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 (LDH)'s administrative region where the member resides. The provider must have sufficient space, facilities, and supplies to ensure effective record keeping. In addition, the provider must keep sufficient records to document compliance with LDH requirements for the member served and the provision of services.

A separate record must be maintained on each member that supports medical necessity for each billed service and fully documents service(s) for which payment(s) have been made. Documentation must be sufficient to enable LDH, or its designee, to verify that prior to payment each charge is due and proper. All records must be made available that LDH or its designee finds necessary to determine compliance with all federal or state laws, rules, or regulations promulgated by LDH.

Retention of Records

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

1. Records are reviewed and all review questions are answered; or

2. Six (6) years from the date of the last payment period.

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 agency.

Confidentiality and Protection of Records

All records, including administrative and member 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, members or their families, directly or indirectly, to any unauthorized person. The provider must

safeguard the confidentiality of any information that might identify the members or their families. Information may be released only under the following conditions:

1. Court order;

2. Member's written informed consent for release of information;

3. Written consent of the individual's legal guardian or legal representative when the member has been declared legally incompetent; or

4. 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 member 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 member, that information may be withheld from the member, 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.

Material from case records may be used 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 member 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 member records.

NOTE: Under no circumstances shall providers allow staff to take member's case records from the office without appropriate utilization of standard best practices in compliance with all HIPPA standards related to privacy and security**.**

Review by State and Federal Agencies

All administrative, personnel and member records must be made available to LDH, or its designee, and appropriate state and federal personnel at all times. Providers must always safeguard the confidentiality of member information.

Member Records

Providers must have a separate written record for each member 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 members they serve. This documentation is an on-going chronology of activities undertaken on behalf of the member.

Providers shall maintain case records that include, at a minimum:

1. Member Rights - reviewed, signed by, and given to the member and/or responsible party, if applicable:

    a. Psychiatric advanced directive and Medical advanced directive;

    b. Consent for treatment/Informed consent; and

    c. Informed consent to deliver telemedicine/telehealth services. The consent form must include the following:

        i. Rationale for using telemedicine/telehealth in place of in-person services;

        ii. Risks and benefits of the telemedicine/telehealth, including privacy-related risks;

        iii. Possible treatment alternatives and those risks and benefits; and

        iv. Risks and benefits of no treatment.

    d. Rights to confidentiality must be reviewed, signed by, and given to the member and/or responsible party, if applicable.

2. Name and date of birth of the member;

    Note: Each page of the record shall have a member identifier such as member name, member initials, member's client ID number, etc.

3. Social security number of the member;

4. Address of the individual;

5. Dates and time of service;

6. Assessments;

7. Treatment plans, based on and consistent with the assessment, which include at a minimum:

    a. Indication if treatment plan is an initial or an updated treatment plan;

    b. Goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;

    c. Specific interventions;

    d. Service locations for each intervention;

    e. Staff providing the intervention;

    f. Estimated frequency and duration of service; and

    g. Signatures of the licensed mental health professional (LMHP), member, and responsible party, i.e., guardian/caregiver, if applicable;

    h. Updated when there are significant life changes, achieved goals, or new problems identified; and

    i. Progression made towards all goals.

5. Progress notes;

6. Units of services provided;

7. Crisis plan;

    a. Crisis plan must be directed by the member and/or the responsible party, i.e., guardian/caregiver, if applicable; and

b. Crisis plan must include signatures of the member and/or the responsible party, i.e., guardian/caregiver, if applicable.

8. Continuity and coordination of care:

a. The record includes the primary care physician (PCP) name, address, phone number, and documentation of continuity and coordination of care between PCP and the member's treating provider;

b. The record includes any other treating behavioral health clinician's name, address, phone number, and documentation of continuity and coordination of care between any other treating behavioral health clinician's and the member's treating provider;

c. The record includes documentation of any referrals made on behalf of the member, if applicable; and

d. The record must include a signed Release of Information form by the member and/or responsible party, i.e., guardian/caregiver, if applicable, for communication and coordination of care to occur; if member and/or responsible party refuses, then this refusal must be noted within the record.

9. Medication management, if applicable:

a. The record must indicate the following:

i. Medication name;

ii. Medication type;

iii. Medication frequency of administration;

iv. Medication dosage;

v. Person who administered each medication;

vi. Medication route;

vii. Ordered lab work that has been reviewed by the clinician ordering the lab work as evidenced by date and signature of clinician;

viii. Evidence of member education on prescribed medication including benefits, risks, side effects, and alternatives of each medication;

ix. Signed consent for psychotropic medications by the member and/or responsible party, i.e., guardian/caregiver, if applicable; if member and/or responsible party refuses, then this refusal must be noted within the record;

x. AIMS (Abnormal Involuntary Movement Scale) preformed when appropriate (e.g., member is being treated with antipsychotic medication);

xi. Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs, and chronic conditions to document ongoing monitoring; and

xii. Documentation of monitoring medication adherence, efficacy, and adverse effects.

10. Discharge plan;

a. Appointment date and/or time period of follow up with transitioning behavioral health provider and/or primary care physician, if medical co-morbidity is present, must be documented on the discharge plan. Provider must document any barriers if unable to schedule an appointment when member is discharged or transitioned to a different level of care;

b. Provider must ensure collaborative transition of care occurred with the receiving clinician/program as evidenced by documented communication. Provider must document any barriers if unable to communicate with the receiving clinician/program when member is discharged or transitioned to a different level of care; and

c. Medication profile, if applicable, provided to outpatient provider and to member during transition of care. Provider must document any barriers while reviewing the transition of care with member or while providing the medication profile to the outpatient provider.

A member can sign the assessment and treatment plans electronically. A member's electronic signature will be deemed valid under federal law if it is authorized by state law. Under the

Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if:

1. Signer intentionally, voluntary agrees to electronically sign the document;

2. Electronic signature is attributable to signer (i.e. be sure to have patient's printed name under signature); and

3. Appropriate security measures are in place which can authenticate the signature and prevent alteration of the signature (i.e. date and signature cannot be modified in the electronic health record).

Organization of Records, Record Entries and Corrections

Organization of individual member 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 member records must be legible, written in ink (not black) and include the following:

1. Name of the person making the entry;

2. Signature of the person making the entry;

3. Functional title, applicable educational degree and/or professional license of the person making the entry;

4. Full date of documentation; and

5. Reviewed by the supervisor, if required.

Any error made by the staff in a member'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 member'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 must be entered in the service/progress notes to provide a clear audit trail and to document claims:

1. Name of member;
2. Name of provider and employee providing the service(s);
3. Service provider contact telephone number;
4. Date of service contact;
5. Start and stop time of service contact; and
6. Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

A sample of the service/progress notes for each member seen by a non-LMHP must be reviewed by an LMHP supervisor at least monthly, or more if needed. The signature of the LMHP attests to the date and time that the review occurred.

The service/progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are medically necessary and clinically appropriate. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill. Service/progress notes should include each member'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 member. Each service/progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

The only staff who may complete a service/progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

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

Progress summaries must:

1. Document the time period summarized;

2. Indicate who was contacted, where contact occurred and what activity occurred;

3. Record activities and actions taken, by whom, and progress made;

4. Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable;

5. Document delivery of each service identified on the treatment plan, as applicable;

6. Document any deviation from the treatment plan;

7. Record any changes in the member's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;

8. Be legible (including signature) and include the functional title of the person making the entry and date;

9. Be complete and updated in the record in the time specified;

10. Be complete and updated by the supervisor (if applicable) in the record as progress summary at the time specified;

11. Be recorded more frequently when there is frequent activity or when significant changes occur in the member's service needs and progress;

12. Be signed by the person providing the services; and

13. Be entered in the member'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 member", "supported member", or "assisted member" are not sufficient and do not reflect adequate content. Checklists alone are not adequate documentation.

Discharge Summary for Transfers and Closures

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