RECORD KEEPING

Providers must make available to the Bureau of Health Services Financing (BHSF) all records of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to children with special health needs upon request. The following documentation must be maintained for at least **five years** from the date of payment on all children for whom claims have been submitted.

- Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying an individualized education program (IEP), individualized family services plan (IFSP), or individualized health plan (IHP) for nursing services, including the specific tests performed and copies of evaluation and diagnostic assessment reports signed by the individual and supervisor, if appropriate, that conducted the assessment;

- Copies of the IEP, IFSP, or IHP for nursing services documenting the need for the specific therapy or treatment services, the time and frequency required;

- Documentation of the provision of treatment services by the therapists and other qualified professionals including dates and times of services, billing forms, log books, reports on services provided, and the child's record(s) signed by the individual providing the services and signature of supervisor, if appropriate;

- Written referral or prescription from a licensed physician for any occupational therapy services for the current school year (must be dated within the last 365 days);

- A copy of the IEP, IFSP, or IHP for nursing services which establishes the need for the service to be provided through the Individuals with Disabilities Education Act (IDEA) Part B or Part C program; and

- Documentation of dates and results of the most recent medical, vision, and/or hearing screening(s) or dates contacted to determine screening status.

Documentation Components

Documentation of each individual or group session must include the following information:

- Eligible child's name;
- Date of service;
- Type of service;
- If a group session, the number of eligible children in the group;
- Length of time the therapy was performed (time may be recorded based on start

and stop times or length of time spent with eligible child);
- Description of therapy activity or method used;
- Eligible child's progress toward established goals; and
- Signature of service provider, title and date.

All documentation must be signed, titled and dated by the provider of the services at the time services are rendered. Late entries must be noted accordingly.

Therapy session attendance forms alone do not constitute documentation, unless they meet all of the service documentation requirements outlined above.

All documentation must be signed, titled and dated by the provider of the services and by the supervising therapist if supervision is required. Services provided may also be documented electronically in a state approved system. The electronic system must:

- Have the capability to incorporate the date, time, and duration of the service provided, and the goals and progress notes of each session; and

- Have the capability to produce reports for the provider of the services, the supervising therapist (if required) and for auditing purposes as needed.

Staff may be required to sign the reports to certify the services were provided as reported.