SAN BERNARDINO COUNTY
Behavioral Health
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Medical Record Document Corrections in myAvatar Procedure

Effective Date 07/08/2025
Revised Date 07/08/2025

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Purpose

To provide instruction to the Department of Behavioral Health (DBH) workforce for completing document corrections in client medical records within myAvatar. DBH staff will be responsible for identifying inaccurate service entries, including those presenting a potential compromise of DBH client protected health information (PHI), and processing or requesting all corrections and/or service deletions.

Corrections

Upon identification of an error in a client medical record in myAvatar, DBH staff must report the need for correction to a DBH designated "Super User" who will be responsible for initiating the correction(s) following the guidelines below:

If…	**Then…**
Information is entered into a document in a client's medical record in error and does not contain PHI of another client	Document is to be voided. Ex: If Mary's progress notes had the wrong diagnosis in error, an addendum to the legal document needs to be added as soon as possible with the correct information, the person making the change should be identified, and the reason should be noted, the document(s) with the original entry should be voided.
Documents are filed in the wrong client's medical record/episode	Document is to be removed from the incorrect medical record using the Move Selected Data function and placed in the correct client's medical record.

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Corrections, continued

If…	Then…
There is associated billing to the wrong client	A Charge Data Correction Invoice (CDCI) (CLP010) must be submitted to the Revenue Cycle by the provider/supervisor. • Ensure that claims are not attached to the document before deleting; • If claims are attached to a document containing PHI of another client, the document must be immediately removed from the wrong chart and deleted to avoid a breach, and • Confirm that the service shows as claimed on the Client Ledger (found in add location) before submitting CDCI.
Information entered into a document in a client's medical record in error that pertains to and contains PHI of another client	Document is to be removed from the incorrect medical record using the Move Selected Data function and placed in the correct client's medical record.

- The SuperUser deleting the note should be identified and reason for deletion should be notated.
  - Ex: *Superuser name* deleted service because the RU number was incorrect.
- In the event the service provider is unavailable to correct their own documentation, the program and/or provider's supervisor will indicate on the corrected document <u>what was corrected</u> and <u>for what reason as follows:</u>
  - *"(Service type) was provided to the client on this (date) by (staff name with title). However, the service information required a correction. The (correct service is …). This note will replace the original service note in the client's medical record to update the service information. No clinical information has been changed. The original service can be located as a VOIDED document in the client's record.".*
  - The comment on the 'ID Progress Note' should also include the reason that the original author is not correcting the document, this is to explain why the submitting provider is not the same as the service provider.

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Corrections, continued

Note: PHI belonging to another client may not remain in the wrong client's medical record as it poses a breach risk.

Note: Services documented on behalf of staff no longer with DBH should not be billed

Incomplete Chart Documentation - Staff is No Longer With DBH

If chart documentation is left incomplete due to the separation of a DBH staff member, follow the guidelines below:

If…	Then…
Clinical assessment is incomplete	• Complete new clinical assessment; • The staff or supervisor completing the new assessment may use information from the incomplete document provided the information has not changed, and • Time needed to re-assess the client can be billed.
Replacement Progress Notes	• Progress notes cannot be claimed if they were not finalized; • Draft notes should be voided and a non-billable note created by the staff's former supervisor, documenting the content of the session and/or draft note. "(Service type) was provided to the client on this (date) by (staff name with title). However, the service provider was not available to finalize the note. The (content of the draft note is…). This note will replace the original service note in the client's chart to update the service information. No clinical information has been changed. The original service can be located as a VOIDED document in the client's record." • If a progress note was not created for the service a non-billable note should be created by the staff's former supervisor, documenting the service took place and language should be included explaining that the service provider did not complete the documentation prior to departure: *"(service type) was provided to the consumer on this (date) by (staff name with title). However, the service provider was not available to finalize the note. This note will stand as documentation of the service record.*

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Related Policy or Procedure

DBH Standard Practice Manual and Departmental Forms:

- Charge Data Correction Invoice (CLP010)
- Service Corrections, Replacements and Deletions Policy (CLK0708)
- Service Corrections, Replacements and Deletions Procedure (CLK0708-1)
- Medical Record Document Correctios in myAvatar Policy (COM0960)