Behavioral Health Services Provider Manual Update

Background: The Louisiana Department of Health (LDH) has revised **Section 2.6 – Record Keeping** of the **Behavioral Health Services Provider Manual**. The sections with substantive changes are included below for your convenience. New language is underlined. Deleted language is denoted with a ~~strikethrough~~.

Member Records

Providers must have a separate written record for each member served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, service providers must have adequate documentation of services offered and provided to members they serve. This documentation is an on-going chronology of activities undertaken on behalf of the member.

Providers shall maintain case records that include, at a minimum:

- Name of the individual;
- Dates and time of service;
- Assessments;
- Copy of the treatment plans, which include at a minimum:
    - Goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;
    - Specific interventions;
    - Service locations for each intervention;
    - Staff providing the intervention;
    - Estimated frequency and duration of service; and
    - Signatures of the LMHP, member, and guardian (if applicable);
- Progress notes;
- Units of services provided;
- Crisis plan;
- Discharge plan; and
- Advanced directive.

A member can sign the assessment and treatment plans electronically. A member's electronic signature will be deemed valid under federal law if it is authorized by state law. Under the Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if:

- The signer intentionally, voluntary agrees to electronically sign the document;
- The electronic signature is attributable to signer (i.e. be sure to have patient's printed name under signature); and
- There are appropriate security measures in place which can authenticate the signature and prevent alteration of the signature (i.e. date and signature cannot be modified in the electronic health record).

Organization of Records, Record Entries and Corrections

Organization of individual member 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 member records must be legible, written in ink (not black) and include the following:

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- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title, applicable educational degree and/or professional license of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

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

Service/Progress Notes

Service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered.

The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:

- Name of member;
- Name of provider and employee providing the service(s);
- Service provider contact telephone number;
- Date of service contact;
- Start and stop time of service contact; and
- Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.

~~Service/progress notes must be reviewed by the supervisor (if applicable) to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.~~ A sample of the service/progress notes for each member seen by a non-LMHP must be reviewed by an LMHP supervisor at least monthly or more if needed. The signature of the LMHP attests to the date and time that the review occurred.

The service/progress note must clearly document that the services provided are related to the member's goals, objectives and interventions in the treatment plan, and are ~~deemed~~ medically necessary and clinically appropriate. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill ~~and document the progress of the recipient with very specific information regarding response to the intervention and the plan for next time~~. Service/progress notes should include each member's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the member. Each service/progress note must include sufficient detail to support the length of the contact. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

The only staff who may complete a service/progress note is the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-844-521-6942**.