Chapter 5:
Quality Management

Review/Revised: 01/18, 01/19, 01/20, 06/20, 01/21, 12/21, 12/22, 02/23, 10/24, 01/25, 12/25

5.0 OVERVIEW

Blue Cross Blue Shield of Arizona Health Choice Pathway Quality Management/Performance Improvement (QM/PI) Program, under the leadership of the Chief Medical Officer and/or Medical Director(s), with the Quality Management Committee, provides the framework for a systematic and organization-wide approach for quality-of-care measurement, evaluation and improvement. Activities are planned in accordance with the goals of Health Choice and all applicable regulatory agencies. (NCQA HPA 2025, MA 20A, MA 20B; MA 17A, MA 17B)

The purpose of the QM/PI Program is to continuously improve care and service outcomes to meet the needs/expectations of Health Choice beneficiary's/beneficiaries and their providers while fulfilling all regulatory and contractual requirements. The QM/PI Program encompasses all Health Choice departments, primary care providers, advance practice practitioners, ancillary services, behavioral health, extended care and acute care facilities.

All referrals of potential quality of care issues are investigated within the Health Choice QM Department under the direction of the Health Choice Quality Management Director in collaboration with the Chief Medical Officer and/or Medical Director(s), and oversight by the Quality Management Committee. A possible quality of care incident can involve a facility, staff member, a physician, or another entity providing a health care service to the member. All cases referred to the QM Department are investigated and reviewed for potential quality issues. Cases are assigned a severity level and tracked for trending purposes. Reported potential quality of care concerns or service issues may require additional evaluations/reviews.

The Health Choice Quality Management Department also processes and retains records of complaints from beneficiaries and providers that may not be directly related to quality of care. These complaints are evaluated and trended as indicated per Health Choice Policy and Procedure.

The Health Choice Quality Management/Performance Improvement Committee (QMPIC), chaired by the Health Choice Chief Medical Officer/Medical Director, provides oversight for the QM/PI Program and is responsible for the quality of care and peer review functions. Non-staff contracted network physicians, representing a variety of medical specialties, advise the Committee through the Community Practitioner Advisory Committee (CPAC) and are appointed by the Chief Medical Officer/Medical Director. If a provider issue is investigated by the QMPIC, and that particular specialty is not represented within the Committee, the Chief Medical Officer/Medical Director may consult on an ad hoc basis with a peer from that specialty.

All contracted Health Choice providers are required to undergo initial credentialing and are recredentialed at least every thirty-six (36) months. Credentialing and recredentialing requirements are detailed in Chapter 3 of this manual.

Health Choice encourages communication between the Health Plan and Provider regarding quality-of-care issues or concerns. Issues may involve specific patient cases or systems problems, which can impact patient care. Concerns may be communicated directly to the QM Department or Chief Medical Officer/Medical Director. All information is confidential and is peer-protected.

5.1 PEER REVIEW

The formal peer review process at Health Choice is accomplished by evaluating the clinical activities and qualifications of practitioners and providers through the efforts of the QM Department. This confidential process is pursuant to A.R.S. 36-2401 et seq. and 36-2917 ("Arizona Peer Review Laws"). (NCQA HPA 2025, MA 9D). The Peer Review Committee scope includes treatment concerns where this is suspected issues below the standard of care.

Peer Review activities and considered Quality assurance activities and are therefore protected from discovery in legal proceedings. If an adverse action is taken against a provider as a result of the peer review process, the provider has the right to appeal through the administrative process described in § A.R.S. 41-1092, et seq. The Peer Review and Appeals policy is distributed to providers in the event of a for cause termination. This policy is also made available to providers upon request (NCQA HPA 2025, CR 6A-2). Providers denied initial credentialing for participation in the Health Choice network are not granted a right to an appeal.

If you are interested in participating in the Peer Review Committee, please call the Director of Quality Management at (928) 214-2208.

This process, in summary, contains the following provisions:

- The Health Choice Chief Medical Officer/Medical Director and/or QM Director will review all issues referred to the QM department, and the issue may be referred to the Peer Review Committee if the care involved is questioned and had potential to harm or did harm the member. If a provider in the same medical specialty is not represented on the Committee, the Health Choice Chief Medical Officer/Medical Director and/or the Committee may secure an ad hoc consultation and participation in the investigation from a provider of the same specialty if necessary.
- If the Peer Review Committee determines, after initial review of all available information regarding a referred Quality of Care concern, that further information is needed, the Committee may invite the provider for a formal interview to obtain the provider's perspective on the case and/or send the provider a letter of inquiry.

The Peer Review Committee may take one or more of several possible actions:

- It may impose concurrent or retrospective review of care for specified periods of time, or

a Provider Focused Review.

- It may recommend focused informal education for the provider, communicated by Health Choice staff.
- It may recommend formal CME requirements.
- It may recommend limitation of privileges, or termination of privileges.

5.2 PERFORMANCE MEASURES

As a health plan serving Medicare beneficiaries, Blue Cross Blue Shield of Arizona Health Choice Pathway HMO is held accountable to the Centers for Medicare and Medicaid Services (CMS) to meet performance outcomes, as identified in Part C and Part D Star Ratings. Practitioner and provider performance data is used to monitor performance and close gaps across all domains of care. Both practitioners and providers agree to participate in quality improvement activities as per their contractual agreement with Health Choice Pathway.

The Star Ratings are made up of several domains, including Staying Healthy: Screenings, Tests and Vaccines, Managing Chronic Conditions, and Beneficiary Experience, to name a few.

The Star Ratings are also based on several sources of data and information, including but not limited to: HEDIS®, CAHPS®, Health Outcome Survey, and Patient Safety, all which will be explained below.

5.3 HEDIS®: THE HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

The **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et (HEDIS) is the most widely used set of performance measures in the managed care industry. HEDIS® is designed to ensure that purchasers, regulators and consumers have the information they need to reliably compare the performance of managed care plans. The performance measures in HEDIS® are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA) with funding from CMS for the Medicare related measures.

HEDIS Measures included in the Star Ratings:

CMS Star Rating Measures (Targeted Measure Performance)
Breast Cancer Screening
Colorectal Cancer Screening
Care for Older Adults – Medication Review
Care for Older Adults – Pain Assessment
Osteoporosis Management in Women who had a Fracture
Diabetes Care – Eye Exam
Diabetes Care – Blood Sugar Controlled
Kidney Health Evaluation for Patients with Diabetes
Controlling Blood Pressure

Controlling Blood Pressure
Medication Reconciliation Post-Discharge
Statin Therapy for Patients with Cardiovascular Disease

5.4 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®)

CMS is committed to measuring and reporting information from the consumer perspective for Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) contracts. The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are a set of surveys that provide information to Medicare beneficiaries on the quality of health services provided through MA and Medicare Part D programs. Consumer evaluations of health care and prescription drug services, such as those collected through the Medicare CAHPS® surveys, measure important aspects of a patient's experience that cannot be assessed by other means.

The Medicare CAHPS® surveys produce data on the patient's experience of care on domains that are important to consumers, including: Your Health Plan, Your Healthcare in the Last 6 Months, Your Personal Doctor, Getting Healthcare from Specialists, Coordination of Care, Your Medicare Rights, Your Prescription Drug Plan, and About You.

Star Ratings include CAHPS® questions related to:

- Obtaining an Annual Flu Vaccine
- Overall Rating of Health Care Quality
- Getting Needed Care
  - *In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?*
  - *In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?*
- Getting Appointments and Care Quickly
  - *In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?*
  - *In the last 6 months, how often did you get an appointment for a checkup or routine care as soon as you needed?*
  - *Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?*
- Care Coordination
  - *When you talked with your personal doctor during a scheduled appointment, how often did he/she have your medical records or other information about your care?*
  - *When your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?*
  - *When your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?*

- *How often did you and your personal doctor talk about all the prescription medicines you were taking?*
- *Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?*
- *How often did your personal doctor seem informed and up-to-date about the care you got from specialists?*

5.5 HEALTH OUTCOMES SURVEY (HOS)

Each spring, a random sample of Medicare beneficiaries is surveyed using the Health Outcomes Survey (HOS) that includes three HEDIS Effectiveness of Care and two functional health measures.

The HEDIS Effectiveness of Care measures use a series of questions that ask Medicare members about information and care they receive from their health care providers regarding the following:

- *Treatment of Urinary Incontinence*: Percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who discussed treatment options for their urinary incontinence with a health care provider.
- *Advising Physical Activity*: Percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase, or maintain their level of exercise or physical activity.
- *Managing Fall Risk*: Percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

The functional health measures the change in physical and mental health status at the beginning and again at the end of a 2-year period for the same survey respondents to assess if beneficiaries' physical and mental health was the same, better or worse than expected between the baseline survey and the subsequent re-measurement. The survey questions for the Improving or Maintaining Physical/Mental Health measures are derived from the Veterans RAND 12-Item Health Survey (VR-12).

5.6 PATIENT SAFETY

Performance and quality measures are used by CMS so that Medicare beneficiaries have the information necessary to make informed enrollment decisions by comparing available health and prescription drug plans.

As part of this effort, CMS currently calculates and publicizes eight patient safety measures:

- High Risk Medication (HRM)**
- Diabetes Treatment (DT)**

- Drug-Drug Interaction (DDI)
- Diabetes Medication Dosage (DMD)
- Adherence (ADH) for four therapeutic areas
    - Diabetes**,
    - Hypertension**,
    - Cholesterol**,
    - HIV/AIDS

** Impact Stars Ratings

5.7 MEDICAL RECORD REQUESTS

Each year, Blue Cross Blue Shield of Arizona Health Choice Pathway HMO participates in an audit of the data collected for HEDIS measures that make up part of our Star Rating. We rely on participation from our partners and providers to have a successful audit.

Health Choice Pathway HMO has developed a medical records retrieval team to perform HEDIS® medical record data abstraction. It is important that you know our record retrieval specialists serve Health Choice Pathway HMO in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA).

As defined by HIPAA, our specialist's role is of "Covered Entities," and as such, our specialists are ethically and legally bound to protect, preserve, and maintain the confidentiality of any Protected Health Information (PHI) it gleans from clinical records provided by medical practice locations pursuant to its contractual obligations to Health Choice Pathway HMO. In this setting, you may be assured that Health Choice will treat your patients' PHI with the appropriate level of protection and confidentiality.

The HEDIS® medical record data abstraction process will begin in late February or early March. Prior to conducting an onsite review, one of our specialists will contact your office to schedule a visit and subsequently distribute information about the scheduled visit to explain its data abstraction process. Specialists may also request that copies of chart components be sent via mail, fax or provider portal for off-site review.

Your cooperation in extending Health Choice to your professional courtesy is very much appreciated. If you have questions or concerns about any component of this process, please contact us at (480) 760-4800.

We thank you for partnering with us to improve the health of individuals, families, and communities.

5.8 PRIVACY

Blue Cross Blue Shield of Arizona Health Choice Pathway HMO appreciates the diligence of provider office staff in following protocol and protecting patient health information. Below are references to the disclosure and permitted use of such information for healthcare operations, including activities related to quality assessment and improvement.

In 45 CFR 164.502 (a)(1)(ii) Uses and Disclosures of Protected Health Information: general rules include permitted uses and disclosures for the treatment, payment or health care operations, as permitted by and in compliance with §164.506.

In 45 CFR 164.506 (c)(4), the Privacy Rule states:

> *"A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is for a purpose listed in paragraph (1) or (2) of the definition of health care operations."*

In 45 CFR 164.501, Definitions, Health Care Operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions: (1) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines…"

5.9 DISEASE BURDEN MANAGEMENT (Hierarchical Condition Category or HCC)

Blue Cross Blue Shield of Arizona Health Choice will be working with our providers to improve the documentation and coding for our Medicare beneficiaries. Medicare requires appropriate condition coding (ICD-10), to the highest level of specificity.

Through proper documentation and coding, your patients' medical conditions can be better understood and managed by all providers who serve them.

Health Choice has multiple initiatives aimed at reducing coding errors, improving documentation practices, and advancing continuity of care, including:

- Monthly "Tips and Tricks" publications
- Coding quick reference guide
- Comprehensive Health Evaluations
- Clinical documentation improvement consultations
- Annual chronic condition management program
- Continuing Medical Education (CME) offerings

5.10 MEDICAL RECORD STANDARDS (NCQA HPA 2025, MA 16)

Providers are required to maintain medical records in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and which facilitates an adequate system for follow-up treatment. The provider must ensure that records are accessible to authorized persons only. Medical records must be available to Health Choice and AHCCCS for purposes of quality review or other administrative requirements, free of charge to Health Choice and any vendor Health Choice delegates to for the purposes of Medical Record Reviews.

> *A.R.S. 32-1401(2) defines adequate medical records as "legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warning provided to the patient and to provide for another practitioner to assume continuity of the patients care at any point in the course of treatment."*

Health Choice has aligned efforts under the Arizona Association of Health Plans (AzAHP) to conduct an Ambulatory Medical Record Review (AMRR). AzAHP uses a collaborative approach to reduce the burden to your office by decreasing the number of parties requesting medical records. These reviews are completed in accordance with the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM), Chapter 900 – Quality Management and Performance Improvement Program related to on-going monitoring of medical records for contracted Pediatricians, Primary Care Physicians (PCPs), and Obstetrician/Gynecologists (OB/GYNs).

The medical record/chart review will consist of, but will not be limited to, reviewing compliance related to the following areas:

- General Medical Record Documentation
- Medical/Social History/Medical Management
- Health Maintenance (Laboratory/Diagnostic Studies)
- Behavioral Health
- Family Planning
- Perinatal and Postpartum Depression Screenings

Medical record reviews are required every three years. We request your assistance in securing the medical records necessary to complete this review. As outlined in existing contracts with the Health Plans, providers are required to provide a copy of medical records within specified timeframes and at no charge to the Health Plan. It is important that you work collaboratively with the Health Plan in providing the requested records when contacted to avoid jeopardizing your status with one or more of the Health Plans.

Should you use a vendor that provides copies of your medical records, such as HealthPort, please provide notification to them of your requirement to provide records to the health plans, at no cost.

Please advise them of the following AHCCCS requirement and Arizona Administrative Code:

AHCCCS contracted providers are required to furnish copies of medical records to an AHCCCS contractor free of charge. According to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rules (CFR 164) health care providers are permitted to disclose protected health information for the purposes of treatment, payment and/or healthcare operations without authorization from the member. Health plans receive these records for official purposes directly related to its operations as an AHCCCS contractor.

Federal and State Legal Reference:

AHCCCS states: under Arizona Administrative Code R9-22-512 (E)

A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

All information in the medical record and information received from other providers must be kept confidential. Per AHCCCS requirements, when a member changes PCPs, his or her medical records or copies of the medical records must be forwarded to the new PCP within 10 working days of receipt of a properly executed request for the medical records.

Health Choice supports the AHCCCS, URAC, and NCQA medical record standards. These are the minimum standards acceptable for medical record documentation within Health Choice's contracted network of primary care physicians, primary care obstetricians, and high- volume specialists.

Primary Care Providers (PCPs) must maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical 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.

PCPs are further required to ensure the medical record documents provider referrals to other providers, coordination of care with other providers, and transfer of care to behavioral health providers, as appropriate, make certain the medical record is legible, kept up to date, 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.

Health education, preventive services recommendations and wellness counseling should be clearly noted and incorporated in the progress notes or in a designated section of the medical records. These services should be documented as applicable:

- Annual Well Visit
- Date of last cervical cancer screening
- Date of mammogram screening
- Prostate screening

- Alcohol, smoking, or substance abuse assessment and treatment recommendations
- Exercise recommendation
- Nutritional status body mass index (BMI) and weight deviations from normal
- Immunizations
- Family planning counseling
- Children Dental Visit
- Colorectal Cancer Screening
- Diabetic Eye Exam
- Diabetic Blood Sugar Control
- Diabetic Monitoring for Nephropathy
- Medication Adherence
- When to use the ED or urgent care Medication Review (Reconciliation)
- Osteoporosis Management in Women with Prior Fractures

PCPs must maintain a comprehensive record that incorporates at least the following components:

- 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.
- Member identification information on each page of the medical record (i.e.name or AHCCCS identification number).
- 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.
- 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).
- 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.
- Immunization records (required for children; recommended for adult members if available.
- Dental history, if available, and current dental needs and/or services.
- Current problem list
- Current medications
- Current and complete EPSDT forms (required for all members age 0 through 20 years).
- Documentation, initialed by the member's provider, to signify review of:
    - Diagnostic information including:
    - Laboratory tests and screenings,
    - Radiology reports,

    - Physical examinations notes, and
    - Other pertinent data
    - Reports from referrals, consultations, and specialists,
    - Emergency/urgent care reports.
    - Hospital discharge summaries,
    - 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.
- Behavioral health history and information.
- Documentation as to whether an adult member has completed advance directives and location of the document.
- Documentation that the provider responds to behavioral health provider information request 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.
- Documentation related to requests for release of information and subsequent releases.
- 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.
- Obstetric providers must 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 Gynecologist [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.
- Ensure that PCPs utilize AHCCCS approved developmental screening tools.
- Organization provider services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation etc.) maintain a record of services provided to the member including:
    - Physician or provider orders for the service,
    - Applicable diagnostic or evaluation documentation,
    - A plan of treatment,
    - Periodic summary of the member's progress toward treatment goals,
    - The date and description of service modalities provided, and
    - Signature/initials of the provider for each service
- Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
- Must have an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified.
- 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 professionals provide services.

Medical records may be documented on paper or in an electronic format.

- 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 of each entry.
- If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape is not allowed.
- If kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.
- If revisions to information are made, a system must be in place to track when, and by whom they are made. In addition, a back-up system, including initial and revised information, must be maintained. 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.
- Documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.

The member:

- May review, request, and annually receive a copy, free of charge, of those portions of the Designated Record Set (DRS) that were generated by the provider
- May request that specific provider information isamended or corrected, and
- May not review, request, amend, correct, or receive a copy of the portions of the DRS that are prohibited from view under the Health Insurance Portability and Accountability Act (HIPAA)

AHCCCS and Blue Cross Blue Shield of Arizona Health Choice are not required to obtain written approval from a member before requesting the member DRS from a healthcare provider or any agency. For purposes

relating to treatment, payment, or health care operations, AHCCCS and Blue Cross Blue Shield of Arizona Health Choice may request sufficient copies of records necessary for administrative purposes, free of charge.

Written approval from the member is not required by the Primary Care Provider (PCP) when:

- Transmitting member records to a provider when services are rendered to the member through referral to a Contractor's subcontracted provider,
- Sharing treatment or diagnostic information with the member's Integrated Regional Behavioral Health Authority (Integrated RBHA) or Regional Behavioral Health Authority (RBHA) acting as a provider, or its contracted providers, if the member is receiving behavioral health services through the Integrated RBHA/RBHA system, or

- Sharing medical records with the member's health plans.

Information related to fraud and abuse against the AHCCCS program may be released to authorized officials in compliance with Federal and State statutes and rules.

ALL ORGANIZATIONAL PROVIDERS OF SERVICES

For example, hospitals, nursing facilities, rehabilitation clinics, transportation, etc. all maintain a record of the services provided to a member, including:

- Physician or provider orders for the service,
- Applicable diagnostic or evaluation documentation,
- A plan of treatment,
- Periodic summary of the member's progress toward treatment goals,
- The date and description of service modalities provided, and
- Signature/initials of the provider for each service.
- 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 paraprofessionals provide services.

TRANSPORTATION SERVICES DOCUMENTATION

- For providers that supply transportation services for recipients using employees (i.e., facility vans, drivers, etc.) the following documentation requirements apply:
    - Complete service provider's name and address;
    - Signature and credentials of the driver who provided the service;
    - Vehicle identification (car, van, wheelchair van, etc.);
    - Members' Arizona Health Care Cost Containment System (AHCCCS) identification number;
    - Date of service, including month day and year;
    - Address of pick-up site;
    - Address of drop off destination;
    - Odometer reading at pick up;
    - Odometer reading at drop off;
    - Type of trip – round trip or one way;
    - Escort (if any) must be identified by name and relationship to the member being transported; and
    - 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.
- 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 Policy 201, Covered Services for a list of elements recommended for documenting non- emergency transportation services.

- 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.

DISCLOSURE OF RECORDS

All medical records, data and information obtained, created, or collected by the provider related to member, including confidential information must be made available electronically to Health Choice, AHCCCS or any government agency upon request.

When a recipient changes his or her PCP, the provider must forward the member's medical record or copies of it to the new PCP within ten (10) business days from receipt of the request for transfer of the record.

Behavioral health records must be maintained as confidential and must only be disclosed according to the following provisions:

- When requested by a member's primary care provider (PCP) or the member's 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
- Health Choice and subcontracted providers must provide each member who makes a request one copy of his or her medical record free of charge annually.
- Health Choice 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.

Behavioral health records must contain the following elements:

- Intake paperwork documentation that includes:
  - For members receiving substance abuse treatment services under the Substance Abuse Block Grant (SABG), 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;
  - Documentation of recipient's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
  - Contact information for the member's PCP if applicable.
- Assessment documentation that includes:

- Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information
- Diagnostic information including psychiatric, psychological, and medical evaluations
- Copies of Notification of Persons in Need of Special Assistance
- An English version of the assessment and/or service plan if the documents are completed in any other language other than English; and
- For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.

- Treatment and service plans documentation that includes:
  - The recipient's treatment and service plan;
  - Child and Family Team (CFT) documentation;
  - Adult Recovery Team (ART) documentation; and
  - Progress reports or service plans from all other additional service providers.
- Progress notes documentation that includes:
  - Documentation of the type of services provided;
  - 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;
- The date the service was delivered;
  - Duration of the service (time increments) including the code used for billing the service;
  - A description of what occurred during the provision of the service related to the recipient's treatment plan;
  - 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;
  - The recipient's response to service; and
  - For recipients 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 member's physical and behavioral health care;
  - The member's treatment plan related to medical services;
  - Physician orders;
  - Requests for service authorizations;
  - Documentation of facility-based or inpatient care;

- Documentation of preventative care services;
- Medication record, when applicable;
- Documentation of psychotropic and antipsychotic medication assessment by the Behavioral Health Medical Professional prior to prescribing or providing the medication; and
- Documentation of Certification of Need (CON) and Re-Certification of Need (RON when applicable.

- Reports from other agencies that include:
  - Reports from providers of services, consultations, and specialists;
  - Emergency/urgent care reports; and
  - Hospital discharge summaries.
- Paper or electronic correspondence that includes:
  - Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management of the recipient's health care;
  - Documentation of any requests for and forwarding behavioral health record information.
- Financial documentation that includes:
  - Documentation of the results of a completed Title XIX/XXI screening.
  - Information regarding establishment of any copayments assessed, if applicable.
- Legal documentation including;
  - Documentation related to requests for release of information and subsequent releases
  - Copies of any advance directives or mental health care power of attorney as defined the Advance Directives section of this Chapter, including:
    - Documentation that the adult person was provided the information on advance directives and whether an advance directive was executed
    - 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;
    - 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
    - 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.
- Providers who are making a referral must transmit necessary information to the provider receiving the referral.

- A provider furnishing a referral service reports appropriate information to the referring provider.
- Providers request information from other treating providers as necessary to provide appropriate and timely care.
- Information about services provided to a member by a non-network provider (i.e., emergency services, etc.) is transmitted to the member's PCP.
- Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.
- The service plan must be sent to all the non-behavioral health home service providers on the plan within 7 days of completion. For additional assistance with receiving a copy of the service plan, please contact Member Services.

Providers must retain the original or copies of member medical records as follows:

- For an adult, for at least six (6) years after the last date the adult member received medical or health care services from the provider; or
- 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 adult member received medical or health care services from the provider, whichever occurs later.

The maintenance and access to the member's medical record shall survive the termination of a Provider's contract with Health Choice, regardless of the cause of the termination. Federal and state law allows for the transfer of behavioral health medical records from one provider to another, without obtaining the member'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.

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 relate to 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.

REQUIREMENTS FOR COMMUNITY SERVICE AGENCIES (CSA), HOME CARE TRAINING TO HOME CARE CLIENT (HCTC) PROVIDERS AND HABILITATION PROVIDERS

- Health Choice requires that CSA, TFC Provider and Habilitation Provider clinical records to

the following standards. Each record entry must be: Dated and signed with credentials noted;

- Legible text, written in blue or black ink or typewritten; and
- Factual and correct.

If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.

CSAs, TFC 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:

- The service provided (including the code used for billing the service) and the time increment;
- Signature and the date the service was provided;
- The name title and credentials of the person providing the service;
- The recipient's CIS identification number and AHCCCS identification number;
- Health Choice conducts routine audits to 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
- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

Every thirty (30) days, a summary of the information required in this chapter must be transmitted from the CSA, HCTC Provider, or Habilitation Provider to the recipient's clinical team for inclusion in the comprehensive clinical record.