

**Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL**

Section 4.2 Behavioral Health Medical Record Standards

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4.2.1 Introduction

The behavioral health medical record contains a wealth of clinical information pertaining to a behavioral health recipient. The information can assist behavioral health providers in successfully treating and supporting the individual. 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, leads to compliance during periodic medical record reviews, and can protect practitioners against potential litigation.

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

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes the value of an accurate and comprehensive behavioral health record. As such, ADHS/DBHS has established the standards in this section to guide behavioral health providers in ensuring the proper organization, content, maintenance, and retention of behavioral health medical records.

4.2.2 References

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

- [A.R.S. § 12-2291 et. seq](#)
- [A.A.C. R9-20-211](#)
- [A.A.C. R9-21-209](#)
- [AHCCCS/ADHS Contract](#)
- [ADHS/RBHA Contracts](#)
- [ADHS/T/RBHA IGAs](#)
- [AHCCCS Medical Policy Manual, Policy 940](#)
- [Section 3.4, Co-payments](#)
- [Section 3.7, Clinical Liaison](#)
- [Section 3.9, Intake, Assessment and Service Planning](#)

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[Section 3.11, General and Informed Consent to Treatment](#)

[Section 3.12, Advance Directives](#)

[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 7.4, Reporting of Incidents, Accidents and Deaths](#)

[Section 7.5, Enrollment, Disenrollment and Other Data Submission](#)

4.2.3 Scope

To whom does this apply?

All providers contracting with a Tribal and Regional Behavioral Health Authority (T/RBHA) to provide services in Arizona's public behavioral health system.

4.2.4 Did you know...?

The behavioral health record is the property of the entity that generates the record.

Arizona Health Care Cost Containment System (AHCCCS) or its designee may inspect Title XIX and Title XXI behavioral health medical records at any time during regular business hours at the offices of ADHS/DBHS, the T/RBHAs, or behavioral health providers.

4.2.5 Objectives

To establish standards to ensure that each behavioral health record is complete, accurate, legible, and current.

4.2.6 Procedures

4.2.6-A. Paper or electronic format

Records may be documented in paper or electronic format.

For paper documentation the record must be:

Dated;

Signed with an original signature and credential;

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

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.

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](#)).

For electronic documentation, including email correspondence, there must be a method to:
Indicate the identity of the person making an entry into the record and the date for each entry;

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Ensure that the information is not altered inadvertently;

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

Maintain a backup system including initial and revised information.

4.2.6-B. Retention of records

A behavioral health provider must retain the original or copies of a person's medical records as follows:

For an adult, for at least six years after the last date the adult person received medical or health care services from the T/RBHA or behavioral health provider; and

For a child, either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from the T/RBHA or behavioral health provider, whichever occurs later.

4.2.6-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 person's primary care provider, the behavioral health record or copies of behavioral health record information must be forwarded within 10 days of the request.

ADHS shall ensure that each member is guaranteed the right to request and receive a copy of the member's medical record and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164.

4.2.6-D. Comprehensive clinical record

The designated Clinical Liaison must ensure the development and maintenance of a comprehensive clinical record for each enrolled person. 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 person. If changes in a person's Clinical Liaison occur, behavioral health providers must ensure that the person's comprehensive clinical record is transitioned to the new Clinical Liaison (See [Section 3.7, Clinical Liaison](#), and [Section 3.17, Transition of Persons](#)).

The comprehensive clinical record must contain the following elements:

- Documentation of Title XIX or Title XXI eligibility verification;
- Information (e.g., [PM Form 3.4.1, Non-Title XIX/XXI Co-payment Assessment](#)) regarding any co-payments assessed, if applicable (see [Section 3.4, Co-payments](#)).
- Contact information for the person's primary care provider (PCP), if applicable;

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- Identification information on each page of the record (i.e., person's name and identification number);
- Documentation of all information collected in the Behavioral Health Assessment, including the Core Assessment, any applicable addenda and required demographic information (see [Section 3.9, Intake, Assessment and Service Planning](#), and [Section 7.5, Enrollment, Disenrollment and Other Data Submission](#));
- An English version of the assessment and/or service plan if the documents are completed in Spanish;
- The person's treatment and service plan;
- Documentation, initialed and dated by the person's Clinical Liaison to signify review of:
 - Diagnostic information including psychiatric, psychological, and medical evaluations;
 - Reports from providers of services, consultations, and specialists;
 - Emergency/urgent care reports; and
 - Hospital discharge summaries.
- For persons receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews;
- Discharge summaries from previous behavioral health treatment;
- Progress notes;
- Email printed out;
- Documentation of person's receipt of the Member Handbook and receipt of Notice of Privacy Practice;
- Copies of any advance directives or mental health power of attorney as defined in [Section 3.12, Advance Directives](#), if applicable;
- 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](#);
- Authorization to disclose information pursuant to [Section 4.1, Disclosure of Behavioral Health Information](#);
- 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;

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- 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 person's health care;
- For persons receiving substance abuse treatment services under the Substance Abuse Prevention & Treatment Block Grant, documentation that notice was provided regarding the person's right to receive services from a provider to whose religious character the person does not object (See [Section 3.19, Special Populations](#));
- For persons 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;
- Documentation of Certification of Need and Re-Certification of Need (see [Section 3.14, Securing Services and Prior Authorization](#)), when applicable;
- Laboratory, x-ray, and other findings related to the person's behavioral health care;
- Medication record, when applicable;
- Documentation of any requests for and forwarding of behavioral health record information; 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 member.

4.2.6-E. Behavioral health provider records

Sometimes, a person may receive behavioral health services from multiple behavioral health providers. Behavioral health providers who are licensed through the Office of Behavioral Health Licensure (OBHL) must maintain a behavioral health record that meets the requirements of A.A.C. Title 9, Chapter 20 (see [A.A.C. R9-20-211](#)). In addition, OBHL licensed behavioral health provider records must include:

Periodic summary of the person's progress towards treatment goals;

Physician and practitioner orders for the service;

Applicable diagnostic or evaluation documentation;

Signature/initials of the provider for each service;

Documentation of adherence to reporting requirements;

- For OBHL 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](#)):
 - Has been reported to AHCCCS and the Arizona Center for Disability Law (ACDL);
 - A copy of the information sent to AHCCCS and ACDL; and

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- 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).

Progress notes including:

- Documentation of the type of services provided;
- The date the service was delivered;
- Duration of the service;
- A description of what occurred during the provision of the service related to the person's treatment plan;
- The person's response to service; and
- In the event that more than one provider simultaneously provides the same service to a behavioral health recipient:
 - Documentation of reasons for the involvement of multiple providers, including the names and roles of each provider involved in the service delivery; and
 - 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 person'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 person's comprehensive clinical record.

(T/RBHA insert specific information here)

4.2.6-F. Requirements for community service agencies, therapeutic foster care homes for children and habilitation providers

Community Service Agencies, Therapeutic Foster Care Homes for Children, and Habilitation providers must maintain a record of the services provided to behavioral health recipients. The minimum written requirement for each person's record must include:
The service provided and the time increment;

The date the service was provided;

The name of the person providing the service; and

A mechanism to track this information to the encounter, as well as to the person's comprehensive clinical record ([PM Form 4.2.1, Clinical Record Documentation Form](#), may be used as a mechanism to capture this information).

Each 30 days, a summary of the person's clinical progress must be transmitted from the Community Service Agency, the Therapeutic Foster Care Home for Children, or the Habilitation

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provider to the person's assigned Clinical Liaison. [PM Form 4.2.1, Clinical Record Documentation Form](#), may be used as monthly summary.