Comprehensive Medical Record

Medical Records
All communications related to a patient’s physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Medical records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities. (A.R.S. § 12-2291)

Per A.R.S. § 12-2291:
"Medical records" means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including medical records that are prepared by a health care provider or by other providers. Medical 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 36-441, 36-445, 36-2402 or 36-2917. Medical records do not include recorded telephone and radio calls to and from a publicly operated emergency dispatch office relating to requests for emergency services or reports of suspected criminal activity, but include communications that are recorded in any form or medium between emergency medical personnel and medical personnel concerning the diagnosis or treatment of a person.

Per AHCCCS Medical Policy Manual (gives specific requirements):
The medical record is legible, kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the provider 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, 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 problem list

ix. Current medications

x. Current and complete EPSDT forms (required for all members age 0 through 20 years)

xi. 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 a Regional Behavioral Health Authority (RBHA) behavioral health provider who is also treating the member.

x. Documentation as to whether or not an adult member has completed advance directives and the location of the document.

xi. Documentation that the provider responds to behavioral health provider information requests pertaining to behavioral health recipient members 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.

xii. Documentation related to requests for release of information and subsequent releases, and

xiii. 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.