Using Diagnosis within EverHealth Scribe

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> Scribe drafts the diagnoses you addressed with the codes already attached. You review and adjust them on the **Diagnoses** tab, and **Send to EHR** puts them on the patient's Problem List, where OfficeEMR carries them through to the Superbill.

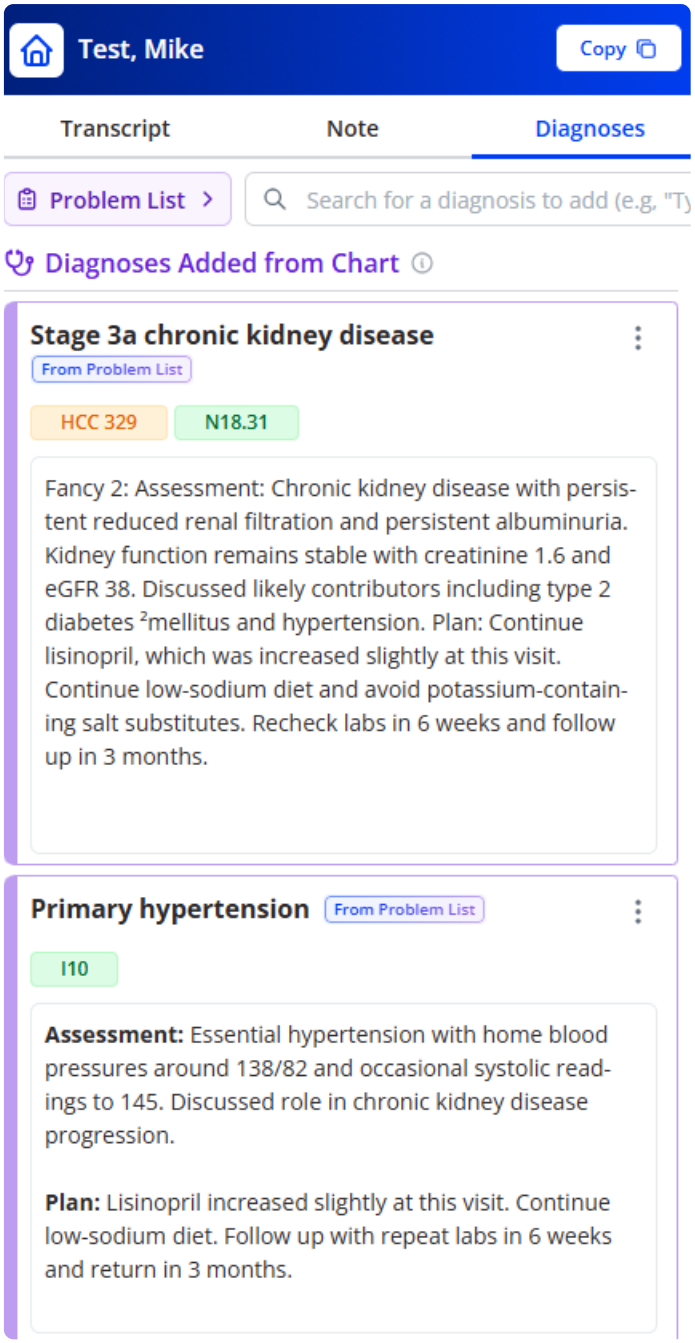
EverHealth Scribe drafts more than the narrative note. It also reads the visit for the conditions you addressed, attaches ICD-10 codes, and writes an Assessment and Plan for each one. You stop hunting for codes and start reviewing them.

The three views

After you stop recording, Scribe drafts the visit and gives you three tabs across the top:

- **Transcript** shows what was said during the visit. Use it when you want to verify where a detail came from.
- **Note** is the drafted clinical note, organized into the sections you already use.
- **Diagnoses** is the coded picture of the visit: the conditions you addressed, the ICD-10 codes for each, and the Assessment and Plan that goes with them.

The Note and the Diagnoses tabs are drawn from the same visit, so they should tell the same story. If you change something material in one, check the other before you send.



What Scribe puts on the Diagnoses tab

Scribe uses the transcript to work out which conditions the visit actually addressed, then separates them into two kinds:

Kind	How you recognize it	What it means
Already on the Problem List	A **From Problem List** chip on the card	The condition is already on this patient's Problem List and you addressed it during this encounter. Scribe is documenting the visit against an existing problem, not proposing a new one.
Suggested from the visit	No **From Problem List** chip	Scribe heard something in the conversation that isn't on the Problem List yet and is proposing it as a new problem for you to accept, adjust, or remove.

That distinction is worth a glance before you review anything else. It tells you whether you are confirming known

history or deciding to add something new to the chart.

Reading a diagnosis card

Each diagnosis appears as a card. Here is what is on it:

On the card	What it is
Diagnosis description	The condition as Scribe would document it, often more specific than what was said out loud. For example, *"Type 2 diabetes mellitus with stage 3a chronic kidney disease, without long-term current use of insulin."*
From Problem List chip	This condition is already on the patient's Problem List and is being addressed during this encounter.
ICD-10 code chips	The billing codes Scribe attached, for example **E11.22** and **N18.31**. A diagnosis can carry more than one.
HCC chips	Informational. Shows the risk-adjustment category the coded condition maps to. See *Why HCC categories appear* below.
+ Add ICD-10	Attach another code to this diagnosis yourself.
Refine	Opens Scribe's more specific alternatives for this diagnosis, each with its codes and the reason it fits. See Refining a Diagnosis in EverHealth Scribe.
Assessment and **Plan**	The drafted clinical reasoning and next steps for this specific condition: labs, medication decisions, referrals, follow-up interval. Editable like any other text.
Card actions	Regenerate this diagnosis, remove it from the visit, or open the additional options menu.

Why HCC categories appear

Some coded conditions map to an HCC (Hierarchical Condition Category), which is how risk-adjusted payment models account for how sick a population is. Scribe surfaces the category on the card so you can see when a condition you are documenting carries that weight. Just as usefully, you can see when a vaguer version of the same condition would not.

The chips are informational. They do not change what is billed and they are not a prompt to code differently than the visit supports. Document what you addressed and what your documentation supports; the categories simply make the consequence of specificity visible.

Working the Diagnoses tab

Scan the list first. Check that every condition you addressed is present and that nothing is there you did not address. Missing and extra are easier to spot before you start reading codes.

Check the source of each one. Note which cards carry **From Problem List** and which are new suggestions. New problems deserve a closer look, because you are deciding to add them to the chart.

Read the codes against the description. Confirm the attached ICD-10 codes match the condition as written, including laterality, stage, and any causal relationship the description claims.

Refine where you can support it. If a card offers **Refine**, review the suggestions. A more specific code is better only when your documentation actually supports it. See Refining a Diagnosis in EverHealth Scribe.

Read the Assessment and Plan. These carry into the note and into the chart. Correct anything that misstates your reasoning, and edit directly in the text.

Remove what does not belong. Use the remove action on any card that reflects a condition you discussed but did not address, or one Scribe misread.

Send to EHR when the Note and the Diagnoses tab both reflect the visit.

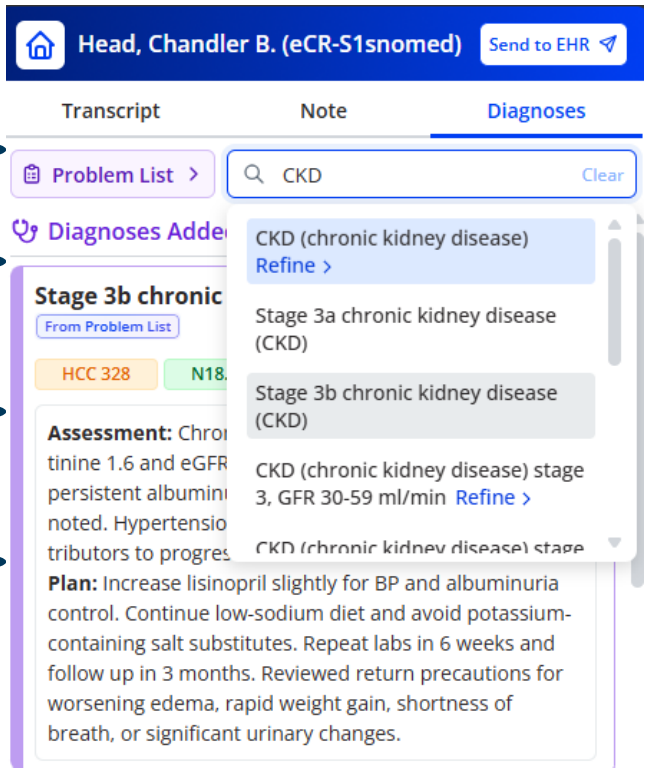
Adding a diagnosis Scribe missed

Use the search field at the top of the **Diagnoses** tab.

Type the condition or the code, for example, *Type 2 diabetes* or *E11*.

Select the diagnosis you want. It is added to the visit as a card.

Add an Assessment and Plan, and attach any additional codes with **+ Add ICD-10**.



Faster than the code search you are used to. If a condition came up late in the visit or you dictated it after the patient left, adding it here means you never leave Scribe to look up a code, and it still flows to the Problem List and Superbill with everything else.

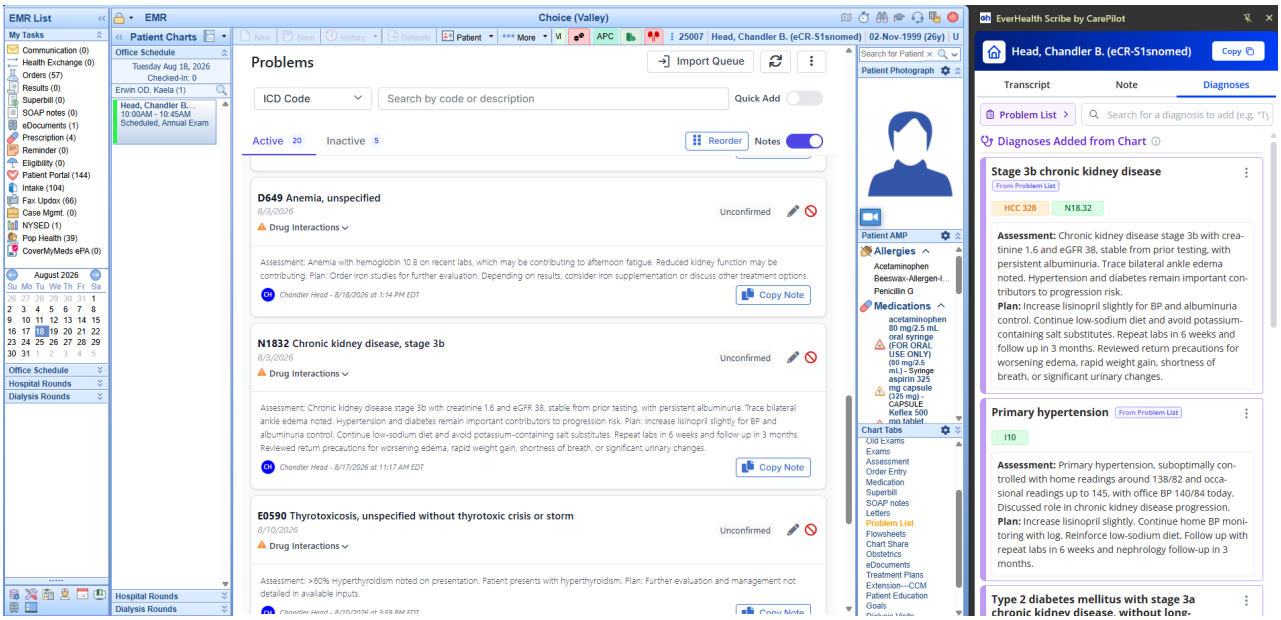
Where diagnoses go when you send

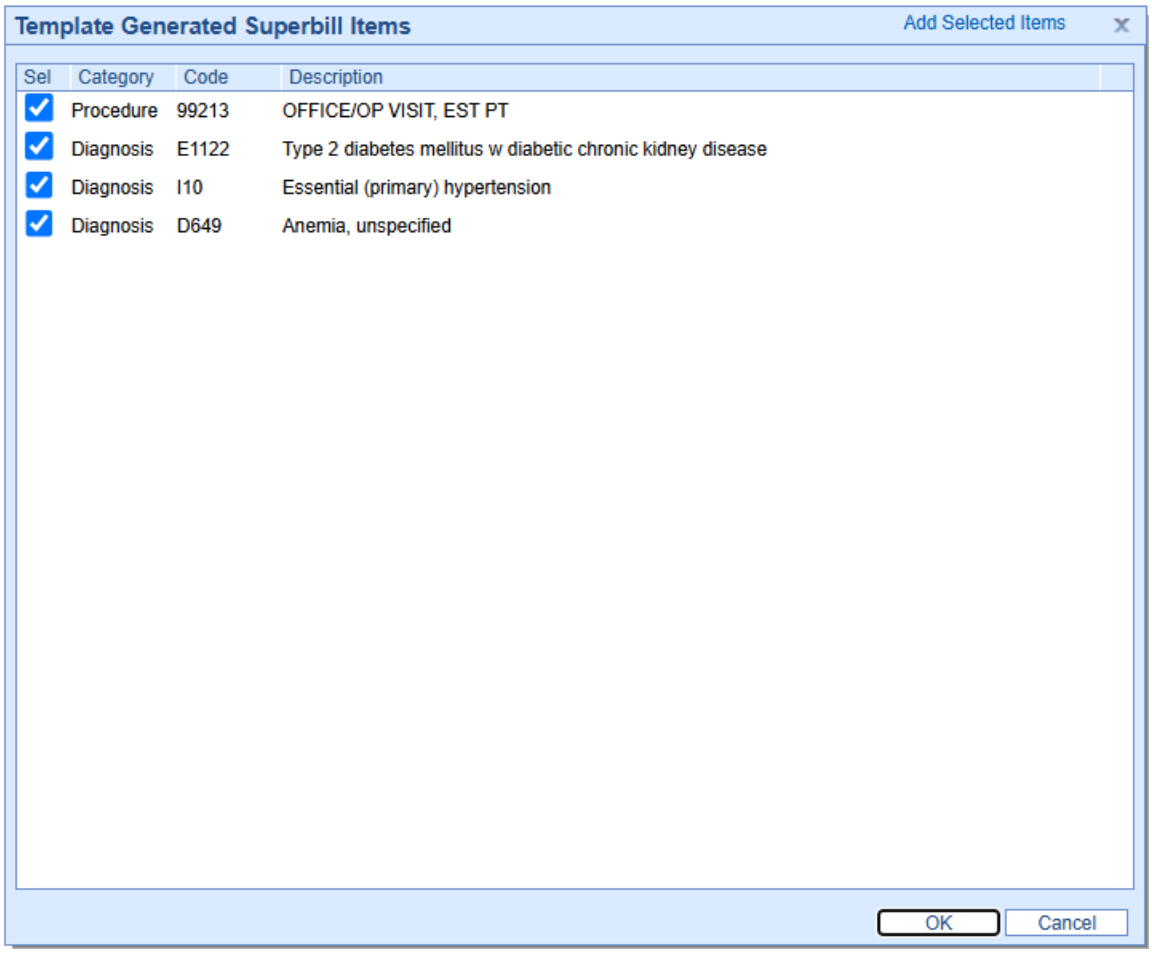
One action moves everything. When you select **Send to EHR**:

The narrative note writes into the chart tabs your practice configured. See Where Scribe Writes in the Chart.

The diagnoses write to the patient's **Problem List**, with their codes and their Assessment and Plan.

The Superbill follows automatically. OfficeEMR already carries Problem List items through to the day's Superbill, so the diagnoses you approved in Scribe appear there as the encounter's diagnosis codes. No extra step in Scribe, and no extra step in OfficeEMR.





Reload the patient in OfficeEMR to see it. If the chart was already open before you sent, refresh it by selecting the patient from the Office Schedule again. See Sending the Note to OfficeEMR for Signoff.

Still entered the way you do today: Orders, Medications, and the procedure and charge side of the Superbill. Scribe now supplies the encounter's diagnoses; the CPT and charge entry remains your normal workflow.

What to double-check, every time

You own the codes. Scribe produces a draft, including the coded diagnoses. You review and correct it before signing, the same standard you apply to any documentation and the same standard that applies to a claim. See Using EverHealth Scribe Safely.

Before you send, give particular attention to:

- **Specificity you can support.** A more precise code is only better if the note backs it up. If the documentation does not establish the stage, the type, or the cause, the less specific code is the correct one.
- **Causal links.** Descriptions that say *"due to," "with,"* or *"secondary to"* assert a relationship between two conditions. Confirm the note establishes that relationship.
- **Laterality and site.** Left versus right, and the specific site.
- **Acute versus chronic**, and the status of anything already on the Problem List: active, resolved, or in remission.
- **New problems.** Anything without a **From Problem List** chip is about to be added to the patient's permanent Problem List. Confirm you intend that.
- **Conditions discussed but not addressed.** Mentioning a condition in passing is not the same as managing it. Remove cards for conditions you did not address this visit.

You can also make corrections in OfficeEMR before you sign off. Diagnoses that reach the Problem List are editable there like any other Problem List entry.

Frequently asked questions

Do I have to code anything during the visit?

No. Talk with your patient as usual. Scribe drafts the diagnoses along with the note, and your job afterward is to review them. Orders, Medications, and the procedure and charge side of the Superbill still need to be entered the way you do today.

Do the diagnoses reach the Superbill?

Yes. They write to the Problem List, and OfficeEMR carries Problem List items through to the day's Superbill as the encounter's diagnosis codes. There is nothing extra to do.

What if Scribe suggests a condition I did not address?

Remove the card. A condition mentioned in passing is not one you managed, and it should not reach the Problem List or the claim.

Am I responsible for the codes?

Yes. Scribe drafts, but you are the author of record for the note and the codes. Review both before sending.