

**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**SECTION 31.6: RECORD KEEPING**

**RECORD KEEPING**

Provider records must be maintained in an organized and standardized format at the enrolled office site. Original records shall not be kept in off-site service delivery locations. The provider must have adequate space, facilities, and supplies to ensure effective record keeping.

**Retention of Records**

The provider must retain administrative, personnel and recipient records for five (5) years from the date of the last payment. However, if the provider is being audited, records must be retained until the audit is complete, even if the five (5) years is exceeded.

In the event records are destroyed or partially destroyed in a disaster, such as a fire, flood or hurricane and rendered unreadable and unusable, such records must be properly disposed of in a manner, which protects recipients' confidentiality. A letter of attestation (refer to Appendix B) must be submitted to:

For USPS mail delivery:

For hand delivery or delivery via a parcel service:

Medicaid Behavioral Health Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030

Medicaid Behavioral Health Section  
Bienville Bldg., 7<sup>th</sup> Floor  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802

Fax: (225) 342-1972 or (225) 342-1973 or Toll Free at (866) 427-2148

**NOTE:** Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements. The Bureau must be notified of the location of the records.

**Destruction of Records**

After the required record retention period has expired, records may be destroyed. Confidential records must be incinerated or shredded to protect sensitive information. Non-paper files, such as computer files, require a special means of destruction. Disks or drives can be erased and reused, but care must be taken to ensure all data is removed prior to reuse. Commercially available software programs can be used to ensure all confidential data is removed.

**Confidentiality and Protection of Records**

Administrative and recipient records are the property of the provider. Records must be secured against loss, tampering, destruction or unauthorized use in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

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The provider must safeguard the confidentiality of any information, which may identify the recipients or their families. The information may be released only under the following conditions:

- By a court order,
- By the recipient's written, informed consent for release of information,
- If the recipient has been declared legally incompetent, his/her legal representative must provide written consent, or
- If the recipient is a minor, the parent or legal guardian must provide written consent, or

Upon request, a provider must make available information in the recipient records to the recipient, legally responsible guardian, or other service providers including another MHR provider in the case of a recipient transfer. If, in the professional judgment of the provider, information contained in the record would be harmful to the recipient, that information may be withheld from him/her except under court order.

A provider may use material from recipient records for educational purposes if names are deleted and other identifying information is removed. For research purposes, providers must comply with the Bureau's research policy (refer to Appendix C), which is posted on the MHR website, [www.mhrsla.org](http://www.mhrsla.org).

**NOTE:** Under no circumstances should providers allow staff to remove recipient records from the provider's site.

### **Review by State and Federal Agencies**

Providers must make all administrative, personnel and recipient records available to the Bureau and appropriate state and federal personnel upon request. Failure to allow access to records in a timely manner may result in a sanction.

### **Administrative and Personnel Records**

The provider's administrative files must have critical program information including but not limited to documentation of Medicaid enrollment, insurance policies, minutes of formal meetings, bylaws of the governing body, if applicable, training and supervision documentation, and required policies and procedures as detailed in Section 31.5.

Personnel records shall be maintained for all staff, subcontractors, volunteers and interns. The record must contain all documents detailed in Section 31.5 Staffing and Training-Personnel Records). An employee must have reasonable access to his/her personnel file and must be allowed to include any written statement he/she wishes in the file.

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A provider must not release a personnel file without the employee's written permission except according to state law.

**Recipient Records**

Records must be maintained in chronological order. Documentation shall be sufficient to verify that services conform to the Bureau policy as stated below and that the reimbursement amount is correct.

The organization of individual records and location of documents must be uniform. Records must be appropriately thinned so that current material can be easily located. Records must contain at least six (6) months of current pertinent information relating to services provided. Records older than six (6) months must be kept on-site and be available for review upon the request of the Bureau.

All entries and forms completed by staff in recipient records must be:

- In ink, in a color other than black,
- Legible,
- Fully dated,
- Legibly signed, and
- Include the functional title of the individual making the entry.

Any error 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.** If information is typed, signatures must be in ink, in a color other than black.

**Components of Recipient Records**

The recipient's record must consist of the active recipient record and stored files or folders. The active record must contain the following current information unless a recipient refuses disclosure, which may include race, ethnic origin, sex, or marital status.

Identifying information recorded on a standardized form including the following:

- Name,
- Home address,
- Home telephone number,
- Date of birth,
- Sex,
- Race or ethnic origin,

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- Living arrangements,
  - Closest living relative/guardian,
  - Education,
  - Marital status,
  - Name, address, and telephone number of employer or school,
  - Date of initial contact,
  - Court and/or legal status, including relevant legal documents,
  - Names, addresses, and telephone numbers of other involved with the recipient's ISRP,
  - Date this information was gathered,
  - Required signatures on all forms, and
  - Signed release of information form.
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- Documentation verifying that the recipient meets medical necessity criteria including copies of required professional evaluations, past treatment records, LOCUS/CALOUS rating, the MHR screening form, the MHR initial and reassessment reports, and other reports and information concerning the recipient's medical, social, familial, cultural, developmental, legal, educational, vocational, psychiatric and economic status.
  - Electronic clinical data inquiry printout.
  - Medicaid eligibility information for Medicaid recipients.
  - A copy of the Freedom of Choice form, confidentiality information, complaint procedures, etc. signed by the recipient.
  - A completed and signed ISRP including the crisis plan and discharge plan.
  - Reason for case closure and any agreements with the recipient at closure.
  - Service logs.
  - Copies of all pertinent correspondence.
  - If the provider is aware that a recipient has been interdicted, a statement to this effect must be noted and the court appointed guardian named.
  - A description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies. This may include documentation from the treating physician.

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**Service Logs**

Service logs document the allowable services billed and must reflect the services delivered. To obtain a copy of the service log, refer to Appendix D. They will be reviewed during recertification, monitoring, and when deemed necessary by the Bureau. Record entries must correspond with the services provided including billable services entered into the statewide data system as well as non-billable services.

Non-billable services, such as team planning or services provided during a lapse in authorizations must be documented on a service log with the statement "Non-billable Service" written at the top of the log. Federal and state requirements for documenting claims require that the following information must be entered on the service log:

- Service log number,
- Name of recipient,
- Name of provider and employee providing the service,
- Date of service contact,
- Begin and end time for service rendered,
- Indication if a crisis occurred during the contact,
- Place of service contact,
- Type of contact,
- Service provided,
- Service Participants, and
- Narrative describing the service.

Service logs must include specific documentation instead of using general terms such as "assisted recipient to" and "supported recipient" do not constitute adequate documentation. When more than one service is provided to a recipient during a contact, a service log must be completed for each service. For each log entry, the goal, objective, and intervention as documented in the ISRP must be paraphrased. The use of goal, objective, and intervention numbering is not acceptable. For example, "Goal 1, Objective 1, Intervention 1" does not constitute acceptable documentation. All of the following documentation components must be included for each log entry:

- Goals, objectives, and interventions documented in the recipient's current ISRP. If crisis services are provided, the ISRP must be updated to reflect the needed services.
- Services are appropriate in terms of frequency and intensity.
- Services are clinically appropriate to the needs of the recipient.

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- Specific intervention (s) and training material used during the contact.
- Recipient's response to interventions using observable/behaviors terms.
- Recipient's progress with accomplishing the targeted goal or objective.
- A plan for the next recipient contact to ensure continuity of services.
- Specific location when services are provided in the community.

Only the staff member providing the services may develop, sign, and make any necessary corrections to the service log. Service logs must be completed at or near the time of service to ensure accuracy.

Services logs must be reviewed and signed by the supervisor on a regular basis to ensure that all activities are appropriate, relative to the service type, location, service participant and duration and that documentation is sufficient to indicate progress towards achievement of treatment goals. Supervision is not billable.