



North Carolina Department of Health and Human Services
Division of Medical Assistance

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Medical Record Correction Policy for MDS Validation Reviews

Policy: Minor changes or corrections in the resident's status should be noted in the resident's record, in accordance with standards of clinical practice and documentation. Once documentation is recorded in the medical record, facilities may not "change" previously recorded documentation. This policy allows for a correction methodology in accordance with standards of clinical practice and documentation.

Procedure: Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. However, it is important to remember that the medical record is the legal assessment. Changes made to the electronic record or paper record maintained in the medical record after data transmission are not recognized as proper corrections.

Therefore, the Division of Medical Assistance has made provisions to allow proper corrections for the electronic record or paper record maintained in the medical record.

- a) If an error is discovered on or after but within 7 days of the Assessment Reference Date (A3a) of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.
- b) Any corrections including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction.
- c) If a major error is discovered in a record in the State MDS database, modification or inactivation procedures must be implemented by the facility to assure that the database information is corrected.
- d) Clinical documentation corrections must also be made as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed.
- e) A quarterly or summary note will not substitute for an occurrence correction.
- f) A standard medical correction consists of drawing a line through the incorrect information, entering the correct information, dating and initialing the change. Improper or illegible corrections will not be accepted for the review.

