5.5 MDS Correction Policy

Once completed, edited, and accepted into iQIES, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay—the MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 for details).

It is important to remember that the electronic record submitted to and accepted into iQIES is the legal assessment. Corrections made to the electronic record after iQIES acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to iQIES in accordance with the MDS Correction Policy.

Several processes have been put into place to assure that the MDS data are accurate both at the provider and in iQIES:

- If an error is discovered within 7 days of the completion of an MDS and before submission to iQIES, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.

- Software used by the provider to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent (e.g., a skip pattern is not observed), the record is rejected. Rejected records are not stored in the iQIES database.
- If an error is discovered in a record that has been accepted by iQIES, Modification or Inactivation procedures **must** be implemented by the provider to assure that iQIES information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA), Significant Correction to Prior Quarterly (SCQA), or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in iQIES. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps. A flow chart is provided at the end of these sections that summarizes these decisions and correction steps.