Section 4.2 - Medical Record Standards

4.2.1 Introduction
The medical record contains clinical information pertaining to a behavioral health/integrated care recipient. The information assists providers in successfully treating and supporting recipients. Maintaining current, accurate, and comprehensive medical records is important for many reasons. Documentation in the 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 kept in a legible, detailed, organized and comprehensive manner and must remain confidential and accessible and in accordance with applicable law to authorized persons only. Behavioral health medical records must also be accurate and reflect a behavioral health member’s behavioral health status, changes in behavioral health status, and reflect all behavioral health care needs and services provided.

Arizona Health Care Cost Containment System (AHCCCS), ADHS/DBHS and federal and state authorities establish the standards to guide providers in ensuring the proper organization, content, maintenance and retention of medical records.

4.2.2 Scope
This applies to all providers contracting with Mercy Maricopa Integrated Care (Mercy Maricopa) to provide behavioral health and medical services.
The medical record is the property of the entity that generates the record.

AHCCCS or its designee may inspect Title XIX and Title XXI medical records at any time during regular business hours at the offices of ADHS/DBHS, Mercy Maricopa, or provider.

The Department of Economic Security, Division of Developmental Disabilities (DES/DDD) or its designee may inspect the medical records of their enrolled Title XIX, Title XXI, and DES/DDD Arizona Long Term Care Services (ATLCS) recipients at any time during regular business hours at the offices of ADHS/DBHS, Mercy Maricopa, or providers.

### 4.2.3 Terms


The following terms are referenced in this section:

- Assessment
- Behavioral Health Status
- Certification of Need (CON)
- Community Service Agency (CSA)
- General Consent
- Habilitation Provider
- Home Care Training to Home Care Client (HCTC) Provider
- Informed Consent
- Medical Records
- Recertification of Need (RON)
- Telemedicine
- Treatment

### 4.2.4 Objectives

To outline requirements for subcontracted providers related to the maintenance of medical records, which are documented accurately, timely, are readily accessible and permit prompt and systematic retrieval of information while maintaining confidentiality.

To ensure that medical records document the delivery of medically necessary services and that each medical record is complete, accurate, legible, and current by establishing consistent standards for providers.

### 4.2.5 Procedures

Subcontracted service providers are required to create and maintain ownership of a medical record when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member’s medical record as soon as one is established. Subcontracted providers 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;
4.2.5-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;
- 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
- 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.

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

Providers that use electronic medical records and documentation must require that:
- Safeguards are in use to prevent unauthorized access;
- The date and time of an entry in a medical record is recorded by the computer’s internal clock;
- The record is recorded only by personnel authorized to make entries using provider established policies and procedures;
- The record indicates the identity of the person making an entry; and
- 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:
  - 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.

4.2.5-B. 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 Mercy Maricopa, AHCCCS or any government agency upon request.

Subcontracted providers must provide each recipient who requests one copy of his or her medical record free of charge annually and review the member’s request to amend or correct
the medical record, as specified in 45 CFR part 164 and applicable state law.

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.

Subcontracted providers must provide ADHS/DBHS and Mercy Maricopa access to all recipients’ medical records whether electronic or paper format within the timeframe specified by ADHS/DBHS and/or Mercy Maricopa.

Subcontracted providers must comply with federal and state confidentiality statutes, rules and regulations to protect medical records and any other personal health information that may identify a particular member or subset of members.

Subcontracted providers must release the recipient’s medical records as directed by Mercy Maricopa without written approval of the member, if the reason for such request is directly related to the administration of service delivery.

Subcontracted providers must release information as directed by Mercy Maricopa related to fraud and abuse so long as protected HIV-related information is not disclosed (A.R.S. §36-664).

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 which contains information regarding the review of behavioral health medical records by behavioral health members.

When requested by a member’s primary care provider or the member’s 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. (Please refer to PM Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, for more information).

Mercy Maricopa 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.

4.2.5-C. Medical comprehensive clinical record
The provider serves as the member’s “medical home” and is responsible for providing quality health care, coordinating all other medically necessary services and documenting such services in the member’s medical record including behavioral health information. The member’s medical record must be kept in a legible, detailed, organized and comprehensive manner and
must remain confidential and accessible and in accordance with applicable law to authorized persons only. The medical record will comply with all customary medical practice, Government Sponsor directives, applicable Federal and state laws and accreditation standards.

**Access to Information and 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 Mercy Maricopa, ADHS/DBHS, AHCCCS or any government agency upon request. Medical records necessary for the payment of claims must be made available to Mercy Maricopa within fourteen (14) days of request. Clinical documentation related to payment incentives and outcomes, including all pay for performance data will be made available to Mercy Maricopa or any government entity upon request. Mercy Maricopa may request medical records for the purpose of transitioning a member to a new health plan or provider. The medical record will be made available free of charge to Mercy Maricopa for these purposes.

- Each member is entitled to one copy of his or her medical record free of charge. Members have the right to amend or correct medical records. The record must be supplied to the member within fourteen (14) days of the receipt of the request.
- All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements. The following requirements are taken directly from the AHCCCS Medical Policy Manual 940.1:
  - 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 presenting concerns
  - Current medications
  - Current and complete EPSDT forms (required for all members age 0 through 20 years)
  - Documentation, initialed by the member's PCP, to signify review of diagnostic information including:
    - Laboratory tests and screenings
- Radiology reports
- Physical examination notes, and
- Other pertinent data.
  - Reports from referrals, consultations and specialists
  - Documentation that reflects assessments, requests, referrals and issuance of medically necessary medical supplies, durable medical equipment and orthotic/prosthetic devices.
  - 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
  - Documentation as to whether or not an adult member has completed advance directives and location of the document
  - Documentation related to requests for release of information and subsequent releases and
  - Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member’s health care.

**Medical Record Maintenance**
The provider must maintain member information and records for the longer of six (6) years after the last date provider services were provided to Member, or the period required by applicable law or Government Sponsor directions. The maintenance and access to the member medical record shall survive the termination of a Provider’s contract with Mercy Maricopa, regardless of the cause of the termination.

**PCP Medication Management and Care Coordination with Behavioral Health Providers**
When a PCP has initiated medical management services for a member to treat depression, anxiety, and/or ADD/ADHD, and it is subsequently determined by the PCP or Mercy Maricopa that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, Mercy Maricopa will require and 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.

**Medical Record Audits**
Mercy Maricopa will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when Mercy Maricopa is responding
to an inquiry on behalf of a member or provider, administrative responsibilities quality of care issues, and/or DBHS monitoring and validation audits. Providers must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available to AHCCCS/DBHS for quality review upon request. Mercy Maricopa shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions.

**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:
- Complete service provider’s name and address;
- Name signature and credentials of the driver who provided the service;
- Vehicle identification (car, van, wheelchair van, etc.);
- Member’s’ AHCCCS ID number;
- Complete date of service, including month day and year;
- Complete address of pick up site;
- Complete 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/care giver, verifying services were rendered.

**4.2.5-D. Behavioral Health 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, should contain all information contributed by any other service providers involved with the care and treatment of a recipient.

The comprehensive clinical record must include the following:
- Identification information on each page of the record (i.e., recipient’s name and AHCCCS /CIS identification number);
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;

Initial history for the member that includes family medical/behavioral health history, social history and laboratory screenings;

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;

Current presenting concerns; and

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. Mercy Maricopa in conjunction with ADHS/DBHS 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 (PM Section 3.19 Special Populations);
- Documentation of recipient’s receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
- Contact information for the recipient’s primary care provider (PCP).

**Financial**

- Documentation of the results of a completed initial Title XIX/XXI screening, annual screening and screening conducted when a significant change occurs using the Health-e-Arizona Plus on-line module in a person’s financial status; and
- Information regarding establishment of any co-payments assessed, if applicable (see Section 3.4 Co-payments).

**Legal**

- 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 in PM Section 3.12 Advance Directives, if applicable including:
- 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;
- 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; and

- 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 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;
- 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);
- 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; and
- Copies of any order for guardianship and letters of acceptance.

Assessments

- Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see PM Section 3.3 Referral and Intake Process, PM Section 3.9 Assessment and Service Planning, and PM Section 7.5 Enrollment, Disenrollment and Other Data Submission);
- Documentation of all information collected in the annual update to the behavioral health assessment including any applicable addenda and updated demographic information.
- Diagnostic information including psychiatric, psychological and medical evaluations;
- Copies of PM Form 5.4.1 Notification of Persons in Need of Special Assistance (see PM Section 5.4 Special Assistance for Persons Determined to Have a Serious Mental Illness.
- An English version of the assessment and/or service plan if the documents are completed in Spanish; and
- For recipients receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.

Treatment and Service Plans

- The recipient’s treatment and service plan;
- Child and Family Team (CFT) documentation; and
- Adult Recovery Team (ART) documentation.

Progress Notes that include the following:

- 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. 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 ICD-9/DSM-IV 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;
- 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**
- Laboratory, x-ray, and other findings related to the recipient’s behavioral health and medical care;
- The recipient’s treatment plan related to medical services;
- Physician’s orders;
- Requests for service authorizations;
- Documentation of facility-based or inpatient care;
- Documentation of preventive care services;
- Medication record, when applicable; and
- Documentation of Certification of Need (CON) and Re-Certification of Need (RON), (see Section 3.14 Securing Services and Prior Authorization) when applicable.

**Reports from other agencies**
- Reports from providers of services, consultations, and specialists;
- Emergency/urgent care reports; and
- Hospital discharge summaries.

**Correspondence**
- 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;

- Documentation of any requests for and forwarding of behavioral health record information.

4.2.5-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 ADHS Division of Licensing Services (DLS) must maintain a behavioral health record that meets the requirements of A.A.C. R9-20-211. In addition, DLS licensed behavioral health provider records must include:

- A periodic summary of the recipient’s progress towards treatment goals;
- Physician and practitioner service orders;
- Applicable diagnostic or evaluation documentation;
- Signature/initials of the provider for each service;
- Documentation of adherence to reporting requirements;
- For licensed inpatient behavioral health 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,
  - 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:
  - Letters;
  - E-mails, printed out; and
  - 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;
  - The date the service was delivered;
  - Duration of the service;
  - A description of what occurred during the provision of the service related to the recipient’s treatment plan; and
  - The recipient’s response to service.

- 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 start/stop time for each service provided, consistent with the encounter submission for the service(s).
Information Forwarded to 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 4.2.5-C. 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 T/RBHA (see PM Section 3.17 Transition of Persons, for additional information on Inter-T/RBHA transfers) and/or provider, or Mercy Maricopa 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.

- **Written Authorization:** 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).

- **Information Sent to New Provider:** 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 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.

- **Retain of Original Records:** 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 4.2.5-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).

4.2.5-F. **Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers**

Mercy Maricopa requires that CSA, HCTC Provider and Habilitation Provider clinical records to the following standards. Each record entry must be:
Dated and signed with credentials noted;
Legible;
Typed or written in blue or black ink; 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, 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:

- 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;
- Mercy Maricopa 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.

**PM Form 4.2.1** is a recommended format that may be utilized to meet the requirements identified in this section.

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.

**4.2.5-G. 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 Mercy Maricopa 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 ADHS/DBHS and Mercy Maricopa, 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 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.

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 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 Mercy Maricopa.

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.

4.2.7-H. Retention of records
Providers must retain the original or copies of a recipient’s medical records as follows:
- For an adult, for at least six (6) years after the last date the adult recipient received medical or health care services from Mercy Maricopa or a provider; and
- 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 Mercy Maricopa or behavioral health provider, whichever occurs later.

4.2.7 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. R9-20-211  
A.A.C. R9-21-209  
AHCCCS/ADHS Contract ADHS/RBHA  
Contracts  
ADHS/TRBHA IGAs  
AHCCCS Medical Policy Manual, Policy 940  
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, Primary Care Providers and Medicare 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  
Section 7.4, Reporting of Incidents, Accidents and Deaths  
Section 7.5, Enrollment, Disenrollment and Other Data Submission  
ADHS/DBHS Policy and Procedure Manual Section MI 5.2 Community Service Agencies-Title XIX Certification