940 – MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

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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 the 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).

II. DEFINITIONS

Refer to the AHCCCS ~~Contract and Policy~~ ACOM and AMPM Dictionary[1] for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

~~**HEALTH HOME**~~	~~A provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health and services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center (FQHC) or an Integrated Care Provider. Members may or may not be formally assigned to a health home.~~[2]
PRIMARY BEHAVIORAL HEALTH PROVIDER	An AHCCCS registered behavioral health provider that provides and/or coordinates and monitors the provision of all behavioral health services and supports to treat the whole person but is not identified as a Health Home by AHCCCS or the AHCCCS contracted health plan. A primary behavioral health provider may be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center (FQHC) or an Integrated Care Provider.

[1] Revised due to title change.
[2] Removed as it can be found in the ACOM and AMPM Dictionary, throughout the section.

SPECIALTY BEHAVIORAL HEALTH PROVIDER	A behavioral health provider who is not serving as a member's Health Home, that provides behavioral health services in a specific treatment area within their scope of practice and in accordance with a current assessment and treatment plan.
~~**TREATMENT PLAN**~~	~~A written plan of specific physical and/or behavioral health services that a provider anticipates providing to a member.~~

III. POLICY

All AHCCCS registered providers are required to maintain comprehensive documentation related to care and services provided to members. The Contractor and ~~FFS~~ providers serving FFS members[3] 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.

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

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. The medical record requirements are applicable to paper, electronic format medical records, and telemedicine. The 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. The providers shall maintain a list of persons and/or organizations who inspect the 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), Designated Representative (DR)[4], provider or health plan, it must indicate that the information is available in paper format upon request.

2. The provider records shall include the following:
   a. Identifying demographics, 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),

[3] Updated language as all AHCCCS providers are FFS providers.
[4] Adding Designated Representative as they also receive information electronically and the requirement applies equally to them.

viii. Marital status,
ix. Next of kin, and
x. Parent/guardian/HCDM, DR if applicable.

b. The member identification information on the first page of the medical record including:
i. Member name, and
ii. Member AHCCCS Identification (ID), or
iii. Member DOB.

c. The subsequent pages of the medical record shall include member's name and either AHCCCS ID or member's DOB,

d. The 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 and adolescents under the age of 19[5], recommended for adult members if available).

e. The 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,

~~e.~~f. The electronic format medical records shall also include the name and credentials[6] of the provider who made the entry and the date and time for each entry ~~as specified in AAC R9-10-1009~~. Electronic signatures must meet the requirements in ARS 44-7031. The electronic signature must be unique to the individual using it. Manually typed or word-processed names are insufficient to meet the requirements of an electronic signature[7],

g. The 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,

h. Documentation cloning, on paper format or electronic format, is strictly prohibited. Pursuant to the Centers for Medicare and Medicaid Services (CMS) sub regulatory guidance CMS Fact Sheet 121115[8], 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,

[5] Revised to clarify specific age range requirement due to the legal requirements for submitting records in ASIIS (immunization information system) that apply to children but not adults.
[6] Adding clarification.
[7] Revised to align with ARS 44-7031 and remove reference to AAC R9-10-1009.
[8] Adding reference to the CMS.gov website related to the CMS Fact Sheet 121115.

~~f.~~i. If revisions to information in the medical record 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.

~~g.~~i. The medical records shall identify the treating or consulting provider including the provider's name and credentials[9]. 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's signature shall occur as close to the actual entry of the treatment notes as possible. ~~and~~ Ttreatment notes must be based on ~~either~~ professional standards of care and/or requirements specified with AAC Title 9, Chapter 10,

~~h.~~k. The evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances,

~~i.~~l. The documentation of coordination of care activities including, but not limited to:
   i. Referrals to other providers 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,
   vi. Care coordination activities with Contractors, TRBHAs, Tribal ALTCS and other involved agencies (e.g. DCS, Tribal Social Services, ~~DES~~ DDD),
   vii. Transfer of care to other providers, and
   viii. Any notification when a member's health status changes or new medications are prescribed.

m. When telemedicine is conducted, the medical record 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),

~~j.~~n. Legal documentation that includes:
   i. The documentation related to requests for release of information and subsequent releases,
   ii. The documentation of a Health Care Power of Attorney or documentation authorizing a HCDM,
   iii. The copies of any Advance Directives or Mental Health Care Power of Attorney:

[9] Adding clarifying language to include provider's name and credentials in the medical records.

1) The documentation that the adult member was provided with information on Advance Directives and whether an advance directive ~~as~~ has been executed (as specified in AMPM Policy 640),
2) The documentation of general and informed consent to treatment, as specified in AMPM Policy 320-Q, and
3) The authorization to disclose information.

o. Medication Administration Record (MAR) documentation to include:
i. Medication name, strength, dosage, and route of administration,
ii. Date and exact time of administration,
iii. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication,
iv. Documentation of refusals, omissions, or errors, when applicable,
v. For a medication administered for pain:
1) An assessment of the patient's pain before administering the medication, and
2) The effect of the medication administered.
vi. For a psychotropic medication:
1) An assessment of the patient's behavior before administering the psychotropic medication, and
2) The effect of the psychotropic medication administered.
vii. Documentation of adverse reactions and actions taken, when applicable.[10]

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
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:
a. The initial history and comprehensive physical examination findings for the member that include 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),
b. The 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,
c. The 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~~,~~ 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),

[10] This clarification is included to promote consistency in medical record documentation and to ensure clear expectations for Medication Administration Record (MAR) documentation when medication administration is applicable.

d. The documentation, initialed by the provider, to signify review of diagnostic information including:
   i. Laboratory tests and screenings,
   ii. Radiology reports,
   iii. Physical examination notes,
   iv. Medications,
   v. Last provider visit,
   vi. Recent hospitalizations, and
   vii. Other pertinent data.
e. The evidence that the 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,
f. The 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,
g. The evidence that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members. Refer to AMPM Policy 410, and
h. The 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
   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:
   a. A Comprehensive Assessment. The comprehensive assessment shall be completed as specified in AMPM Policy 320-O,
   b. The documentation of all information collected in the behavioral health assessment and any applicable addenda and required demographic information,
   c. A current Service ~~p~~Plan. The Service ~~p~~Plan shall be complete and include all required components as specified in AMPM Policy 320-O,
   d. A current Safety Plan, included in the Service Plan,[11] as specified in AMPM Policy 320-O,
   e. The progress reports, ~~service~~ Service ~~p~~Plans, or ~~t~~Treatment ~~p~~Plans from Specialty Behavioral Health (or other) Providers (as applicable). Refer to AMPM Policy 320-~~0~~O for required elements of a Treatment Plan,
   f. The 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,
   g. 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),
   h. The ART or FFS outpatient treatment team documentation for adults aged 18 and older,
   i. The Supplemental CFT, ART, or FFS outpatient treatment team documentation and updates,

[11] Revised to align with AMPM Policy 320-O.

~~i.~~j. 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.]~~),~~ ,

~~j.~~k. The diagnostic information including historical and current psychiatric, psychological, and physical health evaluations as applicable,

~~k.~~l. Additional S~~s~~ervice P~~p~~lans or T~~t~~reatment P~~p~~lans from other entities involved with the member. These may include, but are not limited to:

i. The Person-Centered Service Plans (PCSP)~~s~~ (e.g., from ~~DES~~ [12]DDD or ALTCS E/PD),
ii. The Individual Education Plan (IEP) from Arizona Department of Education,
iii. The Service P~~p~~lans from Arizona Department of Corrections (ADOC), or Arizona Department of Juvenile Corrections (ADJC), and
iv. Specialty provider ~~treatment~~ Treatment P~~p~~lans (e.g., counseling, ABA, Peer Support or day treatment programs, etc.).

m. ~~The progress notes. All progress notes and documentation shall include:~~

~~l.~~ All treatment entries, including progress notes and other documentation supporting services rendered, shall include:[13]

i. The documentation of the type of services provided ,
~~i.~~ii. Whether the service is performed as individual, family, or in a group setting,[14]
iii. The diagnosis, including an indicator that clearly identifies whether the ~~progress note~~service is intended to treat ~~is for~~ a [15]new diagnosis, or the continuation of a previous diagnosis identified in a current assessment,
~~ii.~~iv. The duration of the service as indicated by service start and stop time,[16]
~~iii.~~v. The date the service was delivered,
vi. The date and time the progress note was signed,
~~iv.~~vii. ~~The signature of the staff that provided the service, including the staff member's credentials,~~ The signature or authenticated electronic signature of the rendering staff member and identification of the staff member's professional designation,~~.~~ credentials must be included on the document or be identifiable within the medical record to allow verification of the staff member's scope of practice,[17]
~~v. The duration of the service (time increments),~~
~~vi.~~viii. A detailed description of what occurred during the provision of the service including one or more treatment methods used and treatment goals addressed, as they relate~~related~~ to the member's S~~s~~ervice P~~p~~lan or T~~t~~reatment P~~p~~lan,[18]

[12] Removed not needed.
[13] Revised to align with Centers for Medicare and Medicaid Services (CMS) documentation standards across behavioral and physical health services.
[14] Added to align with AAC R9 -10-1011.
[15] Revised as section applicability has expanded beyond progress notes.
[16] Moved from below for continuity.
[17] Revised to align with Centers for Medicare and Medicaid Services (CMS) documentation standards across behavioral and physical health services.
[18] Added to clarify expected details required.

~~vii.~~ix. The documentation of the member's progress toward objectives,
~~viii.~~x. The member's individualized[19] response to service,
~~ix.~~xi. 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, dated and time[20] stamped,
~~x.~~xii. 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
~~xi.~~xiii. 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.

~~m.~~n. The documentation of the member's choice for receipt of the member handbook (either paper format or electronic format),
~~n.~~o. The receipt of notice of privacy practice,
~~o.~~p. The contact information for the member's PCP,
~~p.~~q. The 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,
~~q.~~r. The documentation to reflect appropriate follow-up for duty to report, as required under ARS 13-3620 and AMPM Policy 961,
~~r.~~s. An English version of all documents if the documents are completed in any language other than English,
~~s.~~t. The 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,
~~t.~~u. The Court Ordered Treatment Orders and related documents, and
~~u.~~v. The Guardianship, Guardianship with Powers, and/or ~~Health Care Decision Maker (~~HCDM~~)~~ orders as applicable to the services provided.

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

1. The Contractor and providers serving FFS members~~Providers~~ shall implement and maintain policies and procedures that address internal protection of oral, written, and electronic information across the organization.
   The Contractor shall 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:

[19] Clarified to reinforce that cloning documentation is prohibited and response to services shall be individualized and align with the member's vision and goal for recovery.
[20] Added for descriptive clarity.

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, 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. The medical record requirements for paper format and electronic medical records.

2. The Contractor and providers serving FFS members~~Providers~~ 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. The 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 providers serving FFS members~~Providers~~ 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 as required under ~~[~~45 CFR Part 160 and 164, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi)~~]~~, AAC 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 providers serving FFS members~~Providers~~ shall implement a process to ensure that unauthorized individuals cannot gain access to, or alter member records, and
   c. The medical records are maintained in a secure manner that maintains the integrity, accuracy, and confidentiality of member medical information.

4. The Contractor and providers serving FFS members~~Providers~~ 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. The Contractors 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. The providers request information from other treating providers as necessary to provide appropriate and timely care, and
d. The information about services provided to a member by a non-network provider (e.g., emergency services) is transmitted to the member's provider:
   i. The 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 from the receipt of the request for transfer of the medical records, and
   ~~ii. From receipt of the request for transfer of the medical records, and~~
   ~~iii.~~ii. The 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 review process will include the AMRR and the BHCCA. The Contractor may utilize Arizona Association of Health Plans (AzAHP) to conduct the AMRR and BHCCA. The 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. The medical record reviews shall be conducted using a standardized tool that has been approved by AHCCCS,
   b. The providers that may be audited include those physicians that serve as the primary care provider. This may include, but is not limited to:
      i. Pediatricians,
      ii. Internists, and
      iii. Obstetricians/Gynecologists (OB/GYNs).
   c. The physical health records shall include, but are not limited to:
      i. ~~The~~ Documentation of EPSDT services, as applicable for members under age 21,[21]
      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 AAC ~~R~~Title 9, Chapters 10~~-10~~ and ~~R9-~~21, the BHCCA tool shall include:
      i. The evidence of coordination and collaboration with other providers or community stakeholder agencies,

[21] Revised to clarify documentation requirements.

ii. The evidence of assisting the member with identification of Social Determinants of Health (SDOH) or Health Related Social Needs (HRSN), 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 Emotional Disturbance (SED),
c) Serious Mental Illness (SMI),
d) Special Health Care Needs (SHCN),
e) ~~The CHP, or~~ Children receiving services under DCS CHP, or
f) ~~In~~Members~~dividuals~~ receiving services under DDD.[22]

e. The medical record reviews shall be conducted ~~according to the following schedule. A~~at [23]a minimum of every three years for physical health charts (AMRR),
f. The use of a collaborative approach across Contractors, including the use of an AHCCCS approved consultant such as AzAHP, is acceptable provided it will result in only one medical record review process for each provider[24]~~The 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 record reviews for both the AMRR and the BHCCA shall be conducted utilizing staff who have the appropriate licensure and experience:
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 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.
h. The deficiencies identified shall be shared with all Contractors contracted with the provider,
i. If ~~q~~Quality ~~o~~Of ~~c~~Care (QOC) issues are identified during the medical record review process, ~~it is~~ all Contractors ~~which~~ contracted with that provider shall be notified within 24 hours of identification of the QOC [25]in order to conduct an independent on-site provider audit, and
j. The Contractor may request approval from AHCCCS [26]to discontinue conducting the AMRR and/or 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

[22] Revised to align with Policy standard language.
[23] Revised to correct grammar.
[24] Revised to correct grammar.
[25] Revised for clarification of timeframe.
[26] Revised for clarification.

iii. Submit the process the Contractor will utilize to ensure provider compliance with AHCCCS medical record review requirements to the AHCCCS/QM, Clinical Quality Management Administrator prior to discontinuing the medical record review process.

2. The Ambulatory Medical Record Review (AMRR) Process: The providers to be included in the AMRR process shall include all PCPs that serve adults[27], children (children defined as less than 21 years of age), and obstetricians/gynecologists. The AMRR review process shall consist of reviewing charts based on the number of practitioners within the group[28] practice as outlined in Ccontract and include the requirements specified in Contract.

3. The Behavioral Health ~~Record~~ [29]Clinical Chart Audit (BHCCA) Process:

The providers to be included in the BHCCA process shall include ~~(~~Behavioral Health Outpatient Clinic's ~~)~~ and ~~(~~Integrated Clinic~~)~~'s who are designated as Health Homes or serve as Primary Behavioral Health Providers in the capacity of a Health Home. The medical record review process for behavioral health records shall be followed as specified in Contract:

a. Contractors and/or AHCCCS auditors shall utilize the Instruction Guide as the primary operational standard for conducting BHCCA reviews,
b. The Instruction Guide establishes the governing operational requirements for:
   i. Sampling Methodology,
   ii. Reviewer qualifications,
   iii. Inter-rater reliability standards,
   iv. Scoring criteria,
   v. Required reporting templates, and
   vi. Contractor submission requirements.
c. The Behavioral Health Clinical Chart Audit Findings and Summary Report shall be conducted, as specified in the AHCCCS Contract Section F, Attachment F3, Contractor Chart of Deliverables.[30]

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.

2. The integrated electronic medical record shall:
   a. Be available, electronically through HIE, for the multi-specialty treatment team and community providers,

[27] Updated Ambulatory Medical Record Review (AMRR) process to clarify that this process includes adult record reviews
[28] Updated to include *group* in front of practice to add clarity and to align with language in AHCCCS Contract.
[29] Revised to align with current process and term.
[30] Added to update the Behavioral Health Record Clinical Chart Audit (BHCCA) Process to align with Contract.

b. Contain all information necessary to facilitate the coordination and ~~quality of care~~ QOC delivered by multiple providers in multiple locations for care coordination purposes at varying times~~. For care coordination purposes~~, [31]and
c. The 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 providers serving FFS members~~providers~~ 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. The 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. The evidence that services are reflected in the member's S~~s~~ervice P~~p~~lan and T~~t~~reatment P~~p~~lan. Providers shall keep a copy of each member's S~~s~~ervice P~~p~~lan and T~~t~~reatment P~~p~~lan, as applicable in the member's medical record, and
   f. A 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 medical record.

F. AHCCCS-REGISTERED PROVIDERS

~~AHCCCS conducts a variety of site visits and on-site or virtual audits according to PPA and contract for providers serving AHCCCS members, including all providers operating under AHCCCS contracted MCOs and FFS Programs (e.g., AIHP, DDD THP, Tribal ALTCS, TRBHA, and all FFS populations).~~

[31] Reworded for better flow and clarity of intent.

AHCCCS may conduct provider site visits, which may or may not be scheduled in advance. Site visits may be conducted by AHCCCS in person or virtually. Providers shall allow AHCCCS to conduct a site visit once AHCCCS staff arrives on site. If the site visit is conducted virtually, providers shall join the scheduled meeting and use a camera to allow AHCCCS to view the site. AHCCCS has the discretion to conduct announced and unannounced site visits on any provider or prospective provider. [32]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, 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. AHCCCS reserves the right to speak with AHCCCS members and request medical record information (i.e., physical health or behavioral health).

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

~~3.~~4. The providers shall supply the complete documentation as requested by AHCCCS, FFS or MCO Audit Team, within one business day of the request. [33]The documentation shall be delivered as a paper copy and/or secure electronic transfer. For documentation requests determined to be urgent by the AHCCCS, FFS or MCO Audit Team due to health and safety concerns for a member, documentation shall be provided within ~~-~~two hours of the request.[34]

Independent of AHCCCS audits, ~~The~~ TRBHAs and ~~The~~ Tribal ALTCS programs reserve the right to conduct visits at locations where TRBHA or Tribal ALTCS members are receiving services.~~,~~ These visits may include,~~ing~~ but are not limited to, requests~~ing~~ for medical records ~~information~~, ~~performing~~ status checks (including direct member interaction) and ~~conducting~~ ongoing monitoring to ~~for purposes of~~ ensure~~ing~~ that ~~e needs of the TRBHA's and Tribal ALTCS's~~ members needs are being appropriately met. ~~The p~~Providers may not deny TRBHA or Tribal ALTCS representatives' access to the facility or prohibit representatives from speaking with members ~~access to the TRBHA or the Tribal ALTCS programs~~.[35]

AHCCCS, FFS, MCO ~~audit~~ Audit T~~t~~eams, TRBHAs, and Tribal ALTCS reserve the right to notify law enforcement if providers deny entry in cases of suspected member health and safety issues.

[32] Revised to align with AMPM 610.
[33] Revised for clarification.
[34] Adding urgent request timeline for health and safety concerns.
[35] Revised to be clear that providers cannot deny access to TRBHA and Tribal ALTCS representatives and must be given access to the facility and members.

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. The medical and billing records maintained by a provider,
   b. The 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, and
   d. A provider shall make records available to the member when requested, as required under 45 CFR 164.524 and AAC 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. A 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 ARS 36-509, or
   c. Sharing medical records with the member's Contractor.

6. A 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. The medical records or copies of the 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. The~~r~~ information related to fraud, waste, and/or abuse against any ~~the~~ AHCCCS program may be released to authorized officials in compliance with federal and state statutes and rules.

10. Documentation included in the DRS shall provide~~The~~ evidence of the provider's compliance with professional and community standards and with accepted and recognized evidence-based practice guidelines.[36]

    Refer to AMPM ~~Chapter 500~~Policy 520 [37]for a discussion of member medical records regarding member transitions between Contractors and facilities.

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. The ~~require~~required documentation in the medical record must demonstrate~~showing~~ supervision by a licensed professional, who is authorized by the licensing authority to provide supervision, whenever health care assistants or paraprofessionals provide services.

H. LEGAL REQUIREMENTS FOR RECORDS MAINTENANCE

Consistent ~~with AAC~~with AAC Title 9, Chapter 22, Article 5, all AHCCCS~~the~~ Contractors and AHCCCS-registered providers, including those serving FFS members ~~non-contracted FFS providers~~, shall safeguard the privacy of medical records and member information ~~about members who request or receive services from AHCCCS or its Contractors~~.[38]

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 USC 290dd-2 (confidentiality of records), 42 CFR Part 2~~, 2.1 – 2.67~~.[39]

2. The 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 and providers serving FFS members~~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.

[36] Revised to correct grammar.
[37] Revised to add specific policy reference.
[38] Revised for clarity of language.
[39] Subpart citations removed since all chapters are cited in the reference.

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 providers serving FFS members~~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

The 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.

The requirements listed ~~below are~~within this section reflect some of the data required under ~~additional requirements under~~ USCDI. Please see the USCDI webpage for the most current data elements required under USCDI. [40]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. The records may be documented in 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~~ Sex assigned at birth[41],
      vi. Race,
      vii. Ethnicity, and
      viii. Preferred language.
   b. For records relating to the provision of behavioral health services, documentation shall include, but is not limited to:
      i. Behavioral health history,
      ii. Applicable assessments,
      iii. Service ~~p~~Plans and/or ~~t~~Treatment ~~p~~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

[40] Revised for clarification.
[41] Updated to reflect current terminology.

viii. General and/or informed consent.

c. The 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,
   vii. Procedure notes, and
   viii. Progress notes.