RECORD KEEPING

Providers must make all records of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to Medicaid beneficiaries available to the Bureau of Health Services Financing (BHSF) 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. This effort will require cooperation, coordination and communication between the **Local Education Agencies** and the student's Medicaid **Primary Care Provider.**

- Dates and results of all health services provided to students including EPSDT services and evaluation/diagnosis provided in the interest of establishing or modifying an individualized education program (IEP), 504 Plan, individualized health plan (IHP) or other written plan of care (WPC) for all health services, including documentation of the health service provided, student's response to the health service, and disposition of student after health service;

- Any specific tests performed and copies of evaluation and diagnostic assessment reports signed by the individual practitioners and supervisors, if appropriate, that conducted the assessment;

- Copies of the IEP, 504 Plan, IHP or WPC for all health services documenting the need for the specific therapy or treatment services, including the time and frequency required when appropriate;

- Documentation of the provision of health services by all practitioners including dates and times of services, health intervention/service provided, student's response to service, 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. When electronic documentation system is utilized, electronic health record with confidential date/time stamp, logon of provider, and ability to log/track any changes to provider documentation is required;

- All immunizations provided must be documented in Louisiana's immunization database (LINKS);

- A copy of the IEP, 504 Plan, IHP or WPC authorizing documents for all health services provided. Documentation of notification to parents of any health services provided and their results; and

- Documentation of Care coordination efforts with other members of the student's health care team including primary care providers.

Documentation Components

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

- Eligible child's full first and last name;
- Date of service;
- Type of service (CPT Code);
- If a group session, the number of children in the group;
- Time the service begins;
- Length of time the service was performed (time may be recorded based on start and stop times or length of time spent with eligible child);
- Description of service activity or method used;
- Description of child's response to the service;
- 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 licensed 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 time documented by the provider of the services and by the supervising practitioner therapist if supervision is required. Services provided may also be documented electronically in a HIPAA and FERPA compliant electronic health record. The electronic system must:

- Include all information listed above;
- Have the capability to produce reports for the provider of the services, the supervising therapist (if required) and for auditing purposes as needed; and
- Have the capability to track all changes or modifications to a record including the time, date and author of the change.

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