RECORD KEEPING

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order, and format, at the 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 medical necessity for each billed service 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 finds necessary to determine compliance with all federal or state law, rule or regulation promulgated by LDH.

Retention of Records

Administrative, personnel and recipient records must be maintained for whichever of the following time frames is longer:

- Until records are audited and all audit questions are answered; or
- Six years from the date of the last payment period.

NOTE: Upon provider closure, all provider 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 agency.

Confidentiality and Protection of Records

All records, including administrative and recipient records, 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 recipient 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).

Upon request, a provider must 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 agency, 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. A system must be maintained that provides for the control and location of all recipient records.

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

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 at all times. Providers must always safeguard the confidentiality of recipient information.

Member 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, service providers must have adequate documentation of services offered and provided to recipients they serve. This documentation is an on-going chronology of activities undertaken on behalf of the recipient.

Organization of Records, Record Entries and Corrections

Organization of individual recipient records and the 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 (not black) 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**.

Service/Progress Notes

Service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered.

The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:

- Name of recipient;
- Name of provider and employee providing the service(s);
- Service provider contact telephone number;
- Date of service contact;
- Start and stop time of service contact; and
- Content of service contact.

Service/progress notes must be reviewed by the supervisor (if applicable) to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

The service/progress note must clearly document that the services provided are related to the recipient's goals, objectives and interventions in the treatment plan, and are deemed medically necessary and clinically appropriate; document what materials were used when teaching a skill and document the progress of the recipient with very specific information regarding response to the intervention and the plan for next time. Service/progress notes should include each recipient's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the recipient.

Progress Summaries

A progress summary is a synthesis of all activities and services for a specified period (at least every 90 days or more often if required by the managed care organization (MCO) or Coordinated System of Care (CSOC) contractor) which address each recipient's assessed needs, progress

toward the recipient's desired personal outcomes, and changes in the recipient's progress and service needs. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the recipient's treatment plan, sufficient information for use by supervisors, and evaluation of activities by program monitors.

Progress summaries must:

- Document the time period summarized;
- Indicate who was contacted, where contact occurred and what activity occurred;
- Record activities and actions taken, by whom, and progress made;
- Indicate how the recipient is progressing toward the personal outcomes in the treatment plan, as applicable;
- Document delivery of each service identified on the treatment plan, as applicable;
- Document any deviation from the treatment plan;
- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;
- Be legible (including signature) and include the functional title of the person making the entry and date;
- Be complete and updated in the record in the time specified;
- Be complete and updated by the supervisor (if applicable) in the record as progress summary at the time specified;
- Be recorded more frequently when there is frequent activity or when significant changes occur in the recipient's service needs and progress;
- Be signed by the person providing the services; and

- Be entered in the recipient's record when a case is transferred or closed.

Progress summaries must be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact. Progress summaries must be of sufficient content to reflect 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 terms and phrases such as "called the recipient", "supported recipient", or "assisted recipient" are not sufficient and do not reflect adequate content. Check lists alone are not adequate documentation.

Discharge Summary for Transfers and Closures

A discharge summary details the recipient's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a recipient's discharge.