



Section 4.2 **Medical Record Standards**

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4.2.1 **Introduction**

To ensure that NARBHA implements appropriate medical record standards; that medical records document medical needs, changes, and the delivery of necessary services. Medical records must be complete, accurate, accessible, and permit systematic retrieval of information while maintaining confidentiality. Documentation in the medical record facilitates diagnosis and treatment, coordination of care, supports billing reimbursement information, provides evidence of compliance during periodic medical record reviews and can protect practitioners against potential litigation.

4.2.2 **Terms**

Definitions for terms are located online at www.narbha.org or <http://www.azdhs.gov/bhs/definitions/index.php>.

The following terms are referenced in this section:

[Assessment](#)

[Behavioral Health Status](#)

[Certification of Need \(CON\)](#)

[Community Service Agency \(CSA\)](#)

[Comprehensive Medical Record](#)

[Electronic Signature](#)

[General Consent](#)

[Habilitation Provider](#)

[Home Care Training to Home Care Client \(HCTC\) Provider](#)

[Informed Consent](#)

[Medical Records](#)

[Recertification of Need \(RON\)](#)



[Telemedicine](#)

[Treatment](#)

4.2.3 Procedures

- a. The medical record contains clinical information pertaining to a recipient's physical and behavioral health. Maintaining current, accurate, and comprehensive medical records assists providers in successfully treating and supporting recipient care.
- b. Subcontracted providers must maintain legible, signed, and dated medical records in paper or electronic format that are written in a detailed and comprehensive manner; conform to good professional practices; permit effective professional review and audit processes; and facilitate an adequate system for follow up treatment.
- c. Paper or electronic format
 - i. Paper medical records and documentation must include:
 - (1) Date and time;
 - (2) Signature and credentials;
 - (3) Legible text, written in blue or black ink, or typewritten;
 - (4) Corrections with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the person altering the record. Correction fluid or tape is not allowed; and
 - (5) If a rubber-stamp signature is used to authenticate the document or entry, the individual whose signature the stamp represents is accountable for the use of the stamp.
 - ii. A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry.
 - iii. Electronic medical records and documentation must include:
 - (1) Safeguards to prevent unauthorized access, as well as:
 - (a) The date and time of entries in a medical record as noted by the computer's internal clock;
 - (b) The personnel authorized to make entries using NARBHA or provider established policies and procedures;
 - (c) The identity of the person making an entry; and
 - (d) Electronic signatures to authenticate that a document is properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.
 - iv. Electronic medical records and systems must also
 - (1) Ensure that the information is not altered inadvertently;
 - (2) Track when, and by whom, revisions to information are made; and
 - (3) Maintain a backup system including initial and revised information.
 - d. Transportation service documentation
 - i. For providers that supply transportation services for recipients using provider employees (i.e. facility vans, drivers, etc.) the following documentation requirements apply:
 - (1) Complete service provider's name and address;



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- (2) Signature and credentials of the driver who provided the service;
 - (3) Vehicle identification (car, van, wheelchair van, etc.);
 - (4) Members' Arizona Health Care Cost Containment System (AHCCCS) identification number;
 - (5) Date of service, including month day and year;
 - (6) Address of pick up site;
 - (7) Address of drop off destination;
 - (8) Odometer reading at pick up;
 - (9) Odometer reading at drop off;
 - (10) Type of trip – round trip or one way;
 - (11) Escort (if any) must be identified by name and relationship to the member being transported; and
 - (12) Signature of the member, parent and/or guardian/caregiver, verifying services were rendered. 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.
- ii. For providers that use contracted transportation services, for non-emergency transport of recipients, that are not direct employees of the provider (i.e. cab companies, shuttle services, etc.) see [NARBHA Policy 3.13 Covered Behavioral Health Services](#) for a list of elements recommended for documenting non-emergency transportation services.
 - iii. It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.
 - iv. NARBHA must communicate documentation standards listed in [NARBHA Policy 3.13 Covered Behavioral Health Services](#) to their contracted providers.
- e. Disclosure of records
- i. All medical records, data and information obtained, created, or collected by the provider related to the member, including confidential information must be made available electronically to ADHS/DBHS, AHCCCS, or any government agency upon request.
 - ii. Behavioral health records must be maintained as confidential and must only be disclosed according to the following provisions:
 - (1) When requested by a recipient's primary care provider (PCP) or the recipients' Department of Economic Security/Division of Developmental Disabilities/Arizona Long-Term Care System (DES/DDD/ALTCS) support coordinator, the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days of the request. (See [NARBHA Policy 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#) for more information; see the [ADHS/DDD Interagency Service Agreement Amendment 9](#)).
 - (2) NARBHA and subcontracted providers must provide each recipient who makes a request one copy of his or her medical record free of charge annually.



- (3) NARBHA and subcontracted providers must allow, upon request, recipients to view and amend their medical record as specified in [45 C.F.R. § 164.524](#), [164.526](#) and [A.R.S. § 12-2293](#).
- f. Comprehensive clinical record
- i. NARBHA must ensure the development and maintenance of a comprehensive clinical record for each recipient. Comprehensive clinical records, whether electronic or paper, may contain information contributed by several service providers involved with the care and treatment of a recipient.
 - ii. The comprehensive clinical record must include the following information to the fullest extent possible:
 - (1) Recipient identification information on each page of the record (i.e., recipient's name and AHCCCS /Client Information System (CIS) identification number);
 - (2) Identifying demographics including 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;
 - (3) Initial history for the member that includes family medical/behavioral health history, social history and laboratory screenings (the initial history of a member under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member);
 - (4) Past medical/behavioral health history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received;
 - (5) Current presenting concerns;
 - (6) Any review of behavioral health record information by any person or entity (other than members of the clinical team) that includes the name and credentials of the person reviewing the record, the date of the review, and the purpose of the review; and,
 - (7) 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.)
- g. Physical Health Information for the Integrated RBHA (n/a)
- i. The comprehensive clinical record, for the Integrated RBHA, must include the following information:
 - (1) Initial history for the member as defined in section f.ii.(3);
 - (2) Past medical history for the member as defined in section f.ii.(4);
 - (3) Immunization records (required for children; recommended for adult members if available);
 - (4) Current medical and behavioral health problem list;
 - (5) Current physical and behavioral health medications;
 - (6) Current and complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) forms (required for all members age 18 through 20 years);



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- (7) Documentation in the comprehensive medical record, must be initialed and dated by the recipient's, RBHA contracted PCP, to signify review of diagnostic information including:
 - (a) Laboratory tests and screenings,
 - (b) Radiology reports,
 - (c) Physical examination notes,
 - (d) Behavioral health information received from the behavioral health provider;
and
 - (e) Other pertinent data.
 - (8) Reports from referrals, consultations and specialists;
 - (9) Emergency and urgent care reports;
 - (10) Hospital discharge summaries;
 - (11) Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a recipient's health status changes or new medications are prescribed;
 - (12) Behavioral health history;
 - (13) Documentation as to whether or not an adult member has completed advance directives and location of the document;
 - (14) Documentation related to requests for release of information and subsequent releases; and,
 - (15) Documentation that reflects that diagnostic, treatment and disposition information related to a specific recipient was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the recipient's health care.
- h. Behavioral Health Record
- i. For General Mental Health/ Substance Abuse (GMH/SA) and Integrated Health where provisions of behavioral health services are separate from those of physical health services, ADHS/DBHS requires a comprehensive medical record contain the following elements:
 - (1) Intake Paperwork documentation that includes:
 - (a) For recipients receiving substance abuse treatment services under the Substance Abuse Prevention & Treatment (SABG) Block Grant, documentation that notice was provided regarding the recipient's right to receive services from a provider to whose religious character the recipient does not object to (see [NARBHA Policy 3.19 Special Populations](#));
 - (b) Documentation of recipient's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
 - (c) Contact information for the recipient's PCP, if applicable.
 - (2) Assessment documentation that includes:
 - (a) Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see [NARBHA Policy PM 3.9 Assessment and Service Planning](#) and [NARBHA Policy 7.5 Enrollment, Disenrollment and Other Data Submission](#))
 - (b) Diagnostic information including psychiatric, psychological and medical evaluations;



- (c) Copies of [NARBHA PM Form 5.4.1 Notification of Person in Need of Special Assistance](#) (see [NARBHA Policy 5.4 Special Assistance for Persons Determined to have SMI](#)) as applicable;
 - (d) An English version of the assessment and/or service plan if the documents are completed in any language other than English; and
 - (e) For recipients receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.
- (3) Treatment and Service Plan documentation that includes:
- (a) The recipient's treatment and service plan,
 - (b) Child and Family Team (CFT) documentation,
 - (c) Adult Recovery Team (ART) documentation, and
 - (d) Progress reports or Service Plans from all other additional service providers
- (4) Progress Note documentation that includes:
- (a) Documentation of the type of services provided;
 - (b) 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 diagnosis is identified, the person 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;
 - (c) The date the service was delivered;
 - (d) Duration of the service (time increments) including the code used for billing the service;
 - (e) A description of what occurred during the provision of the service related to the recipient's treatment plan;
 - (f) In the event that more than one provider simultaneously provides the same service to a recipient, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
 - (g) The recipient's response to service; and
 - (h) For recipients receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.
- (5) Medical Services documentation that includes:
- (a) Laboratory, x-ray, and other findings related to the recipient's physical and behavioral health care;
 - (b) The recipient's treatment plan related to medical services;
 - (c) Physician's orders;
 - (d) Requests for service authorizations;
 - (e) Documentation of facility-based or inpatient care;
 - (f) Documentation of preventative care services;
 - (g) Medication record, when applicable; and
 - (h) Documentation of Certification of Need (CON) and Re-Certification of Need (RON), (see [NARBHA Policy 3.14 Securing Services and Prior Authorization](#), when applicable)



- (6) Reports from other agencies that include:
 - (a) Reports from providers of services, consultations, and specialists;
 - (b) Emergency/urgent care reports; and
 - (c) Hospital discharge summaries.

- (7) Paper or electronic correspondence documentation that includes:
 - (a) 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; and,
 - (b) Documentation of any requests for and forwarding of behavioral health record information.

- (8) Financial documentation that includes:
 - (a) Documentation of the results of a completed Title XIX/XXI screening as required in [NARBHA Policy 3.1 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program](#), and,
 - (b) Information regarding establishment of any copayments assessed, if applicable (see [NARBHA Policy 3.4 Co-payments](#))

- (9) Legal documentation including:
 - (a) Documentation related to requests for release of information and subsequent releases
 - (b) Copies of any advance directives or mental health care power of attorney as defined in [NARBHA Policy 3.12 Advance Directives](#) if applicable, including:
 - (i) Documentation that the adult person was provided the information on advance directives and whether an advance directive was executed;
 - (ii) Documentation of authorization of any health care power of attorney that appoints a designated person to make health care decisions (not including mental health) on behalf of the person if they are found to be incapable of making these decisions;
 - (iii) Documentation of authorization of any mental health care power of attorney that appoints a designated person to make behavioral health care decisions on behalf of the person if they are found to be incapable of making these decisions. Documentation of general and informed consent to treatment pursuant to [NARBHA Policy 3.11 General and Informed Consent to Treatment](#) and [NARBHA Policy 3.15 Psychotropic Medication: Prescribing and Monitoring](#);
 - (iv) Authorization to disclose information pursuant to [NARBHA Policy 4.1 Disclosure of Behavioral Health Information](#); and,
 - (v) 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 and his/her legal guardian or authorized representative, if applicable (see [NARBHA Policy 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons](#)).



- i. Medical Record Maintenance
 - i. Providers must retain the original or copies of recipient medical records as follows:
 - (1) For an adult, for at least six (6) years after the last date the adult recipient received medical or health care services from the contracted provider
 - (2) For a child, either for at least three (3) years after the child's eighteenth birthday or for at least six (6) years after the last date the child received medical or health care services from the contracted NARBHA provider, whichever occurs later
 - ii. The maintenance and access to the recipient medical record shall survive the termination of a Provider's contract with the NARBHA, regardless of the cause of the termination.

- j. PCP Medication Management and Care Coordination with Behavioral Health Providers
 - i. When a PCP has initiated medical management services for a recipient to treat a behavioral health disorder, and it is subsequently determined by the PCP and NARBHA that the recipient should receive care through the behavioral health system for evaluation and/or continued medication management services, NARBHA 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 [NARBHA Policy 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#)).

- k. Medical Record Audits
 - i. DBHS will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when DBHS is conducting audits or investigating quality of care issues. NARBHA must respond to these requests within fourteen (14) days. Medical records must be made available to AHCCCS for quality review upon request.
 - ii. Behavioral health providers must send copies of any information maintained in their own behavioral health record that must also be maintained in the comprehensive clinical record.

- l. Transition of medical records
 - i. Transfer of the behavioral health recipient's medical records due to transitioning of the behavioral health recipient to a new T/RBHA and/or provider (see [NARBHA PM 3.17 Transition of Persons](#)) is important to ensure that there is minimal disruption to the behavioral health recipient's care and provision of services. The behavioral health medical record must be transferred in a timely manner that ensures continuity of care.
 - ii. Federal and state law allows for the transfer of behavioral health medical records from one provider to another, without obtaining the recipient's written authorization if it is for treatment purposes ([45 C.F.R. § 164.502\(b\)](#), [164.514\(d\)](#) and [A.R.S. 12-2294\(C\)](#)). Generally, the only instance in which a provider must obtain written authorization is for the transfer of alcohol/drug and/or communicable disease treatment information (see [NARBHA Policy 4.1 Disclosure of Behavioral Health Information](#) for other situations that may require written authorization).
 - iii. The original provider must send that portion of the medical record that is necessary to the continuing treatment of the behavioral health recipient. In most cases, this includes all communication that is recorded in any form or medium and that relates to



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patient examination, evaluation or behavioral health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to section [A.R.S. § 36-441](#), [36-445](#), [36-2402](#) and [36-2917](#).

- iv. Federal privacy law indicates that the Designated Record Set (DRS) is the property of the provider who generates the DRS. Therefore, originals of the medical record are retained by the terminating or transitioning provider in accordance with 3.b. of this Section. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (see the [AHCCCS Contractors Operation Manual, Section 402](#))

- m. Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers
 - i. NARBHA must require that CSA, HCTC Provider and Habilitation Provider clinical records conform to the following standards. Each record entry must be:
 - (1) Dated and signed with credentials noted;
 - (2) Legible text, written in blue or black ink, or typewritten; and,
 - (3) Factual and correct.
 - ii. If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.
 - iii. CSAs, HCTC Providers and Habilitation Providers must maintain a record of the services delivered to each behavioral health recipient. The minimum written requirement for each behavioral health recipient's record must include:
 - (1) The service provided (including the code used for billing the service) and the time increment;
 - (2) Signature and the date the service was provided;
 - (3) The name title and credentials of the person providing the service;
 - (4) The recipient's T/RBHA or CIS identification number and AHCCCS identification number;
 - (5) NARBHA must ensure that services provided by the agency/provider are reflected in the behavioral health recipient's service plan. CSAs, HCTC Providers and Habilitation Providers must keep a copy of each behavioral health recipient's service plan in the recipient's record; and
 - (6) Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.
 - iv. [NARBHA PM Form 4.3.1 Clinical Record Documentation Form](#) is a recommended format that may be utilized to meet the requirements identified in this section.
 - v. 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 recipient's clinical team for inclusion in the comprehensive clinical record.

- n. Adequacy and availability of documentation
 - i. All NARBHA 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.
- ii. All providers must prepare, maintain and make available to ADHS/DBHS, adequate documentation related to services provided and the associated encounters/billings.
 - iii. 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, 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.
 - iv. 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.
 - v. NARBHA’s 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 NARBHA.
 - vi. 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.

4.4.4 References

The following citations can serve as additional resources for this content area:

[45 C.F.R. § 164.502\(b\)](#)

[45 C.F.R. § 164.514\(d\)](#)

[A.R.S. § 12-2291 et. seq.](#)

[A.R.S. § 12-2294\(C\)](#)

[A.R.S. § 36-441](#)

[A.R.S. § 36-445](#)

[A.R.S. § 36-2402](#)

[A.R.S. § 36-2917](#)

[A.A.C. R9-21-209](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contracts](#)

[ADHS/TRBHA IGAs](#)

[AHCCCS Medical Policy Manual, Policy 940](#)



[Policy 406, Community Service Agencies-Title XIX Certification](#)
[NARBHA Policy 3.1 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program](#)
[NARBHA Policy 3.3 Referral and Intake Process](#)
[NARBHA Policy 3.4 Co-payments](#)
[NARBHA Policy PM 3.9 Assessment and Service Planning](#)
[NARBHA Policy 3.11 General and Informed Consent to Treatment](#)
[NARBHA Policy 3.12 Advance Directives](#)
[NARBHA Policy 3.13 Covered Behavioral Health Services](#)
[NARBHA Policy 3.14 Securing Services and Prior Authorization](#)
[NARBHA Policy 3.15 Psychotropic Medication: Prescribing and Monitoring](#)
[NARBHA Policy 3.17 Transition of Persons](#)
[NARBHA Policy 3.18 Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment](#)
[NARBHA Policy 3.19 Special Populations](#)
[NARBHA Policy 4.1 Disclosure of Behavioral Health Information](#)
[NARBHA Policy 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#)
[NARBHA Policy 5.1 Title XIX/XXI Notice and Appeal Requirements for Title XIX and Title XXI Eligible Persons](#)
[NARBHA Policy 5.4 Special Assistance for Persons Determined to have a SMI](#)
[NARBHA Policy 7.4 Reporting of Incidents, Accidents and Deaths](#)
[NARBHA Policy 7.5 Enrollment, Disenrollment and Other Data Submission](#)

4.2.5 PM Forms

[PM Form 4.2.1 Clinical Record Documentation](#)



4.2.5 PM Forms
None.

Signature on file	11/01/14
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Mary Jo Gregory President and Chief Executive Officer	Date

Signature on file	11/01/14
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Teresa Bertsch, MD Chief Medical Officer	Date

[Reference ADHS/DBHS Policy 802](#)