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 Louisiana Department of Health (LDH) administrative region where the beneficiary resides. The agency 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 beneficiary served and the provision of services.

A separate record must be maintained on each beneficiary that fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable LDH to verify that prior to payment each charge was due and proper. The provider must make available all records that LDH finds necessary to determine compliance with any federal or state law, rule, or regulation.

Confidentiality and Protection of Records

All records, including but not limited to, administrative and beneficiary files, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with all state and federal laws and regulations concerning confidentiality and that safeguard information and patient/client confidentiality, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the beneficiaries, or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiaries or their families. The wrongful disclosure of such information may result in the imposition by LDH of sanctions pursuant to its Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to the HIPAA Privacy Rule. The information may be released only under the following conditions:

- Court order;
- Beneficiary's written informed consent for release of information;
- Written consent of the individual to whom the beneficiary's rights have devolved when the beneficiary has been declared legally incompetent; or
- Written consent of the parent or legal guardian when the beneficiary is a minor.

A provider must, upon request, make available information in the case records to the beneficiary 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 beneficiary, or reasonably likely to endanger the life or physical safety of the beneficiary, that information may be withheld. This determination must be documented in writing.

The provider may charge a reasonable fee for providing the above records. The cost of copying 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 or the provider's services, or similar educational purposes, if names are deleted and other similar protected health information is redacted or deleted.

A system must be maintained that provides for the control and location of all beneficiary records. Beneficiary records must be located at the enrolled site. **Under no circumstances should providers allow staff to take a beneficiary's case records from the facility.**

Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH and appropriate state and federal personnel at all reasonable times.

Retention of Records

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

- Six years from the date of the last payment period; or
- Until records are audited and all audit questions are resolved.

NOTE: Upon agency closure, all provider records must be maintained according to applicable laws, regulations, and the above record retention requirements along with copies of the required documents transferred to the new agency. The new provider must bear the cost of copying, which cannot exceed the community's competitive copying rate.

Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, LDH administrative rules and Medicaid enrollment agreements.

Beneficiary Records

A provider must have a separate written record for each beneficiary served by the agency. It is the responsibility of the provider to have adequate documentation of services offered to waiver beneficiaries for the purposes of continuity of care, support for the individuals, and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of services received and undertaken on behalf of the beneficiary.

All beneficiary records and location of documents contained therein must be maintained consistently in the agency. Records must be appropriately maintained so that current material can be located in the record.

The Office of Citizens with Developmental Disabilities (OCDD) does not prescribe a specific format for documentation, but all components outlined must be in each beneficiary's active record.

Organization of Records, Record Entries, and Corrections

The organization of individual beneficiary 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 beneficiary records must be legible, be written in ink, and include the following:

- Name of the person making the entry;
- Signature of the person making the entry;
- Functional title of the person making the entry;
- Full date of documentation; and
- Supervisor review, if required.

Any error made by the staff in a beneficiary'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 beneficiary's records.

Components of Beneficiary Records

The beneficiary record must consist of the active record and the agency's storage files or folders. The active record must contain, *at a minimum*, the following information:

- Identifying information on the beneficiary that is recorded on a standardized form to include the following:
  - Name;
  - Home address;
  - Home telephone number;
  - Date of birth;
  - Sex;
  - List of current medications;
  - Primary and secondary disability;
  - Name and phone number of preferred hospital;
  - Closest living relative;
  - Marital status;
  - Name and address of current employment, school, or day program, as appropriate;
  - Date of initial contact;
  - Court and/or legal status, including relevant legal documents, if applicable;

- Names, addresses, and phone numbers of other beneficiaries or providers involved with the beneficiary's Plan of Care, including the beneficiary's primary or attending physician;
- Date when this information was gathered; and
- Signature of the staff member gathering the information.

- Documentation of the need for ongoing services;
- Medicaid eligibility information;
- A copy of assurances of freedom of choice of providers, beneficiary rights and responsibilities, confidentiality, and grievance procedures, etc. signed or initialed by the beneficiary;
- Approved Plan of Care (POC) and provider documents, including any revisions,
- Copy of all critical incident reports, if applicable;
- Formal grievances filed by the beneficiary;
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation below;
- Attendance records;
- Copy of the beneficiary's behavior support plan, if applicable;
- Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the beneficiary's health, safety, and welfare;
- Reason for case closure and any agreements with the beneficiary at closure;
- Copies of all pertinent correspondence;
- At least six months (or all information if services provided less than 6 months) of current pertinent information relating to services provided;

NOTE: Records older than six months may be kept in storage files or folders, but must be available for review.

- Any threatening medical condition, including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies;
- Monitoring reports of waiver service providers to ensure that the services outlined in the Plan of Care are delivered as specified;
- Service logs describing all contacts, services delivered, and/or action taken and identifying the beneficiaries involved in service delivery, the date and place of service, the content of service delivery, and the services relation to the Plan of Care;
- A sign-out sheet that indicates the date and signature of the person(s) who viewed the record; and
- Any other pertinent documents.
- The provider must ensure that drivers have access to needed medical information including emergency contacts in the event of an emergency for all beneficiaries whom they transport.

If this information is kept as a hard copy record in the vehicle, it must be returned to a secure, location at the provider agency at the end of the transportation service.

Beneficiary's transportation records must not be left in a vehicle.

Service Documentation

Support coordination agencies and direct service providers are responsible for documenting activities during the delivery of services. All documentation content and schedule requirements must be met by both support coordination agencies and direct service providers.

Required service documentation includes:

- Service logs;
- Progress notes;
- Project summaries;

- Discharge summaries for transfers and closures; and
- Individualized documentation.

NOTE: Direct service providers, who provide both waiver and state plan services, must maintain separate documentation for these services.

Service Logs

A service log provides a chronological listing of contacts and services provided to a beneficiary. They reflect the service delivered and document the services billed.

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

- Name of beneficiary;
- Name and signature of provider and employee providing the service;
- Service agency contact and telephone number;
- Date of service contact;
- Start and stop time of service contact;

  NOTE: The electronic visit verification (EVV) system will be used to document the start/stop time of service contact. If there is no electronic clock in/out, then paper documentation identifying the exact start and stop times with the date of the service contact is required, including the worker's signature.

- Place of service contact; and
- Purpose of service contact:
  - Personal outcomes addressed;
  - Content and outcome of service contact; and
  - Other issues addressed.

There must be case record entries corresponding to each recorded support coordination and direct service provider activity that relates to one of the personal outcomes.

The service log entries need not be a narrative with every detail of the circumstances; however, all case notes must be clear as to who was contacted and what activity took place. Logs must be reviewed by the supervisor to insure that all activities are appropriate in terms of the nature and time and that documentation is sufficient.

Services billed must clearly be related to the current Plan of Care.

Each support coordination service contact is to be briefly defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note. This documentation should support justification of critical support coordination elements for prior authorization of service in the Case Management Information System (CMIS).

Direct service providers must complete a narrative that reflects each entry into the payroll sheet and elaborates on the activity of the contact.

Progress Notes

Progress notes must be completed by both support coordinators and direct service providers at the time of each activity or service. Progress notes summarize the beneficiary's day-to-day activities and demonstrate progress toward achieving his/her personal outcomes as identified in the approved Plan of Care.

NOTE: An occasional or temporary deviation from a beneficiary's scheduled services is acceptable as long as the services being altered are beneficiary-driven, person-centered, and occur within the approved prior authorization. However, **when a beneficiary's schedule is altered on a consistent basis and results in an increase in services, a revision to the POC is required** indicating the reason for the change. The typical schedule and budget sheets in the POC are intended for scheduling and budgetary purposes only. They are tools to provide guidance and establish budgets and are not a directive of when services MUST be provided. Flexibility within the Residential Opportunities Waiver is allowed as long as it does not result in exceeding the approved prior authorization and the flexibility is based on the beneficiary's needs. Support Coordinators will monitor services on a quarterly basis to ensure they are delivered in accordance with the POC and the needs of the beneficiary.

Progress notes must be of sufficient content to:

- Reflect descriptions of activities, procedures, and incidents;

- Give a picture of the service provided to the beneficiary;
- Show progress towards the beneficiary's personal outcomes;
- Record any change in the beneficiary's medical condition, behavior, or home situation that may indicate a need for reassessment and Plan of Care change;
- Record any changes or deviations from the typical weekly schedule in the beneficiary's approved Plan of Care; and
- Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

The following are examples of general terms, when used alone, are not sufficient and do not reflect adequate content for progress notes:

- "Supported _____"
- "Assisted _____"
- "_____ is doing fine"
- "_____ had a good day"
- "Prepared meals"

Progress notes must be reviewed by the supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

For beneficiaries receiving formal training to learn a specific skill, progress notes must be paired with a skills training data sheet as explained in the OCDD's "Guidelines for Support Planning" manual. In this instance, the progress notes must document the skills training occurred and should serve as a pointer to data collection mechanisms used. (See Appendix D).

Progress Summary

A progress summary is a synthesis of all activities for a specified period that address significant activities, progress toward the beneficiary's desired personal outcomes, and changes in the beneficiary's social history. This summary must be of sufficient detail and analysis such that any

person reviewing the record can determine if the progress is appropriate and satisfactory based on the beneficiary's current POC. The progress summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirements.

A progress summary must be completed at least every quarter for each beneficiary.

Discharge Summary for Transfers and Closures

A discharge summary details the beneficiary's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a beneficiary's discharge. The discharge summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirement.

Individualized Documentation

The support team must ensure that other documentation and data collection methods other than progress notes and discharge summaries are considered so that appropriate measures are used to track the beneficiary's progress toward his/her goals and objectives as specified in the approved Plan of Care.

For persons with behavioral, psychiatric, or medical risk factors, individualized documentation should be utilized as a means of tracking each key area of risk. This documentation is required, but not limited to, beneficiaries with the following risk factors:

- Seizure disorder and/or receiving seizure medication – Data forms used to track this information must include seizure reports. The support team may also need to consider assessing for the presence of side-effects of seizure medication on a monthly or quarterly basis;

- A medical issue which is significantly affected by or has a significant effect upon one's weight – Such issues may include diabetes, cardiovascular issues, medication side-effects, or receiving nutrition via g-tube, peg-tube, etc. Data forms used to track this information must include weight logs. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, and assessing for the presence of medication side-effects;

- Medications which can have severe side effects or potentially cause death if the adherence to medication management protocols is not strictly followed - Data forms used to track this information must include an assessment for the presence of medication side-effects on a monthly or quarterly basis. The support team may also

need to consider tracking meal/fluid intake with a daily meal/fluid log, and tracking frequency/consistency of bowel movements with a daily bowel log;

- A psychiatric diagnosis and/or receiving psychotropic medication – Data forms used to track this information must include a psychiatric symptoms assessment. Based on the beneficiary's presenting symptoms, antecedents, and psychotropic medication guidelines, the support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, tracking frequency/intensity of challenging behaviors with a challenging behavior chart, and assessing for the presence of medication side-effects; and

- Challenging behaviors which are severe or disruptive enough to warrant a behavioral treatment plan – Data forms used to track this information must include behavioral incident reports. The support team may also need to consider tracking frequency/intensity of psychiatric symptoms with a psychiatric symptoms assessment, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, and assessing for the presence of medication side-effects.

The residential provider is responsible for collecting all required individualized documentation for the risk factors listed above and making it available to professionals, nursing, and medical personnel providing services to the beneficiary in order to facilitate quality of care. The data collection mechanism (e.g. the form or other collection method) related to these items must be submitted with the beneficiary's Plan of Care and, if altered, with any succeeding revisions. Refer to the OCDD "Guidelines for Support Planning" manual for additional information regarding data collection revision requests, available technical assistance, and sample documentation forms (See Appendix D).

Schedule of Required Documentation

SUPPORT COORDINATION AGENCIES AND DIRECT SERVICE PROVIDERS			
SERVICE LOG	**PROGRESS NOTES**	**PROGRESS SUMMARY**	**CASE CLOSURE/TRANSFER**
At time of activity	At time of activity	At least once every quarter.	Within 14 calendar days of discharge