940 – Medical Records and Communication of Clinical Information

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I. Purpose

This Policy applies to ACC, ALTCS E/PD, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), and RBHA Contractors; Fee-For-Service (FFS) Programs including American Indian Health Program (AIHP), Tribal ALTCS, TRBHA, and all FFS populations. This Policy establishes requirements for protection of member information and documentation requirements for member physical and behavioral health records and specifies record review requirements including the use of Electronic Health Records (EHR) and external health information systems.

II. Definitions

Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

III. Policy

Providers are required to maintain comprehensive documentation related to care and services provided to members. The Contractor and FFS providers shall ensure via regular monitoring activities that documentation completed and maintained by the providers, meets the requirements specified in this Policy.

Throughout this Policy, all references to Child and Family Team (CFT) or Adult Recovery Team (ART) pertain to Contractors and not to FFS Programs or FFS populations. A CFT or ART is not required in order for FFS.

A. Physical and Behavioral Health Medical Record Requirements

1. Medical record requirements are applicable to both hard copy and electronic medical records. Records may be documented on hard copy or in an electronic format and shall include the following:
   a. Documentation shall be completed contemporaneously,
   b. Up to date, well organized and comprehensive documentation, with sufficient detail to promote effective member care and ease of quality review,
   c. Documentation of identifying demographics, including:
      i. The member's name,
      ii. Address,
      iii. Telephone number or,
      iv. AHCCCS identification number,

v. Gender,
vi. Age,
vii. Date of birth,
viii. Marital status,
ix. Next of kin, and
x. Parent/guardian/Healthcare Decision Maker (HCDM), if applicable.

d. Member identification information on the first page of the medical record including:
   i. Member name,
   ii. Member AHCCCS ID, or
   iii. Member DOB.
e. Subsequent pages of the medical record shall include member name and either AHCCCS ID or Member DOB,
f. 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
   a. Immunization records (required for children, recommended for adult members if available).
g. Medical records documented on hard copy shall be written legibly in blue or black ink, signed, and dated by the rendering provider for each entry. Electronic format medical records shall also include the name of the provider who made the entry and the date for each entry,
h. 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. 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.
i. 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,
j. 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 specified within A.A.C. Title 9, Chapter 10,

k. Medical records shall contain documentation of referrals to other providers,
l. 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,
m. 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,
n. 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,
    ii. Emergency/urgent care reports,
    iii. Hospital discharge summaries, and
    iv. Transfer of care to other providers.
o. Any notification when a member's health status changes or new medications are prescribed. Legal documentation that includes:
    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 HCDM,
    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 (as specified in AMPM Policy 640),
        2) Documentation of general and informed consent to treatment, as specified in AMPM Policy 320-Q, and
        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.

2. Physical Health Medical Record Requirements: Primary Care Provider
    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,
   4) Medications,
   5) Last provider visit,
   6) Recent hospitalizations, and
   7) Other pertinent data.

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 aged zero through 20 years,
   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 CSPMP data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances.

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

3. Behavioral Health Medical Record Requirements

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 hard copy or electronic format),
   ii. Receipt of notice of privacy practice,
   iii. Contact information for the member's PCP, and
   iv. 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.

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, and AHCCCS Technical Interface Guidelines,
   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 (or treatment plan when applicable) if the documents are completed in any language other than English, and
   vi. For members receiving services via telehealth, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.
c. Service plan documentation that includes:
   i. The member's service plan, or treatment plan as applicable,
   ii. CFT documentation, based on member's age (0 to 18 or up to 21 should member choose to continue with CFT team after turning 18),
   iii. ART documentation for adults aged 18 and older, and
   iv. Progress reports or service plans, or treatment plans from all other service providers, as applicable.
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),
   vii. A description of what occurred during the provision of the service related to the member's service plan. Any additions, corrections or changes to the documentation entered after it is finalized/completed by the rendering provider, shall be clearly indicated as a late entry, which is signed and stamped,
   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 telehealth, electronically recorded information of direct, consultative, or collateral clinical interviews.

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 Contractor that was sent to the member and their legal guardian or authorized representative.

B. POLICIES AND PROCEDURES FOR ENSURING MEDICAL (PHYSICAL AND/OR BEHAVIORAL HEALTH) RECORD CONTENT

1. The Contractor 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 hard copy or electronic via:
   a. Onsite or electronic quality review,
   b. Initial and on-going monitoring of medical records,
   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
   g. Medical record requirements for hard copy and electronic medical records.

2. The Contractor shall have policies and procedures in place for use of electronic medical records (physical and behavioral health) and for HIE via the state's Health Information Organization (HIO) 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, 42 CFR 431.300 et seq. and Medicaid Information Technology Architecture (MITA). 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),
   d. Efficiency, and
   e. Medical record review.

3. The Contractor 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)], A.A.C. R9-22-503,
   b. Ensure information from or copies of medical records are released only to the member, their HCDM, a personal representative, or as applicable by law. The

Contractor shall implement a process to ensure that unauthorized individuals cannot gain access to, or alter member records, and

c. Medical records are maintained in a secure manner that maintains the integrity, accuracy, and confidentiality of member medical information.

4. The 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 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
      ii. Member information is shared when a member enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care.

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) and the Behavioral Health Clinical Chart Audit. The Contractor 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 AHCCCS Managed Care Organizations organized to support attainment of member health outcomes as well as efficient and cost-effective processes. This requirement does not apply to FFS.

1. The Contractor shall utilize the following methodology when conducting a medical record review of providers:
   a. Medical record reviews shall be conducted using a standardized tool that has been approved by AHCCCS,
   b. Physical health records shall include, but are not limited to:
      i. EPSDT,
      ii. Family planning, and
      iii. Maternity components not otherwise monitored for provider compliance by the Contractor.
   c. For behavioral health medical records, the tool shall include:

i. Elements that pertain to assessment,
ii. Service, and/or treatment planning, and
iii. As applicable, individual elements shall delineate which requirements pertain to:
1) The unique needs of individual lines of business,
2) Special populations including:
a) General Mental Health/Substance Use (GMH/SU),
b) Serious Mental Illness (SMI),
c) Special Health Care Needs (SHCN),
d) CHP, or
e) Individuals receiving services under DDD.

d. Medical record reviews shall be conducted according to the following schedule:
i. At a minimum of every three years for physical health charts (AMRR), and
ii. Yearly for behavioral health charts, according to methodology as specified in Contract (Behavioral Clinical Chart Audit Methodology and Findings Summary Report).

e. Use of a collaborative approach across Contractors including the use of an AHCCCS approved consultant such as AzAHP. The review process is acceptable, provided it will result in only one medical record review process for each provider. Use of a vendor (as opposed to a 'consultant) 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 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, and
ii. For AMRR Audits, a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) with current Licensure under the Arizona State Board of Nursing shall be utilized to conduct the audit.

g. Results of the record review shall be made available to all Contractors who utilize a consultant such as AzAHP, or in instances when multiple Contractors share the same provider for this process,

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

i. If quality of care issues are identified during the medical record review process, it is expected that all Contractors, which contract with that provider, be notified within 24 hours in order to conduct an independent onsite provider audit,

j. The Contractor 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
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.

2. AMRR Process
Providers to be included in the AMRR process shall include all PCPs that serve children (children defined as less than 21 years of age) and obstetricians/ gynecologists. The AMRR review process shall consist of reviewing eight charts per practitioner and include the requirements specified in Contract.

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

D. MULTI-SPECIALTY INTEGRATED CLINICS

1. The Contractor shall implement written policies and procedures to ensure that 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 HIE, for the multi-specialty treatment team and community providers,
   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.

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 the Contractor 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 professional providing the service,
   d. The member's Date of Birth (DOB) and AHCCCS identification number,
   e. Services are reflected in the member's service plan or treatment plan, as applicable. Providers shall keep a copy of each member's service plan, or treatment plan, as applicable 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.

F. DESIGNATED RECORD SET

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

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.

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.

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 Contractor.

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 hard copy, within at least 20 business days of receipt of a request.

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.

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.

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, the Contractor 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.C. 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 Policies and Contracts. The Contractor shall comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

3. The Contractor shall align the medical records retention processes with AHCCCS Contract requirements. The maintenance and access to medical records shall survive the termination of a provider's contract regardless of the cause of termination.

4. The Contractor and providers shall participate and cooperate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated (bi-directional) clinical data sharing. 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.

H. UNITED STATES CORE DATA FOR INTEROPERABILITY

United States Core Data for Interoperability (USCDI) Data Elements are incorporated as part of the DRS to facilitate the electronic exchange of an individual's medical record data as requested by the individual. Further information regarding USCDI electronic medical record data elements for providers, health plans, and other stakeholders is available at the Center for Medicare and Medicaid Services (CMS) Office of the National Coordinator's (ONCs) USCDI webpage https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi.

The requirements listed below are additional requirements under USCDI. AHCCCS strongly recommends these enhanced data elements be added to the existing Physical and Behavioral Health Medical Record requirements specified in this policy. Per the ONCs, disclosure of these additional data elements is subject to the confidentiality requirements of applicable state laws.

1. Medical record requirements are applicable to both hard copy and electronic medical records. Records may be documented on hard copy or in an electronic format and shall include the following:
   a. Documentation of identifying demographics, including:
      i. Any previous names by which the member is known,
      ii. Previous address,
      iii. Telephone number with cell or home designation, and both if applicable,
      iv. Email address,
      v. Birth sex,
      vi. Race,
      vii. Ethnicity, and
      viii. Preferred language.
   b. For records relating to provision of behavioral health services, documentation shall include, but is not limited to:
      i. Behavioral health history,
      ii. Applicable assessments,
      iii. Service plans and/or treatment plans,
      iv. Crisis and/or safety plan,
      v. Medication information if related to behavioral health diagnosis,
      vi. Medication informed consents, if applicable

vii. Progress notes, and
viii. General and/or informed consent.

c. Documentation, initialed by the provider, to signify review of diagnostic information including vital signs data at each visit, to include:
   i. Body temperature,
   ii. Diastolic and Systolic blood pressure,
   iii. Body height and weight,
   iv. BMI Percentile (two -20 years),
   v. Weight-for-length percentile (birth-36 months),
   vi. Head occipital-frontal circumference percentile (birth-36 months),
   vii. Heart rate and respiratory rate,
   viii. Pulse oximetry,
   ix. Inhaled oxygen concentration, and
   x. Unique device identifier(s) for implantable device(s), as applicable.
d. For Inpatient Settings – Clinical Note Requirements:
   i. Consultation notes,
   ii. Discharge and summary notes,
   iii. History and physical,
   iv. Imaging narrative,
   v. Laboratory report narrative,
   vi. Pathology report narrative,
   vii. Procedure notes, and
   viii. Progress notes.