revised information and a means to assure that information is not altered inadvertently,

d. If revisions to information are made, a system shall be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information shall be maintained,

e. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified. Safeguards shall be in place to ensure that only authorized individual are able to access medical records.

8. Each Contractor shall have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and shall conduct reviews to verify that:
   a. A provider making a referral transmits necessary information to the provider receiving the referral,
   b. A provider furnishing a referral service reports appropriate information to the referring provider,
   c. Providers request information from other treating providers as necessary to provide appropriate and timely care,
   d. Information about services provided to a member by a non-network provider (e.g. emergency services) is transmitted to the member's PCP,
   e. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP,
   f. Member information is shared, when a member subsequently enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care, and
   g. Member information is shared within 10 business days with behavioral health providers and, as appropriate, other providers or entities involved in the member's care for members with ongoing care needs or changes in health status.

9. Information from, or copies of, records may be released only to authorized individuals, and the Contractor shall implement a process to ensure that unauthorized individuals cannot gain access to, or alter, member records.

10. Original and/or copies of medical records shall be released only in accordance with Federal or State laws and AHCCCS policy and contracts. Contractors shall

~~comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.~~

11. ~~Medical records retention shall align with AHCCCS Contract and TRBHA Intergovernmental Agreement (IGA) requirements. The maintenance and access to the member's medical record shall survive the termination of a provider's contract regardless of the cause of termination.~~

12. ~~Contractors shall participate/cooperate in State of Arizona and AHCCCS activities related to the development and implementation of electronic health records and e-prescribing. Electronic EPSDT tracking forms shall include all elements of the AHCCCS approved EPSDT tracking forms.~~

13. ~~Contractors may request approval to discontinue conducting medical record reviews. Prior to receiving approval to discontinue the medical record review process, the Contractor shall:~~
    a. ~~Conduct a comprehensive review of its use of the medical record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT, family planning, maternity and behavioral health services,~~
    b. ~~Document what processes will be used in place of the medical record review process to ensure compliance with AHCCCS requirements,~~
    c. ~~Submit the process the Contractor will utilize to ensure provider compliance with AHCCCS medical record requirements to the AHCCCS Clinical Quality Management Administrator prior to discontinuing the medical record review process, and~~
    d. ~~Refer to AMPM Policy 640 and AHCCCS Contract for a complete discussion on Advanced Directives for adult members.~~

14. ~~Behavioral Health Medical Record Requirements shall include the following elements:~~
    a. ~~Initial evaluation that includes:~~
        i. ~~Documentation of the member's receipt of the Member Handbook and receipt of Notice of Privacy Practice,~~
        ii. ~~Contact information for the member's Primary Care Provider; for members receiving substance use treatment services under the Substance Abuse Prevention & Treatment Block Grant (SABG), documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object. See AMPM Policy 320-T, Exhibit 320-9 for Notice requirements, and~~
    b. ~~For Non-Title XIX/XXI members receiving behavioral health services:~~
        i. ~~Financial documentation that includes:~~
        ii. ~~Documentation of the results of a completed Title XIX/XXI screening at initial evaluation appointment, when the member has had a significant change in his/her income, and at least annually~~

iii. Information regarding establishment of any copayments assessed, if applicable

c. Assessment documentation that includes:
   i. Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see AMPM Policy 580, AMPM Policy 320-O, and AHCCCS Technical Interface Guidelines),
   ii. Diagnostic information including psychiatric, psychological and medical evaluations,
   iii. Copies of Exhibit 320-8, (see AMPM Policy 320-R) as applicable,
   iv. An English version of the assessment and/or service plan if the documents are completed in any language other than English, and
   v. For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.

d. Treatment and Service Plan documentation that includes:
   i. The member's treatment and service plan,
   ii. Child and Family Team (CFT) documentation,
   iii. Adult Recovery Team (ART) documentation, and
   iv. Progress reports or Service Plans from all other additional service providers.

e. Progress Note documentation that includes:
   i. Documentation of the type of services provided,
   ii. The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a principal diagnosis is identified, the member may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable,
   iii. The date the service was delivered,
   iv. The date and time the progress note was signed,
   v. The signature of the staff that provided the service, including the staff member's credentials,
   vi. Duration of the service (time increments),
   vii. A description of what occurred during the provision of the service related to the member's treatment plan,
   viii. In the event that more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services,
   ix. The member's response to service, and
   x. For members receiving services via telemedicine, electronically recorded information of direct, consultative, or collateral clinical interviews.

f. Paper or electronic correspondence documentation that includes:
   i. Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management for the member, and
   ii. Documentation of any requests for and forwarding of behavioral health record information.
g. Legal documentation including:
   i. Documentation related to requests for release of information and subsequent releases,
   ii. Copies of any advance directives or mental health care power of attorney:
      (a) Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed,
      (b) Documentation of authorization of any health care power of attorney that appoints a designated member to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions,
      (c) Documentation of authorization of any mental health care power of attorney that appoints a designated member to make behavioral health care decisions on behalf of the member if they are found to be incapable of making these decisions,
      (d) Documentation of general and informed consent to treatment,
      (e) Authorization to disclose information,

      Any extension granted for the processing of an appeal shall be documented in the case file; including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative.

15. Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC), and Providers and Habilitation Providers:

a. The Contractor shall require that the clinical records of the CSA, HCTC Provider, and Habilitation Provider conform to the following standards. Each record entry shall be:
i. Dated and signed with credentials noted,
ii. Legible text, written in blue or black ink, or typewritten, and
iii. Factual and correct.

b. If required records are kept in more than one location, the agency/provider shall maintain documentation specifying the location of the records. CSAs, HCTC Providers and Habilitation Providers shall maintain a record of the services delivered to each behavioral health member. The minimum written requirement for each behavioral health member's record shall include:
i. The service provided and the time increment,
ii. Signature and the date the service was provided,
iii. The name title and credentials of the member providing the service,
iv. The member's CIS identification number and AHCCCS identification number,

~~v. Services are reflected in the behavioral health member's service plan. CSAs, HCTC Providers and Habilitation Providers shall keep a copy of each behavioral health member's service plan in the member's record, and~~

~~vi. Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals. A summary of the information required in this section shall be transmitted from the CSA, HCTC Provider, or Habilitation Provider to the member's clinical team for inclusion in the comprehensive~~