1620-L CASE FILE DOCUMENTATION STANDARD

REVISION DATES: 10/01/17, 01/01/16, 03/01/13, 05/01/12, 01/01/11, 10/01/07, 10/01/06, 09/01/05, 02/01/05, 10/01/04

INITIAL EFFECTIVE DATE: 02/14/1996

1. Case file documentation must be complete and comprehensive. It may be written by hand or typewritten. Each case file page should indicate the member's name and AHCCCS identification number. Each entry made by the case manager must be signed and dated. If electronic records are utilized, the Contractor must ensure the integrity of the documentation. AHCCCS may request that documentation kept in an electronic system be printed out for purposes of a case file review.

2. Contractors must adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).

3. Case files must be kept secured.

4. Contractors are expected to maintain a uniform tracking system for documenting the begin and end dates of those services listed in the Placement/Service Planning Standard section of this chapter, as applicable, in each member's chart. This documentation is inclusive of renewal of services and the number of units authorized for services.

5. Tribal Contractors must show authorization of services on the CA165/Service Plan.

6. Case files must include, at a minimum:

    a. Member demographic information, including residence address and telephone number, and the emergency contact person and his/her telephone number

    b. Identification of the member's Primary Care Provider (PCP)

    c. Uniform Assessment Tool (UAT), completed at least annually

    d. Information from 90/180 day on-site assessments that addresses at least the following:

i. Member's current medical/functional/behavioral health status, including strengths and needs
ii. The appropriateness of member's current placement/services in meeting his/her needs, including the discharge potential of residentially placed member
iii. The cost effectiveness of Arizona Long Term Care System (ALTCS) services being provided
iv. Identification of family/informal support system or community resources and their availability and willingness to assist the member as uncompensated caregivers, including barriers to assistance
v. Identification of service issues and/or unmet needs, an action plan to address needs and documentation of timely follow-up and resolution
~~v.~~ A detailed description of the member's objectives and services for each mental health agency providing services to the member
vi. Member-specific goals that will allow the member to gain functional skills or maintain/increase their current functioning level. Goals must be evaluated for appropriateness at each review with progress towards each goal documented and adjustments to goals/services made as necessary. Documentation should reflect member involvement in the development of goals
vii. Member's ability to participate in the review and/or who has been designated for the case manager to discuss service needs and goals with if the member is unable to participate, and
viii. Environmental and/or other special needs.

e. Information from the initial on-site assessment that includes all items listed in 4 above, as well as, for those members with HCBS services already in place at the time of enrollment, an assessment of the medical necessity and cost effectiveness of those services and a care/service plan that indicates which Prior Period Coverage (PPC) services will be retroactively authorized by the Contractor.

f. Copies of the member's Cost Effectiveness Studies (CES), placement history and service plans/authorizations. The service plan must be signed by the member or member representative at each service review visit (every 90 or 180 days) and a copy kept in the file.

g. A copy of the HCBS Needs Tool (HNT) completed for all members receiving Attendant Care, Personal Care, Homemaker, Habilitation and/or Respite services that indicates how the service hours were assessed and which portions of care, if any, are provided by the member's informal support system.

h. A copy of the contingency plan and other documentation that indicates the member/representative has been advised regarding how to report unplanned gaps in authorized "critical" services.

i. A copy of the "Spouse Attendant Care Acknowledgement of Understanding" Form (Exhibit 1620-12) signed by any member choosing to have his or her spouse as the paid caregiver, both before that service arrangement is initiated and annually to indicate the member's continued choice for this option.

j. Copies of Agency with Choice (AWC) or Self Directed Attendant Care (SDAC) related forms requiring case manager signature for all members choosing a member directed option, including the AWC Individual Representative form. Member directed forms can be found in Chapter 1300 of this manual.

k. A copy of the managed risk agreement, if indicated for the member, that identifies potential risks associated with service and/or placement decisions the member has made

l. Copies of current Client Assessment Tracking System (CATS) screens (CA160, CA161, CA165) for Tribal Contractors. CATS screens or comparable forms for Contractors.

m. Notices of Action sent to the member regarding denial or changes of services (discontinuance, termination, reduction or suspension)

n. Member-specific correspondence

o. Physician's orders for medical services and equipment

p. Documentation that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and PASRR Level II evaluation, if applicable, have been completed for members in nursing facility placements and that copies are in the facility chart. A copy of the PASRR Level II evaluation, if applicable, must also be retained in the case manager's file.

q. Provider evaluations/assessments and/or progress reports (for example, home health, therapy, behavioral health)

r. Case notes including documentation of the type of contact made with the member and/or all other persons who may be involved with the member's care (e.g. providers). Case notes should also include notifications of services not provided as scheduled (e.g. hospitalization, vacation, or respite outside of the home).

s. Documentation of the initial and quarterly consultation/collaboration with a qualified behavioral health professional, if applicable, and

t. Other documentation as required by the Contractor.

7. ALTCS member file information must be maintained by the Contractor for a minimum of five years.