940 – MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION[1]

EFFECTIVE DATES: 10/01/94, 09/01/20, 10/01/21, 11/14/22, 02/12/24, UPON PUBLISHING[2]

APPROVAL DATES: 10/01/97, 10/01/01, 08/13/03, 01/01/04, 04/01/05, 02/01/07, 10/08/08, 10/01/09, 02/01/11, 04/01/12, 03/01/14, 10/01/15, 07/01/16, 06/18/20, 04/22/21, 09/15/22, 11/09/23, 04/04/25[3]

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS ~~/~~CHP (CHP), and DES ~~/~~DDD (DDD) 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. This Policy also includes audit processes for Ambulatory Medical Record Review (AMRR) and Behavioral Health Clinical Chart Audit (BHCCA).[4]

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy.[5] ~~including:~~

~~ADULT RECOVERY TEAM (ART)~~	~~ARIZONA ASSOCIATION OF HEALTH PLANS (AzAHP)~~	~~BEHAVIORAL HEALTH PROFESSIONAL (BHP)~~
~~BEHAVIORAL HEALTH TECHNICIAN (BHT)~~	~~CHILD AND FAMILY TEAM (CFT)~~	~~DESIGNATED RECORD SET (DRS)~~
~~HEALTHCARE DECISION MAKER (HCDM)~~	~~HEALTH INFORMATION EXCHANGE (HIE)~~	~~HEALTH INFORMATION ORGANIZATION (HIO)~~
~~HEALTH RELATED SOCIAL NEEDS (HRSN)~~	~~MEDICAL RECORDS~~	~~MEMBER~~
~~MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)~~	~~PERSON-CENTERED SERVICE PLAN (PCSP)~~	~~PRIMARY CARE PROVIDER (PCP)~~
~~SOCIAL DETERMINANTS OF HEALTH (SDOH)~~	~~TELEMEDICINE~~	

[1] Policy has been reorganized for better flow.
[2] Date Policy is effective.
[3] Date Policy is approved.
[4] Adding additional key aspects of the Policy to include reference to AHCCCS audit processes.
[5] Removed table to align with Contract and Policy Dictionary.

III. POLICY

All AHCCCS registered providers are required to maintain comprehensive documentation related to care and services provided to members. The Contractor and ~~Fee-For-Service (~~FFS~~)~~[6] providers shall ensure, via regular monitoring activities, that documentation completed and maintained by the providers meets the requirements specified in this Policy and all other applicable Policies.[7]

Throughout this Policy, all references to Child and Family Team (CFT) or Adult Recovery Team (ART) pertain to Contractors and are not ~~to~~required for FFS Programs or ~~FFS~~ populations. ~~A CFT or ART is not required for FFS.~~[8] A CFT/ART is not required in order for FFS members to receive services. However, an equivalent team process through the outpatient treatment team is required for care coordination for FFS members.[9]

A. MEDICAL RECORD REQUIREMENTS

1. The records shall be kept up to date, well organized and comprehensive, with sufficient detail to demonstrate and promote effective member care and ease of quality review. Medical record requirements are applicable to paper, electronic format medical records, and telemedicine. Medical records shall be available to individuals authorized according to policies and procedures for accessing the patient's medical record and as permitted by law:~~.~~
   a. Providers shall maintain a list of persons and/or organizations who inspect member records as identified under AAC R9-21-209, and~~.~~
   b. If an organization also distributes information electronically to any member, Health Care Decision Maker (HCDM), provider or health plan, [10]it must indicate that the information is available in paper format upon request.

2. Provider records[11] ~~and~~ shall include the following:
   a. Identifying demographics, ~~including~~includes but is not limited to:
      i. The member's name,
      ii. Address,
      iii. Telephone number or,
      iv. AHCCCS identification number,
      v. Gender,
      vi. Age,
      vii. Date of Birth (DOB),
      viii. Marital status,
      ix. Next of kin, and
      x. Parent/guardian/ ~~Healthcare Decision Maker (~~HCDM~~)~~, if applicable.

[6] Acronym is already noted in the purpose statement.
[7] Added to clarify.
[8] Removed for flow and to mitigate redundant information.
[9] Added to clarify expectation for Child and Family Team (CFT)/ Adult Recovery Team (ART) service equivalent for FFS members.
[10] Revised to clarify that the requirement is applicable to information distribution to all groups listed.
[11] Revised for clarity.

b. Member identification information on the first page of the medical record including:
   i. Member name,
   ii. Member AHCCCS Identification (ID), or
   iii. Member DOB.
c. Subsequent pages of the medical record shall include member name and either AHCCCS ID or Member DOB,
d. 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).
e. Medical records documented on paper format 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 and time for each entry as specified in A.A.C. [12]R9-10-1009,
f. Documentation shall be generated at the time of service or shortly thereafter. Delayed entries within a reasonable timeframe (24-48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service[13],
g. Documentation cloning, on paper format or electronic format, is strictly prohibited. Pursuant to the Centers for Medicare and Medicaid Services sub regulatory guidance cloning is the practice involving copying and pasting previously recorded information from a prior note into a new note. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable,[14]

[12] Revised to align with section 504 of the Rehabilitation Act, changes made throughout Policy.
[13] Added for clarification of AHCCCS expectation that documentation of services is completed at the time of service or shortly thereafter. This expectation is to ensure consistency with Medicare standards, see https://www.aapc.com/blog/25667-medical-record-entries-what-is-timely-and-reasonable/#:~:text=Medicare%20Comment%20No.&text=%E2%80%9CMedicare%20expects%20the%20documentation%20to,entry%20be%20made%20in%20advance. For additional information.
[14] Added for clarification that documentation cloning is prohibited in accordance with Centers for Medicare and Medicaid Services (CMS) sub regulatory guidance. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

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e.h. If revisions to information in the medical record [15] are made to address errors, needed updates, or any other type of revision, a system shall be in place to track when, and by whom updates 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 revised or 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.

f.i. Medical records shall identify the treating or consulting provider. A member may have more than one medical record kept by various physical and/or behavioral health care providers that have rendered services to the member., The treating provider signature shall occur as close to the actual entry of treatment notes as possible and treatment notes must be based on either professional standards of care and/or requirements specified with AAC Title 9, Chapter 10, Treating provider shall sign their 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.[16]

g.j. Evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) data base database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances,

h.k. Documentation of coordination of care activities including, but not limited to:

i. Referrals to other providers [17] and evidence of the use of the Referring, Ordering, Prescribing, and Attending (ROPA) Provider List, as applicable,
ii. 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,
iii. Reports from referrals, consultations, and specialists for behavioral and/or physical health, as applicable,
iv. Emergency/urgent care reports,
v. Hospital discharge summaries,
v.vi. Care coordination activities with Contractors, TRBHAs, Tribal ALTCS and other involved agencies (e.g. DCS, Tribal Social Services, DES DDD), [18]
vi.vii. Transfer of care to other providers, and
vii.viii. Any notification when a member's health status changes or new medications are prescribed.

[15] Added for clarity to address errors in the actual medical records.
[16] Revised language for flow and clarity.
[17] Added to integrate Referring, Ordering, Prescribing, and Attending (ROPA) into clinical documentation requirements.
[18] Added to clarify requirements for documenting care coordination activities.

i.l. When telemedicine is conducted, the medical [19] records shall clearly identify that the visit is a telemedicine visit including what type of telemedicine visit was conducted (e.g. audio only or audio/visual).[20]

j.m. 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.

3. Physical Health Medical Record Requirements:
   a. Any provider delivering primary care services to a member and acting as their Primary Care Provider (PCP) shall maintain a comprehensive medical 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. Documentation of any requests for forwarding of behavioral health and/or other medical record information. This shall include documentation to verify that request for records was completed,
      iii. Behavioral health history and information received from an AHCCCS Contractor, TRBHA, or other provider involved with the member's behavioral health care, even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record if information is received prior to the first appointment[21], 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. Medical records shall be established within a reasonable timeframe (i.e. 24 to 48 hours from the time of service),[22]

[19] Adding clarity that the medical records shall clearly identify changes made throughout policy.
[20] Added for clarification on documenting the type of telemedicine used.
[21] Added to clarify that this section is accounting for documentation received prior to the first appointment and prior to the development of the record.
[22] Adding to provide clarification that timely documentation standards are applicable to the medical records and including the timeframe as specified in AMPM 320-O.

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iv. 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.

v. Evidence that PCPs are utilizing and retaining developmental screening tools and conducting developmental and Autism Spectrum Disorder (ASD) screenings at required ages, as identified in AMPM Policy 430,

vi. Current and complete Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Sample Templates (or an equivalent including, at minimum, all data elements on the EPSDT Clinical Sample Template) are required for all members aged zero through 20 years. Refer to AMPM Policy 430, Attachment E,

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

viii. Documentation to reflect maternity care providers screen all pregnant members once a trimester through use of the CSPMP database.

4. Behavioral Health Medical Record Requirements[23]

~~a.~~ Any behavioral health provider delivering Health Home services or acting as a Primary Behavioral Health Provider shall maintain a comprehensive record that incorporates at least the following components~~The following elements shall be included in all behavioral health medical records~~:

a.

~~i. Initial behavioral health evaluation that~~ Comprehensive Assessment. The comprehensive assessment shall be completed as specified in AMPM Policy 320-O, ~~includes:~~

i.

~~i.~~ Documentation of all information collected in the behavioral health assessment and any applicable addenda and required demographic information,

ii.

iii. A current Service plan. The Service plan shall be complete and include all required components as specified in AMPM Policy 320-O,

iv. Current Safety Plan as specified in AMPM Policy 320-O,

~~ii.~~v. Progress reports, service plans, or treatment plans[24] from Specialty Behavioral Health (or other) Providers (as applicable). Refer to AMPM Policy 320-0 for required elements of a Treatment Plan~~.~~,

vi. Documentation of any requests for forwarding of behavioral health and/or other medical record information. This shall include documentation to verify that request for records was completed,

[23] Section below revised for clarity and flow.

[24] Treatment Plan differentiated from Service Plan and differing expectations outlined.

vii. The CFT documentation or FFS outpatient treatment team documentation, based on member's age (zero to 18 or up to 21 should member choose to continue with CFT team after turning 18), [25]
viii. The ART or FFS outpatient treatment team ~~documentation~~ documentation for adults aged 18 and older,
~~iii.~~ix. Supplemental CFT, ~~or~~ ART, or FFS outpatient treatment team documentation and updates,
~~iv.~~x. Additional assessment or screening documentation that provides further evidence to ensure member's needs are being identified through either standardized assessment or screening tools (e.g., Protocol for Responding to and Assessment Patients' Assets, Risks & Experiences [PRAPARE], Patient Health Questionnaire [PHQ], Generalized Anxiety Disorder [GAD], Adverse Childhood Experiences [ACES], Child and Adolescent Level of Care Utilization System (CALOCUS), American Society Of Addiction Medicine Criteria (ASAM), etc.),
~~v.~~xi. Diagnostic information including historical and current[26] psychiatric, psychological, and physical health evaluations as applicable,
xii. Additional service plans or treatment plans from other entities involved with the member. These may include, but are not limited to:
    1) Person Centered Service Plans (PCSP)s (e.g., from DES DDD or ALTCS EPD),
    2) Individual Education Plan (IEP) from Arizona Department of Education,
    3) Service plans from Arizona Department of Corrections (ADOC), or Arizona Department of Juvenile Corrections (ADJC), and
    4) Specialty provider treatment plans (e.g., counseling, ABA, Peer Support or day treatment programs, etc.).
xiii. Progress notes. All progress notes and documentation shall include:
    1) Documentation of the type of services provided,
    2) The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis identified in a current assessment,
    3) The date the service was delivered,
    4) The date and time the progress note was signed,
    5) The signature of the staff that provided the service, including the staff member's credentials,
    6) Duration of the service (time increments),
    7) A description of what occurred during the provision of the service related to the member's service plan or treatment plan,
    8) Documentation of the members progress toward objectives,[27]
    9) The member's response to service,
    10) 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, and

[25] Added to broaden requirement applicability to FFS.
[26] Guidance added encouraging the collection of historical mental health experiences of members to build comprehensive understanding of current circumstances and guide treatment planning.
[27] Added to correlate services and treatment with assessed need and benefit of services with needs.

11) 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,
12) Each service provided must have a distinct, corresponding progress note; or if only one progress note is submitted for multiple billable services, each code must have its own separate identifiable description and criteria documented within the progress note to support each code billed.

i. Documentation of the member's choice for receipt of the member handbook (either paper format or electronic format),

xiv.

ii. Receipt of notice of privacy practice,

xv.

xvi. Contact information for the member's PCP,

xvii. 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 their income, and at least annually,.

xviii. Documentation to reflect appropriate follow-up for duty to report, as required under ARS 13-3620 and AMPM Policy 961,

xix. An English version of all documents if the documents are completed in any language other than English,

xx. Documentation (as applicable) for the processing of an appeal shall be documented in the medical record; including the Notice of Extension (NOE) received from the Contractor that was sent to the member and their legal guardian or authorized representative,

xxi. Court Ordered Treatment Orders and related documents, and[28]

xxii. Guardianship, Guardianship with Powers, and/or Health Care Decision Maker (HCDM) orders as applicable to the services provided.[29]

Contact information for the member's PCP, and

Behavioral health assessment documentation that includes:

Documentation to reflect appropriate follow-up for duty to report, as required under A.R.S. § 13-3620 and AMPM Policy 961,[30]

Copies of documentation related to the need for special assistance, if applicable. Refer to AMPM Policy 320-R, and

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.

ii. Service plan documentation that includes:

iii. The member's service plan, or treatment plan as applicable,

CFT documentation, based on member's age (zero to 18 or up to 21 should member choose to continue with CFT team after turning 18),

[28] Section reorganized for flow and revised to align with AMPM Policy 320-O.
[29] Court orders that also have the potential to direct service/treatment decisions.
[30] Moved above for flow.

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~~General clinical information that may include:~~
~~Supplemental CFT or ART documentation and updates, and~~
~~Additional service plans from other entities involved with the member. This may include, but is not limited to:~~
~~Service or treatment plans from other providers,~~
~~Person Centered Service Plans (PCSP)s (e.g., from DES /DDD or ALTCS/EPD),~~
~~Individual Education Plan (IEP) from Arizona Department of Education,~~
~~Service plans from Arizona Department of Corrections (ADOC), or Arizona Department of Juvenile Corrections (ADJC), and~~
~~Progress note documentation that includes:~~
~~Documentation of the type of services provided,~~
~~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,~~
~~The date the service was delivered,~~
~~The date and time the progress note was signed,~~
~~The signature of the staff that provided the service, including the staff member's credentials,~~
~~Duration of the service (time increments),~~
~~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,~~
~~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, and~~
~~The member's response to service.~~
~~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, and~~
~~Progress reports, service plans, or treatment plans from all other service providers, as applicable.~~[31]

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

1. The Contractor and FFS Providers[32] shall implement and maintain policies and procedures that address internal protection of oral, written, and electronic information across the organization.

[31] Section not deleted, moved above during reorganization of this section.
[32] Added to broaden applicability of health information management requirement to FFS providers.

The Contractors shall[33] 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 format via:

a. On-site 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 with other treating providers, TRBHAs[34], State agencies and entities involved in member care and service delivery,
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 paper format and electronic medical records.

2. The Contractor and FFS Providers [35]shall have policies and procedures in place for use of electronic medical records (physical and behavioral health) and for Health Information Exchange (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 and FFS Providers[36] 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 and FFS Providers 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.

[33] Added to specify as a Contractor requirement.
[34] Added to clarify that the Tribal Regional Behavioral Health Authority (TRBHA) coordination must be documented in the record.
[35] Clarity that this is applicable to FFS programs/AHCCCS providers.
[36] Added applicability to FFS providers.

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4. The Contractor and FFS Providers[37] shall have written policies and procedures addressing appropriate and confidential exchange of member information among providers (refer to AMPM Policy 320-Q for requirements related to 42 CFR, Part 2), including behavioral health providers., andContractors 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 treating behavioral health provider that is maintaining primary responsibility for coordinating the member's care. The member's medical records or copies of medical records shall be forwarded to the new PCP or treating behavioral health provider(s) or entity(ies) involved in the member's care, within 10 business days,
      ii. From receipt of the request for transfer of the medical records, and
      iii. 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 REVIEWS

For purposes of this Policy, and as specified in Contract, the medical record audit review process will include the Ambulatory Medical Record Review (AMRR) and the Behavioral Health Clinical Chart Audit (BHCCA)[38]. The Contractor may utilize Arizona Association of Health Plans (AzAHP) to conduct the AMRR and BHCCAmedical record review and other provider documentation review processes.[39] 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. Providers that may be audited include those physicians that serve as the primary care provider. They This may include, but are is not limited to:
      i. Pediatricians,
      ii. Internists, and

[37] Broadened to include FFS provider requirement for appropriate/confidential exchange of member information
[38] Both the Ambulatory Medical Record Review (AMRR) and Behavioral Health Clinical Chart Audit (BHCCA) are now identified in the purpose statement and not needed here.
[39] Revised for clarification.

~~ii.~~ Obstetricians/Gynecologists (OB/GYNs).
iii.

c. Physical health records shall include, but are not limited to:
   i. The EPSDT,
   ii. Family planning, and
   iii. Maternity components not otherwise monitored for provider compliance by the Contractor.
d. For behavioral health medical records, in addition to what is identified within A~~.~~A~~.~~C~~.~~ R9-10-10 and R9-21, the BHCCA tool shall include:
   i. Evidence of coordination and collaboration with other providers or community stakeholder agencies,
   ii. Evidence of assisting the member with identification of Social Determinants of Health (SDOH) or Health Related Social Needs (HRSN),
   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 Emotional Disturbance (SED),
         c) Serious Mental Illness (SMI),
         d) Special Health Care Needs (SHCN),
         e) The CHP, or
         f) Individuals receiving services under DDD.
e. 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 b~~Behavioral [40]health charts, according to methodology as specified in Contract. [41]
f. 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 and is prohibited,
g. The Medical ~~(AMRR or BHCCA) R~~record reviews for both the AMRR and the BHCCA shall be conducted utilizing staff ~~with~~ who have the appropriate licensure and~~/or~~ experience ~~necessary for completion of either clinical charts for behavioral health services or physical health services~~:
   i. 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, and
   ii. For the ~~Behavioral Health Clinical Chart Audits~~ BHCCA, 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 to conduct the audit.

[40] Cadance of the Behavioral Health Clinical Chart Audit (BHCCA) will be reviewed and updated in contracted as needed.
[41] Moved below as a stand-alone requirement.

h. Deficiencies identified shall be shared with all ~~health plans~~Contractors 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~~,~~ shall be notified within 24 hours in order to conduct an independent on-site provider audit,

j. The Contractor may request approval to discontinue conducting the AMRR and/or ~~behavioral health medical record reviews~~BHCCA. 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 m~~M~~edical ~~R~~record review requirements to the AHCCCS/QM, Clinical Quality Management Administrator prior to discontinuing the ~~M~~medical r~~R~~ecord review process.

2. Ambulatory Medical Record Review (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 Clinical Chat Audit (BHCCA)~~Review Process~~: Providers to be included in the ~~behavioral health medical record review~~BHCCA process shall include Behavioral Health Outpatient Clinics, Integrated Care (I/C) facilities, Health Homes and Primary Behavioral Health Providers acting as a Health Home for members [42]~~(Refer to AMPM Policy 610, Attachment A)~~ and other provider types as specified by AHCCCS. The ~~M~~medical record ~~R~~review process for behavioral health records shall be followed as specified in Contract.~~,~~

~~4.~~3.

~~5.~~ 4. Behavioral Clinical Chart Audit Methodology and Behavioral Health Clinical Chart Audit Findings and Summary Report shall be submitted to AHCCCS as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables~~)~~.[43]

   a. Health Plans shall utilize a reporting template, developed and approved by AHCCCS. The reporting template is available as part of the Behavioral Health Clinical Chart Audit Instruction Guide (refer to the AHCCCS Integrated System of Care webpage). [44]

D. MULTI-SPECIALTY INTEGRATED CLINICS

1. The Contractor shall implement written policies and procedures to ensure that Multi-Specialty Interdisciplinary Clinics (MSICs) have an integrated electronic medical record for each member that is served through the MSIC.

[42] Revised to align with new definitions and language in AMPM Policy 320-O.
[43] Moved from above.
[44] Revised for clarity and flow.

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 and FFS providers [45] 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 DOB and AHCCCS identification number,
   e. Evidence that Sservices are reflected in the member's service plan, and treatment plan. Providers shall keep a copy of each member's service plan, or and treatment plan, as applicable in the member's medical record, and
   f. A Mmonthly summary of service documentation progress toward treatment goals. A summary of the information required in this section shall be transmitted from the Pprovider to the member's clinical team for inclusion in the medical record.

[45] Revised to clarify requirement is applicable to FFS providers.

F. AHCCCS-REGISTERED PROVIDERS

AHCCCS conducts a variety of site visits and on-site or virtual audits according to PPA and contract[46] f~~F~~or providers serving AHCCCS members, including all ~~those~~ providers operating under AHCCCS-contracted MCOs~~,~~ and FFS Programs (e.g., AIHP, DDD THP, Tribal ALTCS, TRBHA, and all FFS populations).~~,~~ AHCCCS reserves the right to conduct on-site or virtual audits for quality-of-care purposes, either directly or via a Managed Care Organization (MCO). On-site audits will be conducted on any related documentation or safety related concerns for the members.

1. AHCCCS, FFS[47]~~Division for Fee-For-Service Management (DFSM)~~, and/or MCO audit teams will internally identify documentation to be audited, and a list of specified items will be given to the provider at the commencement of the on-site visit.

2. ~~Audits may occur on-site and~~ [48]AHCCCS reserves the right to speak with AHCCCS members and request ~~clinical chart~~medical record information (i.e., physical health or behavioral health).

3. When AHCCCS, ~~/DFSM~~ FFS, or MCO audit teams are conducting an on-site audit for purposes of ensuring that member needs are being met, or in~~as well as~~ the interest of the AHCCCS, FFS ~~/DFSM~~ , and/or MCO ~~audit teams the~~ providers may not deny access to the facility.

4. Providers shall supply the complete documentation as requested by AHCCCS, FFS~~/DFSM~~ or MCO Audit Team, within one business day. Documentation shall be delivered as a paper copy and/or secure electronic transfer ~~of the documents~~.[49]

Independent of AHCCCS audits, TRBHAs and Tribal ALTCS programs reserve the right to conduct visits where TRBHA or Tribal ALTCS members are receiving services, including requesting ~~clinical chart~~ medical record information, performing status checks (including member interaction) and conducting ongoing monitoring for purposes of ensuring the needs of the TRBHA's and Tribal ALTCS's members are being met. Providers may not deny facility or member access to the TRBHA or the Tribal ALTCS programs.

AHCCCS~~-~~, FFS~~/DFSM~~, MCO audit teams, TRBHAs, and Tribal ALTCS reserve the right to notify law enforcement if providers deny entry in cases of suspected member health and safety issues.

G. 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

[46] Revised for clarity.
[47] Revised for alignment throughout the section.
[48] Removed redundant already stated above.
[49] Removed redundant already stated.

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,
   d. A provider shall make records available to the member when requested, as required under 45 CFR 164.524 and A.A.C. R9-10-1009, as appropriate.

3. Electronic Information to members shall be available upon request as specified in Contract.

4. 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.

5. Written approval from the member is **not** required 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 as specified in A.R.S. § 36-509, or
   c. Sharing medical records with the member's Contractor.

6. Release of Information shall be required from the member when records are subject to Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2).

7. 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.

8. AHCCCS shall have access to all medical records, whether electronic or paper format, within at least 20 business days of receipt of a request.

9. 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.

10. 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.

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

12. 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.

H. LEGAL REQUIREMENTS FOR RECORDS MAINTENANCE

Consistent with 9 A.A.C. 22, Article 5, the Contractor and providers, including non-contracted FFS 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 Ffederal or Sstate laws, and AHCCCS Policies and Contracts. The Contractor and FFS Providers 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 its contracted 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 [50]FFS 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.

I. 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. The most current 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.

[50] Clarified applicability to FFS providers

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. The Medical record requirements are applicable to both paper format and electronic medical records. Records may be documented on paper format 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. Body Mass Index (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,

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vii. Procedure notes, and
viii. Progress notes.