940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

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REFERENCES: A.R.S. §13-3620, 9 A.A.C. R9-10, 45, 9 A.A.C. 22-5, A.A.C. R9-22-503, 45 CFR 160, 162, and 164 ,42 CFR 431, 431.300 et seq., 438.2, 438.100(a)(1), 438.100(b)(2)(vi), 457.10, Part 2, 2.1-2.67, 42 U.S.C. §290 dd-2, Division Medical Manual Policy 320-O, 320-R, 410, AdSS Medical Manual Policy 940

PURPOSE

This policy applies to the Division of Developmental (Division) Service Providers. This policy establishes requirements for protection of Member information, documentation requirements for Member physical and behavioral health records, and specifies record review requirements including the use of Electronic Health Records (EHR) and external health information systems.

DEFINITIONS

1. "Adult Recovery Teams" or "ARTs" means A group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and

service delivery made up of the following people:

a. The Member;

b. The Member's Health Care Decision Maker (HCDM), if one is in place);

c. Any assigned advocates;

d. A qualified behavioral health representative; and

e. Other individuals identified by the Member or HCDM such as. he Member's family, physical health, behavioral health or social service providers, other agencies serving the Member, and professionals representing various areas of expertise related to the Member's needs.

2. "Arizona Association of Health Plans" or "AzAHP" means an organization dedicated to working with elected officials, AHCCCS Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans. AzAHP is involved in administration of the chart audit process for physical health plan sites and they collaborate with the contractors with regard

to the behavioral health chart audit process.

3. "Child and Family Teams" or "CFTs" means a group of individuals made up of the following people:

   a. The child and their family, orHCDM;

   b. A behavioral health representative, and

   c. Any individuals important in the child's life that are identified and invited to participate by the child and family.

4. "Designated Record Set" or "DRS" means a group of records maintained by the Provider that contain following:

   a. Medical and billing records maintained by the Provider;

   b. Case and medical management records; or

   c. Any other records used by the Provider to make medical decisions about the Member.

5. "Health Information Exchange" or "HIE" means the secure sharing of patient health information among authorized Providers.

   a. HIE is a process or action that can be facilitated by an HIO.

   b. HIE can also include the secure sharing of patient health information directly between providers .

6. "Health Information Organization" or "HIO" means an entity that facilitates the secure exchange of electronic patient health information between participating Providers .
7. "Medical Records" means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers, in both hard copy and electronic form. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 122291.
8. "Member" means the same as "Client" prescribed in A.R.S. § 36.551.
9. "Multi-Specialty Interdisciplinary Clinic" or " (MSIC") - An means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.
10. "Provider" means an individual or organization that contracts with the Division for the provision of covered services, or ordering or referring

for those services, to an eligible Division Member, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require Providers to maintain comprehensive documentation related to care and services provided to Members.
2. The Division shall ensure, via regular monitoring activities, that documentation completed and is maintained by the Providers meets the requirements specified in this policy.

B. MEDICAL RECORDS REQUIREMENTS

1. The Division shall required Providers to maintain the following in their Medical Records:
    a. Up to date, well organized and comprehensive documentation, with sufficient detail to promote effective Member care and ease of quality review.
    b. Documentation of the following identifying demographic:

i. The Member's name,

ii. Address,

iii. Telephone number,

iv. AHCCCS identification number,

v. Gender,

vi. Age,

vii. Date of birth,

x. Marital status,

xi. Next of kin,

xii. Parent, guardian, or healthcare decision maker , if applicable.

c. The following Member identification information on the first page of the medical record:

i. Member name,

ii. Member AHCCCS ID,

iii. Member date of birth.

d. Member name and either AHCCCS ID or member date of birth on the subsequent pages of the Medical Record.

e. The following past medical history:

i. Disabilities,

ii. Any previous illness or injuries,

iii. Smoking,

iv. Alcohol/substance use,

v. Allergies,

vi. Adverse reactions to medications,

vii. Hospitalizations, to include discharge summaries,

viii. Surgeries,

ix. Emergent/urgent care received,

x. Immunization records: required for children, recommended for adult Members if available.

2. The Division shall require Providers to do the following regarding Medical Records:

a. Hard copy Medical Records be written legibly in blue or black ink, signed, and dated by the rendering provider for each entry.

b. Electronic format Medical Records contain the name of the Provider who made the entry and the date for each entry.

c. If revisions to information are made, a system is in place to track when, and by whom the revisions are made.

d. That a back-up system is maintained that tracks initial and revised information.

e. That if a Medical Record is physically altered:

   i. The stricken information be identified as a correction and initialed by the rendering Provider altering the record, along with the date when the change was made;

   ii. That correction fluid or tape is not used;

   iii. If Medical Records are kept in an electronic file, the Provider must establish a method for indicating the author; date; and time of added and revised information.

   iv. Ensure that information is not inadvertently altered.

f. That Providers in multi-Provider offices must have the treating provider sign their treatment notes after each appointment and procedure and occurs as close to the actual entry of treatment notes as possible, based on

either professional standards of care/or requirements specified within 9 A.A.C. R9-10.

g. That evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances is documented in the Medical Record.

3. The Division shall require the Provider to document the following coordination of care activities when they occur:

a. Referrals to other Providers;

b. Transmission of the diagnostic, treatment, and disposition information related to a specific Member to the requesting Provider, as appropriate to promote continuity of care and quality management of the Member's health care;

c. Reports from referrals, consultations, and specialists for behavioral and physical health, as applicable;

d. Emergency and urgent care reports;

e. Hospital discharge summaries;

f. Transfer of care to other Providers;

g. Any notification when a Member's health status changes or new medications are prescribed;

h. Legal documentation that includes:

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

ii. Documentation of a Health Care Power of Attorney or documentation authorizing a Health Care Decision Maker, and

iii. Copies of any Advance Directives or Mental Health Care Power of Attorney as follows:

a) Documentation that the adult Member was provided the information on Advance Directives and whether an Advance Directive was executed, as specified in AdSS Medical Policy 640;

b) Documentation of general and informed consent to treatment, as specified in AdSS Medical Policy 320-Q; and

c) Authorization to disclose information.

4. The Division shall refer to AMPM Policy 710 for Medical Record information regarding Members who receive Medicaid direct services through their school system.

C. PRIMARY CARE PROVIDERS PHYSICAL HEALTH MEDICAL RECORD REQUIREMENTS

1. The Division shall require any Provider delivering primary care services to a Member and acting as their Primary Care Provider (PCP) to maintains a comprehensive record that incorporates the following components:

    a. Initial history and comprehensive physical examination findings for the Member that includes family medical history, social history and preventive laboratory screenings.

    b. For Members under age 21, the initial history of prenatal care and birth history of the Member's mother while pregnant with the Member, if known;

    c. Documentation of any requests for forwarding of behavioral health and other Medical Record information;

    d. Behavioral health history and information when received

from a TRBHA or other the behavioral health Provider involved with the Member's behavioral health care;

e. If the Provider has not yet seen the assigned Member, Medical information detailed in this subsection may be kept in an appropriately labeled file until associated with the Member's Medical Record as soon as the Medical Record is established;

f. Documentation, initialed by the Provider, to signify review of the following diagnostic information:

   i. Laboratory tests and screenings,

   ii. Radiology reports,

   iii. Physical examination notes,

   iv. Medications,

   v. Last Provider visit,

   vi. Recent hospitalizations, and

   vii. Other pertinent data to the Member's health conditions;

g. Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools;

h. Current and complete Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Tracking forms or an equivalent including, at minimum all data elements on the EPSDT Tracking Form for:

i. All Members age 0 through 20 years;

ii. Developmental screening tools for children ages nine, 18, and 24 months;

iii. Dental history if available, and current dental needs and services;

iv. Current problem list;

v. Current medications list;

vi. Documentation to reflect review of the CSPMP database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances; and

vii. Evidence that obstetric Providers complete a standardized, evidence-based risk assessment tool for obstetric Members as detailed in AdSS Medical Policy 410.

D. BEHAVIORAL HEALTH MEDICAL RECORD REQUIREMENTS

The Division shall require the following elements to be included in all behavioral health Medical Records:

a. Initial behavioral health evaluation containing the following:

i. Documentation of the Member's choice for receipt of the Member Handbook, either hard copy or electronic format;

ii. Receipt of Notice of Privacy Practice;

iii. Contact information for the Member's PCP;

iv. Financial documentation for Non-Title XIX/XXI Members receiving behavioral health services, as outlined in AMPM Policy 650 occuring at the following:

a) At the initial evaluation appointment,

b) When the Member has had a significant change in their income, and

c) At least annually.

b. Behavioral health assessment documentation consisting of:

i. Documentation of all information collected in the

behavioral health assessment and any applicable addenda and required demographic information;

ii. Diagnostic information including psychiatric, psychological, and physical health evaluations;

iii. Evaluation of the need for reporting as required under A.R.S. §13- 3620;

iv. Copies of documentation related to the need for special assistance, if applicable, as detailed in. AdSS Medical Policy 320-R; and

v. An English version of the behavioral health assessment, Service Plan, and Treatment Plan, when applicable, if the documents are completed in any language other than English.

c. Service Plan documentation that contains:

i. The Member's Service Plan or Treatment Plan, as applicable;

ii. CFT documentation, based on Member's age (0 to

18 or up to 21 should Member choose to continue with Child & Family team after turning 18);

iii. ARTs documentation for adults 18 and older ; and

iv. Progress Reports, Service Plans, or Treatment Plans from all other Providers, as applicable.

d. Progress note documentation that includes:

i. Documentation of the type of services provided;

ii. The diagnosis, containing an indicator that identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis;

iii. The progress note diagnosis code, if applicable;

iv. The date the service was delivered;

v. The date and time the progress note was signed;

vi. The signature of the staff that provided the service, including the staff Member's credentials;

v. Duration of the service (time increments);

vi. A description of what occurred during the provision of the service related to the Member's

Service Plan;

vii. Documentation of the need for the involvement of multiple Providers, including the name and roles of each Provider involved in the delivery of services, in the event that more than one Provider simultaneously provides the same service to a Member; and

viii. The Member's response to service.

e. The Notice of Extension (NOE) and any other documentation used for the processing of any applicable appeal that was sent to the Member and their legal guardian or authorized representative.

E. REQUIREMENTS FOR POLICIES AND PROCEDURES FOR ENSURING MEDICAL RECORD CONTENT

1. The Division shall implement and maintain policies and procedures to ensure that Providers have information required to monitor effective and continuous physical and behavioral health care for Members through accurate Medical Record documentation regardless of whether

records are hard copy or electronic via:

a. Onsite or electronic quality review;

b. Initial and on-going monitoring of Medical Records;

c. Review of health status, changes in health status, health care needs, and services provided;

d. Review of coordination of care activities;

e. Maintenance of a legible Medical Record for each Member who has been seen for physical and behavioral health appointments and procedures;

f. The Medical record shall also contain clinical records from other Providers who also provide care or/ services to the Member; and

g. Medical Record requirements for hard copy and electronic Medical Records.

2. The Division shall have policies and procedures in place that meet federal and state requirements including those related to security and privacy in accordance with 45 CFR 160, 162, and 164, 45 CFR 43142 CFR 431.300 et seq., and Medicaid Information Technology Architecture (MITA) for the use of

electronic Medical Records and for HIE via the state's HIO and digital (electronic) signatures that contain the following elements:

a. Signer authentication;

b. Message authentication;

c. Affirmative act (i.e. an approval function such as a signature which establishes the sense of having legally consummated a transaction);

d. Efficiency; and

e. Medical Record review.

3. The AdSS shall implement policies and procedures that:

a. Support Members' rights to request and receive a copy of their Medical Record at no cost and to request that the Medical Record be amended or corrected;

b. Ensure information from or copies of Medical Records are released only to the Member or their Health Care Decision Maker.

c. Ensure that unauthorized individuals cannot gain access to, or alter Member Medical Records;. and

d. Ensure Medical Records are maintained in a secure manner that maintains the integrity, accuracy, and confidentiality of Member medical information.

4. The Division shall have written policies and procedures addressing appropriate and confidential exchange of Member information among Providers.

5. The Division shall conduct reviews of Provider's policies and procedures to verify that they contain the following requirements:

   a. A Provider making a referral are to transmits necessary information to the Provider receiving the referral,

   b. A Provider furnishing a referral service reports appropriate information to the referring Provider,

   c. Providers request information from other treating Providers as necessary to provide appropriate and timely care, and

   d. Information about services provided to a Member by a non-network provider is transmitted to the Member's Provider:

e. Medical Records are transferred to the new Provider within 10 business days from receipt of the request for transfer of Medical Records to ensure continuity of care when a Member chooses a new Provider; and

f. Member information is shared when a Member enrolls with a new AdSS, in a manner that maintains confidentiality while promoting continuity of care.

F. METHODOLOGY FOR CONDUCTING MEDICAL RECORD REVIEW PROCESS

1. The Division shall require that the Medical Record audit process includes the Ambulatory Medical Record Review (AMRR) and the Behavioral Health Clinical Chart Audit.
2. The Division may, if they choose, utilize the AAzAHP to conduct Medical Record review and other Provider documentation review processes.
3. The Division shall utilize the following methodology when conducting a Medical Record review of Providers:
   a. Medical Record reviews using a standardized tool that has been reviewed by AHCCCS.

b. Review the following physical health records:

   i. EPSDT,

   ii. Family planning, and

   iii. Maternity components not otherwise monitored for Provider compliance by the Division.

c. Review the following elements of behavioral health Medical Records:

   i. Assessments; and

   ii. Service and treatment planning.

   iii. Ensure individual elements delineate which requirements pertain to:

      a) The unique needs of individual lines of business,

      b) The following special populations:

         1) General Mental Health/Substance Use (GMH/SU),

         2) Serious Mental Illness (SMI),

         3) Special Health Care Needs (SHCN),

4) Comprehensive Health Plan (CHP), or

5) Individuals receiving services under

d. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. At a minimum of every three years for physical health charts; and

ii. Yearly for behavioral health charts.

e. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. Conduct medical records reviews at a minimum of every three years for physical health charts (AMRR); and

ii. Yearly for behavioral health charts.

f. Use of AdSSThe Division staff with the appropriate licensure and experience necessary for completion of either clinical charts for behavioral health services or physical health services to conduct the Medical Record reviews.

i. The Division shall utilize licensed behavioral health professionals (BHPs) or behavioral health technicians (BHTs) with a minimum of three years' experience as a BHT and under the supervision of a BHP for behavioral health clinical chart audits; and

ii. The Division shall utilize a registered nurse (RN) or a licensed practical nurse (LPN) with current licensure under the Arizona State Board of Nursing for AMRR audits.

4. The Division shall make available the results of the Medical Record review to all contractors who utilize a consultant such as AzAHP, or in instances when multiple contractors share the same Provider for this process.
5. The Division shall share the deficiencies identified during a Medical Record review with all health plans contracted with the Provider.
6. If quality of care issues are identified during the Medical Record review process, the Division shall notify all

contractors which contract with the identified Provider within 24 hours of identification of the quality of care issue with specifics concerning the quality of care issue.

7. If the Division requests approval from AHCCCS to discontinue conducting the Medical Record reviews, the Division shall do the following prior to making the request:
   a. Conduct a comprehensive review the use of the Medical Record review process and how the process is used to document compliance with the Division and AHCCCS requirements;
   b. Document what processes will be used in place of the Medical Record review process to ensure compliance with the Division and AHCCCS requirements; and
   c. Submit the process the AdSS will utilize to ensure Provider compliance with the Division and AHCCCS Medical Record requirements to the AHCCCS/Quality Management/, Clinical Quality Management Administrator prior to discontinuing the Medical Record review process.
8. The Division shall include all PCPs that serve Members less

than 21 years of age and obstetricians/gynecologists in the AMRR process.

9. The Division shall review process shall consist of reviewing eight charts per practitioner and include the requirements specified in contract as a part of the AMRR.
10. The Division shall include in the behavioral health Medical Record review process:
    a. Behavioral Health Outpatient Clinics, and
    b. Integrated Health Homes and Federally Qualified Healthcare Centers (FQHCs) if they provide both behavioral health and physical health care.
11. The Division shall follow the medical review process for behavioral health records as specified in contract.
12. For changes in methodology or sampling, the Division shall submit to AHCCCS in advance for approval as specified in the contract.

G. MULTI-SPECIALTY INTEGRATED CLINIC

1. The Division shall implement written policies and procedures to require that MSICs have an integrated

electronic Medical Record for each Member that is served through the MSIC.

2. The Division shall require the MSIC's integrated electronic Medical Record:
   a. Be available, electronically through the HIE, for the multi-specialty treatment team and community Providers;
   b. Contains all information necessary to facilitate the coordination and quality of care delivered by multiple Providers in multiple locations at varying times; and
   c. For care coordination purposes, is shared with other care Providers, such as the multi-specialty interdisciplinary team.

H. COMMUNITY SERVICE AGENCY, THERAPEUTIC FOSTER CARE PROVIDERS, AND HABILITATION PROVIDER REQUIREMENTS

1. For Community Service Agencies (CSAs), Therapeutic Foster Care (TFC) Providers, and Habilitation Providers, the Divisions shall require that the Medical Records conform to the following standards:

a. Each record entry be:

1. Dated and signed with credentials noted;

2. Legible text, written in blue or black ink, or typewritten; and

3. Factual and correct.

2. If Medical Records are kept in more than one location, the Division shall require the agency Provider to:

a. Maintain documentation specifying the location of the Medical Records;

b. Maintain a Medical Record of the services delivered to each Member; and

c. Meet the following requirement for each Member's Medical Record:

i. The service provided and the time increment;

ii. Signature and the date the service was provided;

iii. The name, title, and credentials of the professional providing the service;

iv. The Member's Date of Birth and AHCCCS

identification number;

v. Documentation that services are reflected in the Member's Service Plan or Treatment Plan, as applicable;

vi. Maintain a copy of the Member's Service Plan or Treatment Plan, as applicable, in the Member's Medical Record; and

vii. Maintain a monthly summary of service documentation progress toward treatment goals.

d. The Division shall require Providers to transmit a summary of the monthly summary of service to the Member's clinical team for inclusion in the comprehensive Medical Record.

I. DESIGNATED RECORD SET

1. The Division shall treat the DRS as the property of the Provider who generates the DRS.
2. The Division shall require that Providers allow Members to:
   a. Review, request, and annually receive a copy, free of charge, of those portions of the DRS generated

by the Provider;

b. Request that specific Provider information is amended or corrected; and

c. Not review, request, amend, correct, or receive a copy of the portions of the DRS that are prohibited from view under Health Insurance Portability and Accountability Act (HIPAA).

3. The Division shall provide sufficient copies of records necessary for administrative purposes to AHCCCS free of charge for purposes relating to treatment, payment, or health care operations.

4. The Division shall not require the PCP to obtain written approval from the Member when:

a. Transmitting Medical Records to a Provider when services are rendered to the Member through referral to a Division subcontracted Provider,

b. Sharing treatment or diagnostic information with the entity or entities responsible for or directly providing behavioral health services, or

c. Sharing Medical Records with the Member's AdSS.

5. The Division shall require AHCCCS-registered Providers to forward Medical Records or copies of Medical Record information related to a Member to the Member's PCP within 10 business days from receipt of a request from the Member or the Member's PCP.
6. The Division shall provide access to AHCCCS to all Medical Records, whether electronic or hard copy, within 20 business days of receipt of a request.
7. The Division shall release information related to fraud, waste, or abuse against the AHCCCS program to authorized officials in compliance with Federal and State statutes and rules.
8. The Division shall demonstrate evidence of professional and community standards and accepted and recognized evidence-based practice guidelines as specified inDivision Medical Manual Chapter 500.
9. The Division shall require Providers to have an implemented process to assess and improve the content, legibility, organization, and completeness of Medical Records when

concerns are identified with the Providers Medical Records.

10. The Division shall require documentation in the Medical 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.

J. LEGAL REQUIREMENTS FOR RECORD MAINTENANCE

1. Consistent with 9 A.A.C. 22, Article 5, the Division, and Providers, and non-contracted entities providing services to Members shall safeguard the privacy of Medical Records and information about Members who request or receive services from AHCCCS or its contractors.
2. The Division shall require that tThe content of any Medical Record be disclosed in accordance with the prior written consent of the Member with respect to whom such record is maintained as allowed under regulations prescribed pursuant to 42 U.S.C. §290 dd-2 (confidentiality of records), 42 CFR Part 2, 2.1 – 2.67.
3. The Division shall release original and copies of Medical Records

shall only in accordance with Federal or State laws, and AHCCCS and Division policy and contracts.

4. The Division shall comply with HIPAA requirements and 42 CFR 431.300 et seq.
5. The Division shall align the Medical Records retention processes with AHCCCS and Division contract and TRBHA Intergovernmental Agreement (IGA) requirements.
6. The Division shall require that maintenance and access to Medical Records survive the termination of a Provider's contract regardless of the cause of termination.
7. The Division and Providers shall participate and cooperate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.
8. The Division shall encourage non-contracted entities that provide services to Members to cooperate and participate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.

K. UNITED STATES CORE DATA FOR INTEROPERABILITY

The Division shall incorporate United States Core Data for

Interoperability (USCDI) Data Elements as part of the DRS to facilitate the electronic exchange of an individual's Medical Record data as requested by the individual.

Signature of Chief Medical Officer: Anthony Dekker (Aug 30, 2023 16:22 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

The requirements listed below are additional requirements under USCDI. The Division and AHCCCS strongly recommend these enhanced data elements be added to the existing Physical and Behavioral Health Medical Record requirements specified in this policy. Per the ONCs, disclosure of these additional data elements is subject to the confidentiality requirements of applicable state laws.

1. Medical Record requirements are applicable to both hard copy and electronic Medical Records. Medical Records may be documented on hard copy or in an electronic format. The AdSS' Providers shall include the following in their records:
2. Documentation of identifying demographics, including:

a. Any previous names by which the Member is known,

b. Previous address,

c. Telephone number with cell or home designation, and both if applicable,

d. Email address,

e. Birth sex,

f. Race,

g. Ethnicity, and

h. Preferred language.

3. For records relating to provision of behavioral health services, documentation including, but not limited to:

a. Behavioral health history,

b. Applicable assessments,

c. Service plans and/or treatment plans,

d. Crisis and/or safety plan,

e. Medication information if related to behavioral health diagnosis,

f. Medication informed consents, if applicable

g. Progress notes, and

h. General and/or informed consent.

4. Documentation, initialed by the Provider, to signify review of diagnostic information including vital signs data at each visit, to include:
    a. Body temperature,
    b. Diastolic and Systolic blood pressure,
    c. Body height and weight,
    d. BMI Percentile (two -20 years),
    e. Weight-for-length percentile (birth-36 months),
    f. Head occipital-frontal circumference percentile (birth-36 months),
    g. Heart rate and respiratory rate,
    h. Pulse oximetry,
    i. Inhaled oxygen concentration, and
    j. Unique device identifier(s) for implantable device(s), as applicable.
5. For Inpatient Settings – Clinical Note Requirements:
    a. Consultation notes,
    b. Discharge and summary notes,
    c. History and physical,
    d. Imaging narrative,

e. Laboratory report narrative,

f. Pathology report narrative,

g. Procedure notes, and

h. Progress notes.