RECORD KEEPING

Providers should refer to the Medicaid Services Manual, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping. http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Louisiana Department of Health (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 must be maintained on each recipient that supports justification for prior authorization and fully documents services for which payments have been made. 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 any federal or state law, rule or regulation promulgated by LDH.

Retention of Records

The provider must retain administrative, personnel and recipient records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six years)

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 provider**.

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. Providers and their employees must not directly or indirectly disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families to any unauthorized person. The provider must

safeguard the confidentiality of any information which may identify the recipient or his/her family. Confidential information shall only be released 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 Law, Confidentiality 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 it is felt in the professional judgment of the administration of the provider that the 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, as long as names are deleted and other similar identifying information is disguised or deleted.

NOTE: Under no circumstances should providers allow staff to remove recipient records from the office.

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.

Recipient records must be located at the enrolled site.

Review by State and Federal Agencies

Providers must make recipient and personnel records available to LDH its designee, and/or other state and federal agencies within the specified timeframe given by LDH or its designee. The provider shall be responsible for incurring the cost of copying records.

Recipient Records

Providers must have a separate written record for each recipient served by the provider. It is the responsibility of the service provider to accurately document services thereby conveying an on-going chronology of activities/services provided to the recipient. Services provided must clearly be related to the services documented in the recipient's plan of care (POC).

Records at the Recipient's Home

Providers must maintain the following documents at the recipient's home:

- A **current** copy of the recipient's POC and POC revision (if applicable); and
- Copies of the recipient's service logs for the current prior authorized week. (A prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Saturday at 11:59 p.m.).

  Example: If LDH staff or designee goes into the home on a Wednesday, service logs for that day, along with the applicable documentation (if services were performed) from that Sunday, Monday, and Tuesday (the current prior authorized week) are required.

  NOTE: A copy of the "Long-Term Personal Care Services (LT-PCS) Log", along with instructions for using and completing this form, can be found in Appendix D.

LDH or its designee may request copies of these records and, at its discretion, may also request additional records from the provider. Records should be made available to the requestor in accordance with LDH policy and within the time specified.

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 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**. The provider's office staff may not change any of the documentation entered by the LT-PCS worker.

Service Logs

Service logs document the services provided and billed. These service logs are the "paper trail" for services delivered by the worker.

Service logs contain the following information:

- Name of recipient;
- Name of provider and employee providing the service;
- Date of service contact; and
- Content of service contact.

NOTE: The start and stop time of service contacts, as well as the location where check in/check out occurs, are captured through the use of an Electronic Visit Verification (EVV) System.

A separate service log must be kept for each recipient. Reimbursement is only payable for services documented in the service log. Providers are required to use the LT-PCS log issued by OAAS. (*See Appendix D for information on accessing this form and the associated instructions.*)

All portions of the service log must be completed each week. Photocopies of previously completed service logs will not be accepted.

Service logs must be:

- Completed **daily as tasks are performed** (Service logs may not be completed prior to the performance of a task.); and

- Signed and dated by the worker and by the recipient or responsible representative **after the work has been completed at the end of the week**.

Progress notes are located on the second page of the service log and are the means of documenting:

- Observed changes in the recipient's mental and/or medical condition(s), behavior or home situation that may indicate a need for a reassessment and POC, and/or ISP change (as applicable);

- Any **SIGNIFICANT DEVIATIONS** from the POC; and

- Other information important to ensure continuity of care.

Examples of when to document in a narrative progress note include but are not limited to:

- Provided more assistance than what is indicated in the POC due to the recipient's request or his/her increased need;
- Assistance not provided with a particular task/subtask as indicated in the POC due to recipient's request or his/her lack of need;
- Significant deviation from the POC's flexible scheduled arrival/departure time and/or days on which services are provided.

NOTE: Arriving or departing within 15 minutes of the flexible schedule's time due to everyday factors (e.g. traffic, etc.) is NOT considered a significant deviation from

the POC AS LONG AS services are still provided at the same amount, frequency and duration as indicated in the POC.

If a recipient, for any reason, did not use all or part of his/her LT-PCS hours on a particular day but the unused LT-PCS hours were used in other days throughout that week, it MUST be clearly documented how the hours were used and the justification or need for the hours on that day. When hours are not used, they CANNOT be used later in the week just to "make up" the hours; therefore, workers CANNOT do the same task/activity twice in one (1) day just to "make up" the unused hours. There MUST be an ACTUAL need for the unused hours on the day that they are actually used.

When progress notes are written, they must:

- Be legible;
- Include the date of the entry;
- Include the name of the person/worker making the entry; and
- Be completed and updated in the record in the time specified.

Each provider's documentation should support justification for prior authorization or payment of services. Services billed must clearly be related to the current approved POC and Individualized Service Plan (ISP), if applicable.

Transfers and Closures

A progress note MUST be entered in the recipient's record when a case is transferred or closed.

A discharge summary must also be entered in the recipient's record and detail the recipient's progress prior to a transfer or closure. This summary must be completed within 14 calendar days following a recipient's discharge.