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Division of Medical Assistance

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Health Record Policy for MDS Validation Reviews

Policy: It is the policy of the NC Division of Medical Assistance to examine/review original medical record documentation to support resident assessment data (Minimum Data Set--MDS) for the MDS Validation review.

Procedure: More and more health care providers are using Health Information Technology (IT); in particular, Electronic Health Records (EHR). Health care providers (nursing home facilities) who utilize EHR processes are required to comply with the following procedures:

- The provider must grant access to any medical record, including access to EHRs, when requested by the reviewer.
- If access to an EHR is requested by the reviewer, the facility will:
  - o Provide the reviewer with a tutorial on how to use its particular electronic system and
  - o Designate an individual who will, when requested by the reviewer, access the system and
  - o Respond to any questions or assist the reviewer as needed in accessing electronic information in a timely fashion.
- Each reviewer will determine the EHR access method that best meets the need for that review.
- During the entrance conference in a facility using EHRs the reviewer must request that the facility provide a terminal(s) where the reviewer may access records.
- In the case of a hospital or other provider or supplier with terminals at multiple care locations, the reviewer must be provided access to a terminal at each care location.
- If the facility is unable to provide direct print capability to the reviewer, the provider must make available a printout of any record or part of a record upon request in a timeframe that does not impede the review process.
- ***Undue delays in the production of original and or EHR medical records are unacceptable and could result in unsupported documentation.***
- Whenever possible, the facility must provide the reviewer electronic access to records in a read-only format or other secure format to avoid any inadvertent changes to the record.
- The provider is solely responsible for ensuring that all necessary back up of data and security measures are in place.

Health Record Policy* (continued)

The RN reviewer will cooperate and work with facilities that use EHR. During the entrance conference the reviewer will establish with the facility the process they will follow in order to have unrestricted access to the medical record. Electronic access to records will not eliminate the need for a reviewer to print a paper copy or to request a paper copy of certain parts of certain records. However, the reviewer shall make reasonable efforts to avoid, where possible, the printing of entire records. The reviewer should print or request a paper copy of only those parts of records that are necessary.

Conclusion

Existing requirements allow the RN reviewer and others authorized by law to have access to facility records whether those records are paper or electronic record systems. Refusing access to any patient/resident records is a basis for termination of the facility's Medicaid agreement. If the reviewer requests access to EHR, the facility should ensure that data are backed-up and secure, and access does not impede the review process or the provision of care and services to beneficiaries.

*Health Records shall be defined as computer records, scanned records and or any records otherwise maintained as legal medical documentation.

This policy may be accessed at **http://nc.mslc.com/Resources**