RECORD KEEPING

Providers should refer to the *Medicaid Services Manual*, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping. (http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf)

NOTE: For this section 9.6-Record Keeping, the term "provider" is used to refer to either the ADHC provider or the support coordination agency.

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Louisiana Department of Health's (LDH) administrative region where the recipient resides. The provider must have sufficient space, facilities and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the recipient served and the provision of services.

A separate record that supports justification for prior authorization and fully documents services for which payments have been made must be maintained on each recipient. The provider must maintain sufficient documentation to enable LDH or its designee to verify that prior to payment each charge is due and proper. The provider must make available all records that LDH or its designee, including the recipient's support coordination agency, finds necessary to determine compliance with any federal or state law, rule or regulation promulgated by LDH.

Retention of Records

The provider must retain administrative, personnel, and recipient records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six years).

NOTE: Upon provider closure, all records must be maintained according to applicable laws, regulations and the above record retention requirements and copies of the required documents transferred to the new provider.

Confidentiality and Protection of Records

Records, including administrative and recipient, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the recipients or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the recipients or their families. The information may be released only under the following conditions:

- Court order;
- Recipient's written informed consent for release of information;
- Written consent of the individual to whom the recipient's rights have been devolved when the recipient has been declared legally incompetent; or
- Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

A provider must, upon request, make available information in the case records to the recipient or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the recipient, that information may be withheld from the recipient except under court order.

The provider may charge a reasonable fee for providing the above records. This fee cannot exceed the community's competitive copying rate.

A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.

Any electronic communication containing recipient specific identifying information sent by the provider to another provider or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Recipient records must be located at the enrolled site.

NOTE: Under no circumstances should providers allow staff to take recipient's case records from the ADHC center.

Review by State and Federal Agencies

Providers must make all administrative, personnel, and recipient records available to LDH or its designee and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of recipient information.

Recipient Records

Providers must have a separate written record for each recipient served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, support coordination agencies and service providers must have on-going adequate chronological documentation of services offered and provided to recipients they serve. See below for specific information regarding documentation of the following services:

SUPPORT COORDINATION/TRANSITION INTENSIVE SUPPORT COORDINATION SERVICES	
Monthly Contacts	Complete each calendar month at the time of the monthly monitoring contact, according to the Office of Aging and Adult Services (OAAS) documentation and data entry requirements.
Interim Contacts	Complete at the time of interim activities, according to OAAS documentation and data entry requirements.
Quarterly Contacts	Complete each calendar quarter at the time of the quarterly monitoring contact, according to OAAS documentation and data entry requirements.
Annual Contacts	Complete in the last month of the POC year at the time of the annual monitoring contact, according to OAAS documentation and data entry requirements. **NOTE: The annual monitoring may be performed at the same time as the monthly monitoring or at another time during the last month of the POC year.**
Case Closure/Transfer	Complete within 14 calendar days of discharge.

TRANSITION SERVICES	
Receipts/Cancelled Checks	Document deposits, set-up fees, or items purchased and reimbursement made to purchaser(s) if outside of support coordination agency.
Transition Services Form (TSF)	Complete to obtain applicable approval for prior authorization.

ADULT DAY HEALTH CARE SERVICES	
Attendance Log	Complete daily with date and time of arrival and date and time of departure. **NOTE: An EVV system generated report satisfies this requirement.**
Progress Notes	Complete at least weekly and when there is a change in the recipient's condition or routine.
Progress Summary	Complete at least every 90 calendar days.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Organization of Records, Record Entries and Corrections

The organization of individual recipient records and location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in recipient records must be legible, written in ink and include the following:

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title of the person making the entry;

- The full date of documentation; and
- Reviewed by the supervisor, if required.

Any error made by the staff in a recipient's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. **Correction fluid must NEVER be used in a recipient's records.**

Progress Notes and Summaries

Progress notes document the daily delivery of services, activities, and observations, and it records the progress made toward meeting service goals in the recipient's Individualized Service Plan (ISP) and Plan of Care (POC).

Progress summaries are completed every 90calendar days and provide an overview which addresses significant activities, progress toward the recipient's desired personal outcomes, and any changes in the recipient's status and service needs.

Progress notes must:

- Document delivery of services identified on the POC and the ISP, as applicable;
- Record activities and actions taken (by whom, where, etc.);
- Provide adequate descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note;

NOTE: General statements, such as "called the recipient"; "supported recipient"; or "assisted recipient", do not provide enough detail and are not sufficient. Check lists alone are not adequate documentation.

- Record the progress (or lack of progress) being made and indicate whether the approaches in the POC and ISP are working;

- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a re-assessment and POC and ISP change, if applicable.

NOTE: If there is a change in the recipient's condition or his/her normal routine, this must be recorded on the day of the actual occurrence;

- Document the completion of incident reports, when appropriate;

- Document any significant deviation from the POC and/or ISP;

Examples include, but are not limited to:

1) Provided more assistance than what is indicated in the POC/ISP due to the recipient's request or increased need;
2) Assistance not provided with a particular task/subtask as indicated in the POC/ISP due to recipient's request or lack of need; and
3) Significant deviation from the POC's flexible scheduled arrival/departure time.

NOTE: Arriving or departing within a reasonable amount of time (e.g. 15 minutes of the flexible schedule's time) due to everyday factors such as traffic, etc. is NOT considered a significant deviation from the POC, AS LONG AS services are still provided at the same amount, frequency and duration, as indicated in the POC.

- Be signed by the person providing the services.

Progress summaries must:

- Take into account all of the progress notes and document significant trends, progress/lack of progress towards the personal outcomes and changes that may have impacted the POC and/or ISP and the needs of the recipient;

- Include recommendations for any modifications to the POC and/or ISP as necessary; and
- Be completed and updated by the supervisor (if applicable).

BOTH progress notes and progress summaries must:

- Be in narrative format;
- Be legible (including signature) and include the functional title of the person making the entry and date; and
- Be entered in the recipient's record when a case is transferred or closed.

Discharge Summary for Transfers and Closures

In accordance with Medicaid licensing requirements, the ADHC center must provide a summary of the recipient's health record prior to the transfer/closure to the person or agency responsible for the future planning and care of the recipient. The ADHC center must also include any other information, including a progress summary, which would enable the receiving ADHC center/caregivers to provide the continued necessary care.