RECORD KEEPING

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Department of Health and Hospital's (DHH) 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 DHH 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 DHH or its designee to verify that prior to payment each charge is due and proper. The provider must make available all records that DHH 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 DHH.

Retention of Records

The agency must retain administrative, personnel, and recipient records for whichever of the following time frames is longer:

- Until records are audited and all audit questions are answered, **OR**
- Five 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

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,
- 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 agency or to DHH, 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. 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 facility.

Review by State and Federal Agencies

Providers must make all administrative, personnel, and recipient records available to DHH or its designee and appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of recipient information.

Recipient Records

A provider 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 and 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.

See below for specific information regarding documentation of the following services:

Support Coordination/Transition Intensive Support Coordination Providers	
Monthly Contact	Complete each calendar month at time of the Monthly Monitoring Contact according to OAAS documentation and data-entry requirements.
Interim Support Coordination Documentation	Complete at time of interim activities, according to OAAS documentation and data-entry requirements.
Quarterly Service Delivery Monitoring and Risk Assessment	Complete each calendar quarter at time of the Quarterly Monitoring Contact according to OAAS documentation and data-entry requirements.
Case Closure/Transfer	Complete within 14 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 Expense and Planning Approval (TSEPA) form	Complete to obtain applicable approval for prior authorization.

Environmental Accessibility Adaptation Providers	
Assessment	Completed by Assessor/Inspector/Approver with recommendation (either environmental accessibility adaptation job or alternative).
Itemized Bid(s)	Completed by contractor when environmental accessibility adaptation job is recommended.

Personal Assistance Service (PAS) Providers	
Service Log*	Complete after each activity has been performed and/or supports have been provided (Refer to Appendix B for form/instructions).
Progress Notes	Complete daily on Service Log to reflect all activities performed, supports provided and the recipient's response to those services.
Case Closure/Transfer	Complete within 14 days of discharge.

*****The Service Log is not a substitute for a Time Sheet. A separate Time Sheet is required for each worker. The design of the Time Sheet is the responsibility of the provider agency.

Adult Day Health Care Providers	
Attendance Log	Complete daily with date and time of arrival and date and time of departure.
Progress Notes	Complete at least weekly, and when there is a change in recipient's condition or routine.
Progress Summary	Complete at least every 90 days.
Case Closure/Transfer	Complete within 14 days of discharge.

Skilled Maintenance Therapy Providers	
Assessment	Complete at time of activity.
Progress Notes	Complete within 10 days of service activity.
Progress Summary	Complete at least every 90 days or as specified in the Plan of Care.
Case Closure/Transfer	Complete within 14 days of discharge.

Nursing Providers	
Assessment	Complete at time of activity.
Progress Notes	Complete within 10 days of service activity.
Progress Summary	Complete at least every 90 days or as specified in the Plan of Care.
Case Closure/Transfer	Complete within 14 days of discharge.

Home Delivered Meal Providers	
Copy of Invoice	Document delivery of meals to home, including number of meals shipped, date of mailing and price per unit.

Caregiver Temporary Support Providers	
Service Log	Refer to Appendix B for form/instructions.

Assistive Devices and Medical Supply Providers	
Copy of Invoice	Document device and/or medical supplies provided including price per unit.
Training on use of Device/Equipment	Document training provided to the recipient and/or representative on the service, use, maintenance, and safety of the device/equipment.
TeleCare Monitoring, Maintenance and Contact	Maintain clinical documentation of all service activities, data and all recipient contacts.

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.

Service Logs

Service logs document the personal assistance services (PAS) or caregiver temporary support services billed. Service logs must reflect service delivered and are the "paper trail" for services delivered.

Caregiver temporary support providers are to write “OAAS-CCW Caregiver Temporary Support” on the top of the service log and document all PAS and non-PAS tasks and comments in the “progress note” space. (See Appendix B for a copy of this form)

Federal requirements for documenting claims require the following information be entered on the service log to provide a clear audit trail:

- Name of recipient,
- Name of provider and employee providing the service,
- Service provider contact telephone number,
- Date of service contact,
- Start and stop time of service contact, and

- Content of service contact.

Service logs 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.

Each provider's documentation should support justification for prior authorization or payment of services. Services billed must clearly be related to the current Individual Service Plan (if applicable) which is to be based on the approved Plan of Care.

Progress Notes and Summaries

Progress notes are the means of summarizing activities, observations and progress toward meeting service goals in the recipient's Plan of Care.

A progress summary is a synthesis of all activities for a specified period which address significant activities, 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 current Plan of Care, sufficient information for use by other support coordinators, direct service workers, or their supervisors, and evaluation of activities by program monitors.

Progress notes and summaries must:

- Indicate who was contacted, where contact occurred, and what activity occurred,
- Record activities and actions taken, by whom, and progress made; and indicate how the recipient is progressing toward the personal outcomes in the Plan of Care and Individual Service Plan, as applicable,
- Document delivery of each service identified on the Plan of Care and the Individual Service Plan, as applicable,
- Document any deviation from the Plan of Care,
- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and Plan of Care, and/or Individual Service 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 a 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 notes and summaries must be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact. The progress notes and summaries must summarize all activities for the specified period which addresses significant activities and progress/lack of progress toward the desired outcomes and changes that may impact the Plan of Care and/or Individual Service Plan and the needs of the recipient. Progress notes and summaries should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current Plan of Care and Individual Service Plan (if applicable), allow for sufficient information for use by support coordinators, other direct service workers or their supervisors, and allow for evaluation of activities by program monitors.

Progress notes and 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.