Clinical Practice Scenarios and Questions

Go through the scenarios and questions below either individually or as a group to practice navigating around the EHR and documenting visits.

Practice Scenarios:

A biopsy is performed on a patient during their visit. The doctor would like you to modify the morphology and also add the differential diagnosis so that it will show on the pathology report. You also notice that after you edit these changes and you go to print the requisition, you notice the information is not there. What could the issue be?

Your patient is in office for an Excision and Repair from a previous biopsy that was done in office. After you apply the treatment plans and the details, your provider notices that the coding is not pulling over correctly to reflect the procedures that were performed. What could cause this to happen?

A patient is interested in cosmetic procedures after his Skin Cancer Screening. The dermatologist discusses various options such as injectables (Botox, dermal fillers) laser treatments, and chemical peels. The physician states he wants a different note to document this and wants to make sure the cosmetic note is made non-billiable? How would you document this? How do you make the note non-billable?

Your provider performs multiple diagnoses for a patient which require a lot of extra documentation. After adding all of this in, you notice from the linear progress note that your A&P section is italicized. The patient then points out another lesion that requires you to go back into the body map and mark one more diagnosis. Upon returning to the progress note you realize that the last diagnosis is not showing even though you see it in the body map and in the coding screen. What could be the cause of this?

When a patient visits for a cosmetic consultation and expresses interest in purchasing multiple products available at the clinic, it is important to add these items to the progress note to ensure they are included in the patient's shopping cart before they proceed to check out. How would you items to the cart?

Your patient comes in with a very bad wound on their leg. After examination, the provider decides they will prescribe antibiotics and also do a culture to r/o MRSA. After adding the culture you go to print the requisition but none of the ICD-10 codes are pulling and this information is required by the lab. What went wrong?

A patient comes in with a whole list of medications that they are taking. They hand you the list and ask you to help them add them in. How can you search for the medications quickly to bring forward everything they have been prescribed for any of their physicians? Also you want to put a copy of the list in the patient's file for future reference, how can you do that without leaving the progress note?

Your patient comes into the office with a really bad rash. After the exam, the physician states that the patient has Psoriasis and they want to refer them out of the office to see a specialist. You will need to create the outside referral, but also generate a general referral letter back to the patient's PCP. The patient is also requested to have their records from their past 3 visits be sent to them via the patient portal. Where can all of this be done?

You receive a todo message from your attending provider asking you to contact the patient with their biopsy results and schedule them for a procedure. You call the patient and leave a comment in the message. What would be the most efficient way to schedule the patient to come back into the clinic, so the diagnosis will be linked with the upcoming visit? The patient also provided documents that they want sent to the physician to review prior to the procedure, where can you attach these so that the provider can see them and be notified that they have something to view?

Your patient comes in with psoriasis and the provider is going to prescribe a biologic medication, to get this approved you will have to make sure the BSA, PASI and PGA are documented, how would you do this so it appears in your progress note?

A patient is here for an excision of a diagnosed skin cancer within EZDERM, how will you apply the planned procedure in order for this patients plan to be removed from the planned folder?

A patient is here for an excision of a diagnosed skin cancer within EZDERM, you have already performed the procedure but you now need to update the biopsy log. How will you do this from the 3D body map?

A patient is here for Mohs today, you click on the Mohs icon and you do not see patients, what do you have to do to be able to see these patients?

A patient is here for Mohs today, you go to the Mohs module and click on the planned tab, you click on the patient for stage 1 and you are unable to document. What must you do first?

A patient is here for Mohs today, the provider told you that stage 1 is not clear, what do you do to update the documentation in order to have stage 2 appear in the Mohs module?

A patient tells you during the intake process that they already filled out their paperwork. Where do you go to check if they have completed EZCHECK In?

Questions:

- What is the proper way to document the DDX and Morphology so that the information will show on the requisition when you print it?
- What fields need to be filled out when doing an Excision and Repair so that the coding will properly pull forward?
- What causes the text to be italicized in the system?
- How can you bring forward information that is not displaying after free texting has been done?
- What do you do if you go to the inbox to print the requisition but it doesn't show? You know you added the procedure in the body map? Or did you?
- What is the dispensed medications field? How does it work?
- Where can documents be made viewable on the patient portal? Is anything provided on the portal automatically or does everything have to be shared?
- What is MACRA?
- What do you have to do to make sure you are being compliant when answering MACRA questions?
- How do you properly document an HPI? What fields should not be missed?
- Do you have to document ROS (review of systems)
- Does the system save vital signs for follow up encounters?
- What makes a skin cancer appear in the cutaneous malignancy log?
- Can you update/edti/remove any discrepansies from the cutaneous malignancy log?
- The blue R means what in EZDERM?