



940¹ MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

REVISION DATES: [07/01/16](#), 10/01/15, 03/01/14, 10/01/13, 04/01/12, 02/01/11, 10/01/09, 10/01/08, 02/01/07, 04/01/05, 01/01/04, 08/13/03, 10/01/01, 10/01/97

INITIAL
EFFECTIVE DATE: 10/01/1994

1. Contractors must have policies and procedures in place for use of electronic medical (physical and behavioral health) records and for use of an health information exchange (including electronic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking forms) and digital (electronic) signatures (when electronic documents are utilized) that include processes for:
 - a. Signer authentication
 - b. Message authentication
 - c. Affirmative act
 - d. Efficiency
 - e. Record review
2. Contractors must implement appropriate policies and procedures to ensure that the organization and its providers have information required for:
 - a. Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member's health status, changes in health status, health care needs, and health care services provided,
 - b. Quality review,
 - c. Coordination of care, and
 - d. An ongoing program to monitor compliance with those policies and procedures. If during the quality of care review process, or other processes, issues are identified with the quality or content of a provider's medical record, the Contractor must conduct a focused review, implement corrective actions or other remedies until the provider's medical records process meets standards specified in the **AHCCCS Medical Policy Manual (AMPM)**².
3. Contractors must implement policies and procedures for initial and on-going monitoring of medical records ~~for all contracted~~³ ~~primary~~ Primary ~~care~~ Care ~~physicians~~ Physicians (PCPs), ~~Obstetrician/Gynecologists (OB/GYNs), licensed behavioral health professionals, oral health providers and high volume specialist (50 or more referrals per contract year by Contractor).~~ The sample of files chosen for

¹ [DBHS Policy 802, Medical Records Standards was reviewed to merge appropriate provisions into this Policy](#)

² [The meaning of AMPM is provided in the Overview.](#)

³ [Revised this section to reflect AHCCCS work group agreement in partnership with AzAHP](#)



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~~medical record review must be reflective of Geographical Service Area (GSA) served by the Contractor and the AHCCCS Contractor's lines of business. These requirements also apply to professionals employed by or affiliated with a contracted provider such as an Accountable Care Organization (ACO). Review of medical records must be conducted every three years.~~

~~3.4.~~⁴Contractors may utilize Arizona Association of Health Plans (AzAHP) to conduct medical record reviews. AzAHP serves as an alliance that represents

~~4. The Contractors must~~The following methodology must be utilized:

- a. Conduct Medical Record Reviews using a standardized tool that has been reviewed by AHCCCS. The tool must include but is not limited to EPSDT, family planning and maternity components not otherwise monitored for provider compliance by Contractors.⁵
- b. Conduct medical records reviews at a minimum of every ~~3~~three years.
- c. Utilize a collaborative approach (use of a vendor by the AzAHP⁶ Association is acceptable) that will result in only one medical record review for each provider. Use of a vendor would be considered a delegated arrangement that will result in only one AHCCCS Contractor conducting the "routine" medical record review for each provider⁷.
- ~~e.d.~~Ensure ~~r~~Results of the medical record review will be made available to all Contractors who utilize -AzAHP health plans for this process and that contract with that audited⁸ provider.
- e. ~~Ensure samples are by provider, not by provider group.~~Deficiencies identified must be shared with all health plans contracted with the provider.
- f. If quality of care issues are identified during the medical record review process, it is expected that all health plans that contract with that provider be notified promptly (within 24 hours) in order to conduct an independent on-site provider audit.
- g. Providers to be included in the medical record review process shall include all primary care providers that serve children (children defined as under 21 years of age) and obstetricians/gynecologists. The review process will include the following, unless a different methodology is reviewed and approved by AHCCCS:
 - i. The review process shall consist of reviewing eight charts per practitioner.
 - ii. If the score after eight charts is less than 90 percent, technical assistance shall be provided to the practitioner.
 - iii. If the score after eight charts is less than 90 percent, the practitioner shall also be re-audited the following year.
 - iv. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be provided to the practitioner.

⁴ Added post APC change.

⁵ Clarification

⁶ Post APC change.

⁷ Clarification

⁸ Post APC change.



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

- ~~d. Utilize a sample size for each provider's medical record review that consists of of 30thirty (30) records. If the first eight (8) records reviewed are 100 ninety (90) percent in compliance, the review stops at the eight records. If deficiencies or variances are found in any of the first eight (8) records reviewed, the full thirty (30) records must then be reviewed. The sample size must be by provider, not by provider group.~~

~~Ensure that identified deficiencies are shared with all Contractors contracted with the provider.~~

- ~~4. The lead Contractor that conducted the medical record review shall be responsible for working with the provider on corrective actions. However, other Contractor input into those corrective actions may be necessary and appropriate.~~

- ~~5. If quality of care issues are identified during the medical record review process, it is expected that Contractors that contract with that provider be notified promptly of the results in order to conduct an independent on-site provider audit. It is also expected that the Contractor will address noted areas of non-compliance, despite a provider obtaining an overall passing score, to include subsequent follow up measures taken and/or a corrective action plan required to address the noted deficiency.~~

- 5. Each Contractor must implement policies and procedures that address paper and electronic health records, and the methodologies to be used by the organization to:
 - a. Ensure that contracted providers maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical or behavioral health appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member.



- b. Ensure providers, in multi-provider offices, have the treating provider sign his or her treatment notes after each appointment and/or procedure. Progress notes must be documented on the date the event occurs. Any additional information added to progress notes must be identified as a late entry and dated accordingly. Additionally, behavioral health provider signatures must include his/her – the provider’s credentials as part of the signature.⁹
- b.c. Ensure the medical record contains documentation of referrals to other providers, coordination of care activities, and transfer of care to behavioral health and other providers.
- e.d. Make certain the medical record is legible, kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care, quality review, and identifies the treating or consulting provider. A member may have more than one medical record kept by various health care providers that have rendered services to the member. However, the PCP must maintain a comprehensive record that incorporates at least the following components:
- i. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member’s medical record as soon as one is established.
 - ii. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number).
 - iii. Documentation of identifying demographics including the member’s name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
 - iv. Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member’s mother while pregnant with the member).
 - v. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance ~~abuse~~use, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received.
 - vi. Immunization records (required for children; recommended for adult members if available).
 - vii. Dental history if available, and current dental needs and/or services
 - viii. Current ~~physical and behavioral health~~¹⁰ -problem list
 - ix. Current ~~physical and behavioral health~~ medications
 - x. Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or

⁹ Clarification

¹⁰ Clarification



- another medication that is known to adversely interact with controlled substances
- xi. Current and complete EPSDT forms (required for all members age 0 through 20 years)
 - xii. Developmental screening tools for children ages 9, 18 and 24 months
 - xiii. Documentation, initialed by the member's provider, to signify review of:
 - (a) Diagnostic information including:
 - (i) Laboratory tests and screenings,
 - (ii) Radiology reports,
 - (iii) Physical examination notes, and
 - (iv) Other pertinent data.
 - (b) Reports from referrals, consultations and specialists,
 - (c) Emergency/urgent care reports,
 - (d) Hospital discharge summaries,
 - (e) Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and
 - (f) Behavioral health history and behavioral health information received from ~~an Integrated~~¹¹ Regional Behavioral Health Authority (~~Integrated~~ RBHA) or ~~Regional Behavioral Health Authority (RBHA)~~ behavioral health¹² provider who is also treating the member.
 - xiv. Documentation as to whether or not an adult member has completed advance directives and the location of the document.
 - xv. Documentation that the provider responds to behavioral health provider information requests within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.
 - xvi. Documentation related to requests for release of information and subsequent releases, and
 - xvii. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.

~~— Identification of other Stakeholder involvement (DES/DDD, Juvenile Probation Officer/ Department of Corrections (DOC), Department of Child Safety (DCS), DES Adult Protective Services (APS), etc.)~~

~~— When a PCP has initiated medical management services for a recipient to treat a behavioral health disorder, and it is subsequently determined~~

¹¹ Clarification

¹² Information not needed



~~by the PCP and T/RBHA that the recipient should receive care through the behavioral health system for evaluation and/or continued medication management services, the RBHA subcontracted providers will assist the PCP with the coordination of the referral and transfer of care. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care. (See Policy 902, Coordination of Care with AHCCCS Health Plans, PCP and Medicare Providers).¹³~~

- d. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.
- e. Ensure that PCPs utilized AHCCCS approved developmental screening tools.
- f. Ensure each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation, ~~etc.~~) maintains a record of the services provided to a member, including:
 - i. Physician or provider orders for the service,
 - ii. Applicable diagnostic or evaluation documentation,
 - iii. A plan of treatment,
 - iv. Periodic summary of the member's progress toward treatment goals,
 - v. The date and description of service modalities provided, and
 - vi. Signature/initials of the provider for each service.
- g. ~~Ensure that~~ RBHA ~~contracted~~¹⁴ transportation services ~~using that utilize~~ provider employees (i.e.e.g. facility vans, drivers, etc.) ~~must~~ maintain documentation that supports each transport provided. ~~Transportation providers put themselves at risk of recoupment of payment if documentation is not maintained and covered services cannot be verified.~~¹⁵ The follow ~~items~~ information must be documented to verify transportation services:
 - i. Complete service provider's name and address;
 - ii. Signature and credentials of the driver who provided the service;
 - iii. Vehicle identification (car, van, wheelchair van, etc.);
 - iv. Members' Arizona Health Care Cost Containment System (AHCCCS) identification number;
 - v. Date of service, including month day and year;
 - vi. Address of pick up site;
 - vii. Address of drop off destination;
 - viii. Odometer reading at pick up;
 - ix. Odometer reading at drop off;
 - x. Type of trip – round trip or one way;

¹³ Clarification

¹⁴ Clarification

¹⁵ Clarification



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- xi. Escort (if any) must be identified by name and relationship to the member being transported; and
 - xii. Signature of the member, parent and/or guardian/caregiver, verifying services were rendered including documentation by the driver of refusal by a member to sign. — If the member refuses to sign the trip validation form, then the driver should document his/her refusal to sign in the comprehensive medical record.¹⁶
- g.h. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
- h.i. Ensure the Contractor has an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and
- i.j. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or para professionals provide services.
- 6.5. Medical records may be documented on paper or in an electronic format.
- a. If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date for each entry.
 - b. If records are physically altered, the stricken information must be identified as an error and initialed by the ~~person~~member altering the record along with the date when the change was made; correction fluid or tape is not allowed.
 - c. If kept in an electronic file, the provider must establish a method of indicating the author, date, and time ~~initiator~~¹⁷ of added/revised information and a means to assure that information is not altered inadvertently.
 - d. If revisions to information are made, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained.
 - e. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified. Safeguards must be in place to ensure that only authorized individual are able to access medical records¹⁸ ~~and electronic signatures are not misused~~¹⁹.
- 7.6. Each Contractor must have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and must conduct reviews to verify that:
- a. A provider making a referral transmits necessary information to the provider receiving the referral.

¹⁶ Clarification

¹⁷ Clarification

¹⁸ Clarification

¹⁹ Clarification and conformity to current practice



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- 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 (~~i.e., e.g. emergency services, etc.~~) is transmitted to the member's **Primary Care Provider (PCP)**.
 - e. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.
 - f. Member information is shared, when a member subsequently enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care, and
 - g. Member information is shared ~~timely~~ within ten days²⁰ with behavioral health providers ~~and government agencies²¹~~ and, as appropriate, other providers or entities involved in the member's care for members with ongoing care needs or changes in health status.
 - ~~g. RBHAs and subcontracted providers must provide each recipient who makes a request one copy of his or her medical record free of charge and must allow recipients to make changes to their medical records as specified in 45 C.F.R. § 164.524, 164.526 and A.R.S. § 12-2293. Note, recipients do not have the right to access psychotherapy notes.~~
- 8.7. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must implement a process to ensure that unauthorized individuals cannot gain access to, or alter, member records.
8. Original and/or copies of medical records must be released only in accordance with Federal or State laws and AHCCCS policy and contracts. Contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 C.F.R. 431.300 et seq.
9. Medical records retention must align with AHCCCS Contract and TRBHA Intergovernmental Agreement (IGA) requirements²². ~~be maintained for at least six years after the last date an adult recipientmember received medical or health care services from the contracted provider and for at least three years after a child's eighteenth birthday or for at least six years after the last date the child received medical or health care services whichever occurs later.~~ The maintenance and access to the recipientmember's medical record shall survive the termination of a **pP**Provider's contract regardless of the cause of termination.

²⁰ Clarification for submission

²¹ Not needed

²² Post APC change. In compliance with the new Managed Care regulations.



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

11. Contractors may request approval to discontinue conducting medical record reviews. Prior to receiving approval to discontinue the medical record review process, the Contractor must:
 - a. Conduct a comprehensive review of its use of the medical record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT, family planning, maternity and behavioral health services.
 - b. Document what processes will be used in place of the medical record review process to ensure compliance with AHCCCS requirements.
 - c. Submit the process the Contractor will utilize to ensure provider compliance with AHCCCS medical record requirements to the AHCCCS Clinical Quality Management Administrator prior to discontinuing the medical record review process.
 - d. Refer to AMPM Chapter 600, Policy 640 and AHCCCS Ceontract for a complete discussion on Advanced Directives for adult members.

~~Additional Behavioral Health Medical Record Requirements for Behavioral Health Providers~~

- ~~12. For General Mental Health/ Substance Abuse (GMH/SA) and Integrated Health providers where provisions of behavioral health services are separate from those of physical health services, ADHS/DBHS requires a comprehensive medical record must include contain²³ the following elements:~~

- a. ~~Intake Initial evaluation²⁴ Ppaperwork documentation²⁵ that includes:~~
 - ~~For recipientsmembers receiving substance abuse treatment services under the Substance Abuse Prevention & Treatment (SABG) Block Grant, documentation that notice was provided regarding the recipientmember's right to receive services from a provider to whose religious character the recipientmember does not object to, (see Policy 110, Special Populations);:~~
 - i. Documentation of ~~the recipientmember's~~ receipt of the Member Handbook and receipt of Notice of Privacy Practice,; and
~~Contact information for the recipientmember's PCPPrimary Care Provider;:~~
~~and~~

²³ Post APC chance for clarification.

²⁴ Revised to align with terminology used in AMPM 580. Intake definition is different than the initial evaluation which is what is meant here. Revised

²⁵ Deleted for clarification. Post APC change.



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- ii. ~~Additionally, f~~For members receiving substance use treatment services under the Substance Abuse Prevention & Treatment Block Grant (SABG), documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object. See AMPM Policy 320-T, Exhibit 320-9 for Notice requirements.²⁶ and;
- iii. ~~Additionally, for~~For Non-Title XIX/XXI members receiving behavioral health services:
 - (a) Financial documentation that includes :
 - (b) 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~~ his/her income, and at least annually, and
 - (c) Information regarding establishment of any copayments assessed, if applicable, if applicable.
- b. Assessment documentation that includes:
 - i. Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see AMPM Policy 580 ~~Policy 580 Referral and Intake Process, AMPM Policy 105, Assessment and Service Planning Policy 105320 O105320-O, Assessment and Service Planning, Assessment, and Discharge Planning, and Policy 1601, Enrollment, Disenrollment and Other Data Submission AHCCCS Technical Interface Guidelines)~~);
 - ii. Diagnostic information including psychiatric, psychological and medical evaluations;
 - iii. Copies of ~~Policy Form 113.1, Notification of Person~~Member in Need of Special Assistance ~~Exhibit 320-8, Notification of Person~~Member in Need of Special Assistance (see AMPM Policy ~~AAMPAN-320-R~~Policy 320-R, ~~Special Assistance for Person~~Members Determined to have a Serious Mental Illness); as applicable;
 - iv. An English version of the assessment and/or service plan if the documents are completed in any language other than English;
 - v. For ~~recipients~~members receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.
- c. Treatment and Service Plan documentation that includes:
 - i. The ~~recipient~~member's treatment and service plan,
 - ii. Child and Family Team (CFT) documentation,
 - iii. Adult Recovery Team (ART) documentation, and
 - iv. Progress reports or Service Plans from all other additional service providers.
- d. Progress Note documentation that includes:
 - i. Documentation of the type of services provided;

²⁶ Added reference to where the notice can be found, reorganized the order to but grant at bottom for flow



- ii. The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. -After a ~~primary~~²⁷ ~~principal~~ diagnosis is identified, the ~~person~~ ~~member~~ may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. -The addition of the progress note diagnosis code should be included, if applicable.;
- iii. The date the service was delivered;
- iv. The date and time the progress note was signed;
- v. The signature of the staff that provided the service, including the staff member's credentials;
- vi. Duration of the service (time increments), ~~including the code used for billing the service;~~
- vii. A description of what occurred during the provision of the service related to the ~~recipient~~ ~~member~~'s treatment plan.;
- viii. In the event that more than one provider simultaneously provides the same service to a ~~recipient~~ ~~member~~, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services.;
- ix. The ~~recipient~~ ~~member~~'s response to service.; and
- x. For ~~recipient~~ ~~members~~ receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.

~~— Medical Services documentation that includes:~~

- ~~— Laboratory, x ray, and other findings related to the recipient's physical and behavioral health care;~~
- ~~— The recipient's treatment plan related to medical services;~~
- ~~— Physician's orders;~~
- ~~— Requests for service authorizations;~~
- ~~— Documentation of facility based or inpatient care;~~
- ~~— Documentation of preventative care services;~~
- ~~— Medication record, when applicable; and~~
- ~~— Documentation of Certification of Need (CON) and Re-Certification of Need (RON), (see Policy 1101, Securing Services and Prior Authorization), when applicable~~
- ~~— Reports from other agencies that include:~~
- ~~— Reports from providers of services, consultations, and specialists;~~
- ~~— Emergency/urgent care reports; and~~
- ~~— Hospital discharge summaries.~~

- e. Paper or electronic correspondence documentation that includes:

²⁷ Clarification. Post APC change.



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- i. Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management for the ~~recipient~~member; and,
- ii. Documentation of any requests for and forwarding of behavioral health record information.

~~—Financial documentation that includes:~~

- ~~—Documentation of the results of a completed Title XIX/XXI screening as required in Policy 101, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Low Income Subsidy Program; and,~~
- ~~—Information regarding establishment of any copayments assessed, if applicable (see Policy 601, Copayments).~~

f. Legal documentation including:

- i. Documentation related to requests for release of information and subsequent releases
- ii. Copies of any advance directives or mental health care power of attorney as defined in Policy 801, Advance Directives, if applicable, including:
 - (a) Documentation that the adult ~~person~~member was provided the information on advance directives and whether an advance directive was executed.;
 - (b) Documentation of authorization of any health care power of attorney that appoints a designated ~~person~~member to make health care decisions (not including mental health) on behalf of the ~~person~~member if they are found to be incapable of making these decisions.;
 - (c) Documentation of authorization of any mental health care power of attorney that appoints a designated ~~person~~member to make behavioral health care decisions on behalf of the ~~person~~member if they are found to be incapable of making these decisions.
 - (d) Documentation of general and informed consent to treatment, ~~pursuant to Policy 107, General and Informed Consent to Treatment and Policy 108, Psychotropic Medications: Prescribing and Monitoring;~~
 - (e) Authorization to disclose ~~information~~information pursuant to Policy 1401, Confidentiality; and.;

~~—Any extension granted for the processing of an appeal must be documented in the case file, including the Notice regarding the extension sent to the ~~recipient~~member and his/her legal guardian or authorized representative, if applicable (see Policy 1801, Title XIX/XXI Notice and Appeal Requirements).~~

(a)(f) _____

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

- a. The ~~T/RBHA~~Contractor must require that the clinical records of the CSA, HCTC Provider and Habilitation Provider ~~clinical records~~ conform to the following standards. Each record entry must be:



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- i. Dated and signed with credentials noted.;
 - ii. Legible text, written in blue or black ink, or typewritten.; and;
 - iii. Factual and correct.
- b. If required records are kept in more than one location, the agency/provider shall maintain a list indicating documentation specifying the location of the records. CSAs, HCTC Providers and Habilitation Providers must maintain a record of the services delivered to each behavioral health recipientmember. —The minimum written requirement for each behavioral health recipientmember’s record must include:
- i. The service provided (including the code used for billing the service) and the time increment.;
 - ii. Signature and the date the service was provided.;
 - iii. The name title and credentials of the personmember providing the service.;
 - iv. The recipientmember’s T/RBHA or CIS identification number and AHCCCS identification number.;
 - v. T/RBHAsContractors must ensure that services provided by the agency/providerServices are reflected in the behavioral health recipientmember’s service plan. —CSAs, HCTC Providers and Habilitation Providers must keep a copy of each behavioral health recipientmember’s service plan in the recipientmember’s record.; and
—Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.
—Policy Form 802.1 is a recommended format that may be utilized to meet the requirements identified in this section.
 - vi. Every thirty (30) days, —A summary of the information required in this section must be transmitted from the CSA, HCTC Provider or Habilitation Provider to the recipientmember’smember’s clinical team for inclusion in the comprehensive clinical record.

—Adequacy and availability of documentation

—All T/RBHA and subcontracted providers must maintain and store records and data that document and support the services provided to members and the associated encounters/billing for those services. —In addition to any records required to comply with T/RBHA contracts, there must be adequate documentation to support that all billings or reimbursements are accurate, justified and appropriate.

—All providers must prepare, maintain and make available to ADHS/DBHS, adequate documentation related to services provided and the associated encounters/billings.

—Adequate documentation is electronic records and “hard copy” documentation that can be readily discerned and verified with reasonable certainty. —Adequate documentation must establish medical necessity and support all medically necessary services rendered and the amount of reimbursement received (encounter value/billed amount) by a provider; this includes all related clinical, financial, operational and business supporting documentation and electronic records. —It also includes clinical records that support and verify that the member’s assessment,



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~~diagnosis and Individual Service Plan (ISP) are accurate and appropriate and that all services (including those not directly related to clinical care) are supported by the assessment, diagnosis and ISP.~~

- ~~— For monitoring, reviewing and auditing purposes, all documentation and electronic records must be made available at the same site at which the service is rendered. If requested documents and electronic records are not available for review at the time requested, they are considered missing. All missing records are considered inadequate. If documentation is not available due to off-site storage, the provider must submit their applicable policy for off-site storage, demonstrate where the requested documentation is stored and arrange to supply the documentation at the site within 24 hours of the original request.~~
- ~~— A T/RBHAs failure to prepare, retain and provide to ADHS/DBHS adequate documentation and electronic records for services encountered or billed may result in the recovery and/or voiding (not to be resubmitted) of the associated encounter values or payments for those services not adequately documented and/or result in financial sanctions to the provider and their contracted T/RBHA.~~
- ~~— Inadequate documentation may be determined to be evidence of suspected fraud or program abuse that may result in notification or reporting to the appropriate law enforcement or oversight agency. These requirements continue to be applicable in the event the provider discontinues as an active participating and/or contracted provider as the result of a change of ownership or any other circumstance.~~

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