
THREE THINGS TO KNOW ABOUT: EHRS – DOCUMENTATION

1. No matter how good the system, what you get out of it will only be as good as what you put in. In other words, garbage in, garbage out. If you have not been thorough with your documentation in the past, your EHR system might make your record look “prettier” but it will not in and of itself create a record that supports good patient care and would be useful in your defense in the event of a claim or a lawsuit.
2. If you choose to use documentation shortcuts such as templates and the copy/paste function you must remember that it is you who will be responsible for insuring that the encounter is billed using the appropriate code. Though the system may create documentation that meets the coding requirements for the highest code, it does not mean that you should bill at that code. Medical necessity is the key to accurate coding – even if a coding tool suggests a higher level of service.
3. Metadata is literally data about data and provides an audit trail of everything that occurs within the electronic record. What this means is that every time you sign onto an electronic health record system, you leave a trail of your activity including what patient records and what portions of those records were viewed, the actual time the record was viewed, how much time was spent looking at the record (including how long it took to view and override a safety alert or other clinical support tool), what entries were made, and any changes that were made to the record. And, as with all other parts of the medical record, metadata may be discoverable in a medical malpractice lawsuit.

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