Section 4.2 Behavioral Health Medical Record Standards

I. STATEMENT OF PURPOSE:

To establish standards to ensure that each behavioral health record is complete, accurate, legible and current. Maintaining current, accurate and comprehensive behavioral health medical records for persons who receive behavioral health services is important for many reasons. Documentation in the behavioral health medical record facilitates the diagnosis and treatment of persons, but it also supports billing reimbursement information, lends to compliance during periodic medical record reviews and can protect practitioners against potential litigation. The behavioral health medical record contains clinical information pertaining to a behavioral health recipient. The information assists behavioral health providers in successfully treating and supporting recipients.

Maintaining current, accurate, and comprehensive behavioral health medical records is important for many reasons. Documentation in the behavioral health medical record facilitates diagnoses and treatment, facilitates coordination of care, supports billing reimbursement information, provides evidence of compliance during periodic medical record reviews and can protect practitioners against potential litigation.

Medical record documentation must be legible, accurate and reflect a behavioral health recipient's behavioral health status, changes in behavioral health status, and reflect all behavioral health care needs and services provided.

The Arizona Health Care Cost Containment System (AHCCCS) recognizes the value of accurate and comprehensive behavioral health records. AHCCCS and federal and state authorities establish the standards to guide behavioral health providers in ensuring the proper organization, content, maintenance and retention of behavioral health medical records.

II. REFERENCES:

The following Pascua Yaqui (PY) Centered Spirit Program (CSP) Provider Manual sections can serve as additional resources for this content area:

Section 3.3 Referral and Intake Process
Section 3.4, Co-payments
Section 3.9, Assessment and Service Planning
Section 3.11, General and Informed Consent to Treatment
Section 3.12, Advance Directives
Section 3.14, Securing Services and Prior Authorization
Section 3.15, Psychotropic Medications: Prescribing and Monitoring
Section 3.17, Transition of Persons
Section 3.18, Pre-Petition Screening, Court-Ordered Evaluation and Court-Ordered Treatment
Section 3.19, Special Populations
Section 4.1, Disclosure of Behavioral Health Information
Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness (SMI)
Section 7.4, Reporting of Incidents, Accidents and Deaths
Section 7.5, Enrollment, Disenrollment and Other Data Submission

The following citations and AHCCC document 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. R9-20-211
A.A.C. R9-21-209
AHCCCS/TRBHA Intergovernmental Agreement (IGA) 2021

III. STANDARDS:

1. Procedures are maintained for both paper and electronic records.

2. Records are retained according to Arizona state law.

3. Records are maintained as confidential and released only as authorized in *Section 4.1.*

4. A comprehensive clinical record is maintained for each person served by CSP or its subcontracted providers.

5. Patient's medical records are available to personnel members, medical practitioners, and behavioral health professionals who need patient information to provide services or conduct file audits with proper authority.

6. When a non-electronic record is needed by a provider, CSP medical records staff provide that record within 30 minutes of request. Electronic records are available to authorized staff at any time.

IV. PROCEDURES:

A. Records may be documented in paper or electronic format:

For paper documentation the record must be:

1. Dated;

2. Signed with an original signature and credential;

3. Legible and either written in blue or black ink or typewritten;

4. Corrected 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.

6. 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 (see A.A.C. R9-20-211(C), Client Records).

Providers that use electronic medical records and documentation must require that:

1. Safeguards are in use to prevent unauthorized access;

2. The date and time of an entry in a medical record is recorded by the computer's internal clock;

3. The record is recorded only by personnel authorized to make entries using TRBHA or provider established policies and procedures;

4. The record indicates the identity of the person making an entry; and

5. Electronic signatures used to authenticate a document are properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.

Electronic medical records and systems must also:

1. Ensure that the information is not altered inadvertently or changed by the provider to make the initial entry illegible;

2. Track when, and by whom, revisions to information are made; and

3. Maintain a backup system including initial and revised information.

B. Transportation services:

For providers that supply transportation services for recipients using provider employees (i.e. facility vans, drivers, etc.) the following requirements apply.

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.) the original signature and credentials portion of these requirements is waived. Instead, documentation for the recipient record must include a summary log of the transportation event received from the transportation provider that includes all other elements listed as follows:

1. Complete service provider's name and address;
2. Name signature and credentials of the driver who provided the service;
3. Vehicle identification (car, van, wheelchair van, etc.);
4. Member's' AHCCCS ID number;
5. Complete date of service, including month day and year;
6. Complete address of pick-up site;
7. Complete 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.

C. Disclosure of records:

Behavioral health records must be maintained as confidential and must only be disclosed according to the provisions in *Section 4.1, Disclosure of Behavioral Health Information*.

Section 4.1, Disclosure of Behavioral Health Information, contains information regarding the review of behavioral health medical records by behavioral health recipients.

When requested by a recipient's primary care provider or the recipients' 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 *Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers* for more information).

AHCCCS shall ensure that each recipient is guaranteed the right to request and receive a copy of his/her medical record and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164.

D. Comprehensive clinical record:

The designated behavioral health provider must ensure the development and maintenance of a comprehensive clinical record for each recipient. The comprehensive clinical record, whether electronic or hard copy, may contain information contributed by several other service providers involved with the care and treatment of a recipient.

The comprehensive clinical record must include the following:

1. Identification information on each page of the record (i.e., recipient's name and identification number);

2. Documentation of 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 history, social history and laboratory screenings;

4. 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 and results of physical exam if available;

5. Current problem list/presenting concerns and orders;

6. Documentation of 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.

The comprehensive clinical record must also contain the following elements listed below. These elements are listed as follows using a system of topics/tabs for purposes of organization and maintenance of required documentation. AHCCCS strongly recommends the use of this system

Intake paperwork:

For recipients receiving substance abuse treatment services under the Substance Abuse Prevention & Treatment (SAPT) 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 *Section 3.19, Special Populations):*

1. Documentation of recipient's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and

2. Contact information for the recipient's primary care provider (PCP), if applicable.

Financial:

1. Documentation of completed Form AHCCCS AE-01 for initial Title XIX/XXI screening, annual screening and screening conducted then a significant change occurs in a person's financial status**;**

2. Information (see Form 3.4.1, Non-Title XIX/XXI Co-payment Assessment) regarding establishment of any co-payments assessed, if applicable (see *Section 3.4, Co-payments*).

Legal:

1. Documentation related to requests for release of information and subsequent releases;

2. Copies of any advance directives or mental health power of attorney as defined in *Section 3.12, Advance Directives*, if applicable including;

    a. Documentation in the adult person's clinical record that the adult person 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 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;

c. 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.

3. Documentation of general and informed consent to treatment pursuant to *Section 3.11, General and Informed Consent to Treatment,* and *Section 3.15, Psychotropic Medications: Prescribing and Monitoring;*

4. Authorization to disclose information pursuant to *Section 4.1, Disclosure of Behavioral Health Information;*

5. 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 Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons);*

6. For recipients undergoing a voluntary evaluation, as described in *Section 3.18, Pre-Petition Screening, Court-Ordered Evaluation and Court-Ordered Treatment,* a copy of the application for voluntary treatment.

Assessments:

1. Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see *Section 3.3 Referral and Intake Process; Section 3.9, Assessment and Service Planning*, and *Section 7.5, Enrollment, Disenrollment and Other Data Submission)*;

2. Documentation of all information collected in the annual update to the behavioral health assessment including any applicable addenda and updated demographic information;

3. Diagnostic information including psychiatric, psychological and medical evaluations;

4. An English version of the assessment and/or service plan if the documents are completed in Spanish;

5. For recipients receiving services via telemedicine copies of electronically recorded information of direct, consultative or collateral clinical interviews.

Treatment and service plans must address the following:

1. The recipient's treatment and service plan;

2. Child and Family Team (CFT) documentation; and

3. Progress notes that include the following:

    a. Date of the counseling session;

    b. The amount of time spent in counseling;

    c. Whether counseling was individual, family, or group;

    d. The treatment goals addressed in counseling;

    e. The signature of the personnel who provided the counseling;

    f. The date the progress note was signed; and

    g. The client's diagnosis.

The diagnosis must be noted, 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. Each provider that the person is referred to for treatment may be addressing a different or new diagnosis. 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 (accurate to all digits of the specific DSM-V code that applies) will help to ensure that diagnostic codes used for the documentation of delivery of services match the codes used on the billing/encounter claim submitted.

Medical documentation must include the following:

1. Laboratory, x-ray, and other findings related to the recipient's behavioral health care such as sleep disorder reports, diagnostic reports, consultation reports;

2. Medication record, when applicable;

3. Documentation of Certification of Need (CON) and Re-Certification of Need (RON), (see *Section 3.14, Securing Services and Prior Authorization*), when applicable;

4. Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the client's record, and any adverse reaction to medications is also recorded.

5. For any medication box prepared for client's self-administration, the nursing staff member documents name, strength dosage, amount, route of administration and expiration date of each medication.

6. For recipients receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.

Reports from other agencies must include the following, as applicable:

1. Reports from providers of services, consultations, and specialists;
2. Emergency/urgent care reports; and
3. Hospital discharge summaries.

Correspondence refers to the following, as applicable:

1. Documentation of the provision of diagnostic, treatment, and disposition information (as allowed in *Section 4.1, Disclosure of Behavioral Health Information)* to the PCP and other providers to promote continuity of care and quality management of the recipient's health care;
2. Letters;
3. E-mails, printed out;
4. Documentation of any requests for and forwarding of behavioral health record information; and
5. Copies of PM Form 5.4.1, Notification of Person in Need of Special Assistance (see *Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness (SMI)*).

Discharge summary: Documentation includes the status of the patient upon discharge, documentation of follow-up instructions, and a completed discharge summary per *Section 3.17. Transition of Persons*.

E. Behavioral health provider records:

A recipient may receive behavioral health services from multiple behavioral health providers. Behavioral health providers who are licensed through the Bureau of Medical Facility Licensure (BMFL) must maintain a behavioral health record that meets the requirements of A.A.C. R9-20-211). In addition, BMFL licensed behavioral health provider records must include:

1. Periodic summary of the person's progress towards treatment goals;
2. Physician and practitioner orders for the service;
3. Applicable diagnostic or evaluation documentation;
4. Signature/initials of the provider for each service;
5. Documentation of adherence to reporting requirements;
6. Progress notes including:
    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
    c. The date the service was delivered;
    d. Duration of the service;
    e. A description of what occurred during the provision of the service related to the recipient's treatment plan;
    f. The recipient's' response to service

For BMFL licensed Level I facilities, documentation that any serious occurrence or death involving a behavioral health recipient (see *Section 7.4, Reporting of Incidents, Accidents and Deaths)*:

1. Has been reported to AHCCCS and the Arizona Center for Disability Law (ACDL);
2. A copy of the information sent to AHCCCS and ACDL; and
3. In the case of a behavioral health recipient's death that the aforementioned information has been reported to the Center for Medicare and Medicaid Services (CMS).

If more than one provider simultaneously provides the same service to a behavioral health recipient:

1. Documentation of reasons for the involvement of multiple providers, including the names and roles of each provider involved in the service delivery; and

2. The number of units and amount of time spent for each service provided, consistent with the encounter submission for the service(s).

What information must be forwarded to the recipient's comprehensive clinical record?

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. *Subsection 4.2.6-D* describes the elements that must be maintained in the recipient's comprehensive clinical record.

Transition of medical records

Whether it becomes necessary to transfer the behavioral health recipient's medical records due to transitioning of the behavioral health recipient to a new TRBHA (see *Section 3.17, Transition of Persons*, for additional information on Inter-TRBHA transfers) and/or provider, or the TRBHA has terminated the provider contract, it 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.

Is a written authorization required?

Federal and state law allow the transfer of behavioral health medical records from one provider to another, without obtaining the individual'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 *Section 4.1, Disclosure of Behavioral Health Information* for other situations that may require written authorization).

What information must be sent to the new provider?

The original provider must send that portion of the medical record which is necessary to the continuing treatment of the behavioral health recipient. In most cases this includes all communication that are recorded in any form or medium and that relate to patient examination, evaluation or behavioral or mental 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 or 36-2917.

Who retains the original medical record?

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 *Section 4.2.7-B*. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (AHCCCS Contractors Operation Manual, Policy 402).

F. Adequacy and availability of documentation:

All 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 TRBHA 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 AHCCCS, 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, diagnosis and the Individualized 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 provider's failure to prepare, retain and provide to AHCCCS 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 TRBHA.

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.

G. Retention of records:

A behavioral health provider must retain the original or copies of a recipient's 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 TRBHA or behavioral health provider; and

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 TRBHA or behavioral health provider, whichever occurs later.