Make Your EMR Work For You: EMR Solutions to Improve Documentation and Coding

Office visit documentation has evolved over the years. Provider notes were once simple notes on paper that were mostly used to remind a provider of what was done during a visit. That practice evolved and notes became scripted to comply with government and commercial insurance requirements to improve communication and to optimize evaluation and management codes for payment. And now, at least once per year providers are being asked to also document at a face-to-face visit all active chronic conditions and statuses and to ensure these conditions are reflected in claim submissions in the form of ICD-10 codes. This added requirement is essential to fully reflect the disease burden of a provider's patient and of their total patient population. To maximize the risk adjustment opportunities and to minimize the time needed to do the documentation, consider getting the most out of your EHR with templates and structured elements.

Problem List Management

1. Keep the active problem list current for all chronic conditions
2. Move inactive problems to History
3. Include "Status of" diagnoses Z85-Z99; for example, Z89.511 "Acquired absence of right leg below knee"
4. Consider problem list preference lists and eliminate nonspecific diagnoses

Medications

1. Always associate prescription and OTC meds with an active diagnosis
2. Do medication reconciliation at each visit
3. Whenever possible, refill medications within office visits if your system automatically adds the linked diagnosis to the visit diagnoses and drops the diagnosis with the claim

Visit Documentation

1. Ensure that all diagnoses include the ICD-10 code and description
2. Create visit templates for comprehensive chronic disease follow up visits
3. Consider use of links that draw the active problem list into the history of the present illness as a template for comprehensive documentation of interval history of chronic illnesses
4. Use similar links if your EHR can pull in all diagnoses and their associated orders (including medications) into the assessment and plan

Signature Requirements

1. "Electronically signed by" followed by a full signature or first initial and last name and credentials (MD, DO, etc)
2. Date signed (time is recommended but not required)