HCC Department Coding Newsletter

Arizona Priority Care™

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MONTHLY CODING SPOTLIGHT

EMR DOCUMENTATION ERRORS

Some of the more common electronic medical record errors seen are easily fixable with a little knowledge and care as listed below. These can be addressed by the rendering provider without involving an outside IT source.

- **No Chief Complaint**– This must be clearly documented to establish medical necessity. Simply using "follow up" is not a chief complaint, the reason for the visit should be stated.
- **No ROS**– This is important to establish there are no contraindications to treatment. Without this, the service could become a level one determination.
- **Information Carried Forward from Visit to Visit**– Carrying information forward leads to inaccuracies and errors. Examination findings one day may not be the same on a subsequent visit and thus would appear as the findings for that day. Additionally, continuing to add diagnoses to a chart can increase the length of the chart making it harder to decipher.
- **Recording Only the Positive Findings**- A ruled out diagnosis can have significant impact but often does not get into the medical record.
- **Only Listing the Diagnosis in the Assessment**– This portion of the note indicates the conditions addressed during the visit but should also include the provider's judgement and rationale for treatment. Addressing each diagnosis with a status and plan will provide the thought process for the evaluation of the patient's progress.
- **Utilizing the Same List of Diagnoses for Every Patient**- Using a superbill or quick pick list will limit the specificity of the diagnosis and may not represent the true condition. Avoid using favorite codes as not one code applies to all patients.
- **Conflicting Areas of the Note**– The exam portion may say a condition is within normal range while the assessment may state it is out of control or even amputated.
- **Mixed Messages from Dictations**– Common mistakes are "he" instead of "she", "hypo" instead of "hyper", these can be caught by a review or a diligent coder.

THINGS TO IMPROVE THE EHR

- Avoid Copy and Paste Carelessness
- Avoid "unspecified" and "NOS" when possible
- Always have a proper "Chief Complaint" outlining the reason for the visit
- Improve progress notes with the words "due to" or "manifested by"
- Update problem lists with each visit, a CVA is not a current problem on a subsequent visit
- The use of medical scribes can reduce a physicians time spent on paperwork
- Perform independent audits to assess compliance
- Only use standard medical abbreviations
- Have an organized note from the chief complaint to the plan
- Clearly define the conditions being treated
- Specify the acuity of the disease as acute or chronic
- Each note should be signed, completed and locked within a timely manner
- Review final note for possible contradictions
- Only code conditions treated or assessed on the DOS