Electronic Health Records -- Documentation Requirements

- You have the same documentation requirements with electronic health records as you do with paper charts. You can't totally rely on "automatic templates".
- You have to note you have reviewed data that is "static" in the system, such as family medical history, etc.
- Payers look for documentation that is appropriate for the condition, not documentation that covers many more systems than necessary.

Documentation in electronic health records must follow the same documentation requirements as paper charts. If information is located on the face sheet of the patient in electronic medical records, the payer will not know that has been reviewed unless it is mentioned in the documentation for the visit. Also, any information provided by the nurse or other support staff must be re-recorded or mentioned by the physician.

Electronic health records provide many benefits. The patient's medication list, tests and previous visits are at your fingertips, but you have to be more careful about your documentation of the visit because template use can create problems.

If you pull a template into the office visit, you have to be sure to make consistent changes and not have conflicting information. You don't want to say the patient came in for a severe cough in one section and then in another section say they are negative for congestion, sneezing, cough.

You also do not want to have similar or identical information recorded from patient to patient. It will be considered "cloned". All documentation must be specific to the patient and their situation. Templates can certainly be used, just be sure to make any changes needed based on the patient being seen and the treatment performed.

Volume shouldn't determine coding, necessity should. Information is so easy to record using templates, you should be careful to not record unnecessary information to meet higher-level service requirements. It would not be medically necessary or appropriate.

You should also be careful about the current lists in your EHR that you bring over for a patient. For example, if you bring over the problem list, be sure you are treating and documenting each of these problems. You also must be careful which diagnoses are attached to the visit. Electronic Health Records are a great tool, but must be used carefully.