

The EPOWERdoc Coding module is a tool that enables the facility to seamlessly capture the key elements for coding the full Emergency Department visit within the natural course of documenting the encounter. While the clinicians are recording the patient visit, the EPOWERdoc Coding application is extracting the pertinent information to automatically assign facility levels as well as CPT and / or HCPCS codes to the appropriate coding visit template for review by the facility coder.

Key highlights:

- “Guided” prompts to ensure complete documentation
- Warnings tied to signing off / closing out the record to capture pertinent information (i.e. IV stop times)
- Automatic placement on coding worksheet with CPT and Charge code
- Coding worksheet splits screen with actual visit record
- Easy to read summary display
- Ability to code both Facility and Professional pieces without leaving the record or perform at separate times
- Intuitive application with onsite training and support available 24 x 7

## **Facility Coding**

The client has the ability to choose a “leveling”, “Point” or “Occurrence” system for the facility coding methodology. Internal client point or occurrence systems can also be placed into the EPOWERdoc Coding module for use as the methodology.

Below is a quick visual “walk” through the coding application:

1. Once the coding module is open, the options for the chart selection

The screenshot displays the EPOWERdoc Coding Tool interface. It features a title bar with the application name and standard window controls. The main area contains several input fields for patient information: Patient, Identification, Arrival mode, Chief Complaint, Final Impression, Disposition, Departure Time, Physician, and RN. There are also fields for DOS, To, and Acuity. A Queue Type dropdown menu is set to 'To Be Coded', with a 'List Charts Queue <C2>' button below it. A 'Patient Insurance Info' button is also present. At the bottom, a blue bar labeled 'Coding' contains four buttons: 'Facility Coding <C3>', 'Professional Coding <C4>', 'QA Fac', and 'QA Pro'.

2. A Chart is selected from the Queue type

MRN	Hosp/Acct	DOS	Pat Name	Chief Complaint	Facility	Fac Coder	Fac Code Time	Fac Release Time	Fac Print Time	Professional	Pro Coder	Pro Code Time	Pro Release Time	Pro Print Time	Notes
064778	913457	01/11/2013	FRIDAY, SARAH (16 Yr/F)	Blockage in ear	Not Ready					To Be Coded					
12345	723452345	01/15/2013	TEST, ADULT (62 Yr/F)	Eye problem	To Be Coded					Not Ready					
56789		01/17/2013	KAIDEN, LIL (1 Yr/M)	Fever	Not Ready					To Be Coded					
32123	654	01/29/2013	MAKCOLY, ILIAS M (45 Yr/M)	Alcohol intoxication	To Be Coded					To Be Coded					
222555	963258	01/30/2013	BRADLEY, BERNARD (76 Yr/M)	Alcohol intoxication	Coded - To be rel...	Rob	2/4/2013 9:06 AM			To Be Coded					
85749	013101201	01/30/2013	CODING, THREE (25 Yr/M)	Abdominal pain	To Be Coded	Rob	2/4/2013 12:29			To Be Coded	Rob	2/4/2013 11:54			
456789791		02/04/2013	ROBERT, MONDAY E (62 Yr/M)	Back or flank pain	Coded - To be rel...	Rob	2/4/2013 2:21 PM			To Be Coded					
741555	6555	02/05/2013	TESTOLY, TESTINA T (36 Yr/F)	Allergic reaction	To Be Coded					To Be Coded					

3. Once the chart is selected, the fields will automatically populate:

- a. Demographics
- b. Visit details

4. Selecting "Facility Coding" populates these additional fields:

- a. CPT / HCPCS
- b. Level of Service (if applicable)

The screenshot displays the EPOWERdoc Coding Tool interface. On the left, the 'Coding' section is active, showing patient information for PICKLES, DILBERT (61 Yr/M, DOB: 09/05/1951). The 'Facility Coding <C3>' option is selected, and the 'Level of Service' is set to 99285. The 'CPT <C5>' and 'HCPCS <C3>' sections are also visible. On the right, the 'Chart Viewer' displays the patient's room assignment (GN 03), vital signs, nursing notes, and procedure notes, including admission to Internal Medicine Service and various medical interventions.

5. Changes can be made at this point to either add, delete CPTs manually. Can also add multiple modifiers at this time

6. Once the coder has finalized the chart, they can save the facility coding and review via a "Facility Summary"

EPOWERdoc Test Facility  
Coding Summary - Emergency Department  
97 Administrative Drive  
Martinsburg, NE 68124 Phone: 888-417-5588

**Facility Coding**

Visit Identifiers

Patient Name: **PICKLES, DILBERT** Encounter Date: **01/04/2013 08:36**  
DOB: **09/05/1951** Hospital Account: **EPD6753**  
Visit ID: **4643** MRN: **EPD9807**

Visit Information

Chief Complaint: **Dizziness; Facial laceration**  
Final Impression: **SYNCOPE; FACIAL LACERATION**  
Disposition: **Admitted** To: **Admitted**  
Arrival Mode: **Ambulance 06-Camp Hickman** Acuity: **0**  
Departure Time: **1/4/2013 12:30:00 PM** Insurance:  
Physician: **David Ernst, MD** Nurse: **Keith Lastrapes, RN**

ICD Codes

() - [780.2] - Syncope and collapse  
() - [873.42] - Open wound of forehead, without mention of complication

Level Of Service

( 2300044) - [99285] - EMER ROOM - V

CPT Codes

() - [12013] - SIMPLE REPAIR, SUPERFICIAL WOUNDS, FACE/EARS/EYELIDS/NOSE/LIPS/MUCOUS  
MEMBRANES; 2.6-5.0 CM  
( 2305050) - [96374] - IVP: Zofran  
( 2305083) - [96361] - IV HYDRATION EACH ADD L HOUR  
( 2305083) - [96361] - IV HYDRATION EACH ADD L HOUR

## Professional Coding

The EPOWERdoc Coding module follows the 95 Guidelines and all CMS standards. There are several areas that are automatically extrapolated from the physician provider documentation (i.e. Histories count, etc) and these are populated into the coding module when it is opened. The Complexity of Medical Decision Making however, needs to be determined by the coder themselves and then the professional level is completed. Any of the items that are automatically generated can be modified if needed – if the provider free texts several elements of the HPI for example.

Once the chart is selected, the following steps outline the process of completing the Professional coding aspect within the EPOWERdoc Coding module.

1. Selecting “Professional Coding” populates the following fields:
  - a. CPT Procedure codes
  - b. ICD codes (if applicable)

**EPOWERdoc Coding Tool**

Patient: PICKLES, DILBERT 61 Yr/M DOB: 09/05/1951  
 Identification: HA-EPD6753 - MRN: EPD9807 - Visit #: 4643  
 Arrival mode: Ambulance 06 Camp Hickman DOS: 1/4/2013 8:36:00 AM  
 Chief Complaint: Dizziness; Facial laceration  
 Final Impression: SYNCOPE; FACIAL LACERATION  
 Disposition: Admitted To: Internal Medicine Service  
 Departure Time: 1/4/2013 12:30:00 PM Acuity: 0  
 Physician: Ernst, MD RN: Lastrapes, RN

**Coding**

Facility Coding <C> Professional Coding <C> QA Fac QA Pro  
 Coded - To be released To Be Coded

**Visit ICD <C>**

Level of Service: CC Code: Critical Care (Minutes): Notes:

**CPT <C>** **ICD <C>** **Mod <C>**

93010 ELECTROCARDIOGRAM, ROUTE  
 12013 SIMPLE REPAIR, SUPERFICIAL

MDM <C> Save Summary Fac. Summary Pro. Hold Req. Info.

**Codes Search**

Load Codes for: ICD <C> CPT <C> Mod <C>  
 Search:

00.01 THERAPEUTIC US VESSELS HEADNECK  
 00.02 THERAPEUTIC ULTRASOUND OF HEART  
 00.03 THERAPEUTIC US PERIPH VASC VESSELS  
 00.09 OTHER THERAPEUTIC ULTRASOUND  
 00.10 IMPLANTATION CHEMO THERAPEUTIC AGENT  
 00.11 INFUSION OF DRUG TROPICAM ALFA  
 00.12 ADMINISTRATION INHALED NITRIC OXIDE  
 00.13 INJECTION OR INFUSION OF NESIRITIDE  
 00.14 INJ/INFUS OXAZOLIDINONE CLASS ABX

**EPOWERdoc - Chart Viewer**

MRN: EPD9807  
 Acct No: EPD6753  
 DOS: 01/04/2013 08:36  
 Printed: 02/10/2013 00:00  
 Page 1 of 3

**CHIEF COMPLAINT:** Dizziness; Facial laceration

**HPI Dizziness**  
 Assessment time: 01/04/2013 08:36  
 Reviewed: VS SAO2 Nursing notes ALL  
 Timing: Onset time: 2 (Hours) pta  
 Came on: Suddenly  
 Duration:  
 Location: If weakness: Generalized sided  
 Severity: Able to care for self  
 Modifying Factors: Worsens: Change in position Turning head Nothing  
 Context: Symptoms: Faintness Syncope  
 History of: Anemia Electrolyte disorder MI CVX IM GI bleeding DM None of the preceding  
 Associated Symptoms: (N) Chest pain Headache SOB  
 Other history/Staff note:

**HPI Facial laceration**  
 Reviewed: VS SAO2 Nursing notes ALL  
 Timing: Onset time: 2 (Hours) pta  
 Duration: LOC for: 30 (Seconds)  
 Location:  
 Severity: (of pain): Mild (0-10 scale)  
 Context: Symptoms: Pain Swelling Laceration LOC  
 Mechanism: Fall  
 Caused by: Blunt trauma  
 Tetanus: < 5 years  
 Associated Symptoms:  
 Other history/Staff note:

**ROS (complaint-specific):**  
 CONSTITUTIONAL: None  
 EYES: Blurred vision  
 ENT: Ears: None

2. Additional codes can be added, current codes can be deleted and / or modifiers placed if appropriate
3. Clicking on the “MDM” button opens the application to the Medical Decision portion of the tool. The History and the Data Reviewed section have automatic extrapolation from the documentation of the record.

**EPOWERdoc Coding Tool**

Patient: PICKLES, DILBERT 61 Yr/M DOB: 09/05/1951  
 Identification: HA-EPD6753 - MRN: EPD9807 - Visit #: 4643  
 Arrival mode: Ambulance 06 Camp Hickman DOS: 1/4/2013 8:36:00 AM  
 Chief Complaint: Dizziness; Facial laceration  
 Final Impression: SYNCOPE; FACIAL LACERATION  
 Disposition: Admitted To: Internal Medicine Service  
 Departure Time: 1/4/2013 12:30:00 PM Acuity: 0  
 Physician: Ernst, MD RN: Lastrapes, RN

**History**

History Of Present Illness	Qty	Level
HPI (History Of Present Illness)	10	5
ROS (Review of Systems)	14	5
PFSH (patient, family, social history)	3	5
PE (Physical Examination)	8	5
<b>Final Score:</b>		<b>Level: 5</b>

**Number of Diagnosis or Treatment Options**

New Problem (Additional Workup) Points: 4

**Amount and/or complexity of Data Reviewed**

Review and/or order of clinical lab tests  
 Review and/or order of tests in radiology section of CPT  
 Review and/or order of tests in medical section of CPT  
 Discussion of tests results with performing physician  
 Decision to obtain history from old records or someone other than the patient  
 Review and summarization of history from old records and/or from someone other than patient and/or discussion of case with another health care provider  
 Independent visualization of image tracing or specimen as opposed to simply reviewing report  
 Points: 6

**Risk of Complications and/or Morbidity or Mortality**

Minimal  Low  Moderate  High  
 Points: 4

**Final MDM Score**

EBM Code: 99285  
 Save Cancel

**EPOWERdoc - Chart Viewer**

MRN: EPD9807  
 Acct No: EPD6753  
 DOS: 01/04/2013 08:36  
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 Page 1 of 3

**CHIEF COMPLAINT:** Dizziness; Facial laceration

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 Reviewed: VS SAO2 Nursing notes ALL  
 Timing: Onset time: 2 (Hours) pta  
 Came on: Suddenly  
 Duration:  
 Location: If weakness: Generalized sided  
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 Modifying Factors: Worsens: Change in position Turning head Nothing  
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 History of: Anemia Electrolyte disorder MI CVX IM GI bleeding DM None of the preceding  
 Associated Symptoms: (N) Chest pain Headache SOB  
 Other history/Staff note:

**HPI Facial laceration**  
 Reviewed: VS SAO2 Nursing notes ALL  
 Timing: Onset time: 2 (Hours) pta  
 Duration: LOC for: 30 (Seconds)  
 Location:  
 Severity: (of pain): Mild (0-10 scale)  
 Context: Symptoms: Pain Swelling Laceration LOC  
 Mechanism: Fall  
 Caused by: Blunt trauma  
 Tetanus: < 5 years  
 Associated Symptoms:  
 Other history/Staff note:

**ROS (complaint-specific):**  
 CONSTITUTIONAL: None  
 EYES: Blurred vision  
 ENT: Ears: None

- Once the additional fields are filled in and the MDM saved, the level is calculated and displayed for the Professional coding side

The screenshot shows two windows from the EPOWERdoc software. The left window, 'EPOWERdoc Coding Tool', contains patient data for PICKLES, DILBERT (DOB: 09/05/1951, MRN: EPD9807, Visit #: 4643). It shows arrival by ambulance at 8:36 AM on 1/4/2013 with a chief complaint of 'Dizziness; Facial laceration'. The final impression is 'SYNCOPE; FACIAL LACERATION'. The coding tool interface includes buttons for 'Facility Coding', 'Professional Coding', and 'QA Fac', along with a 'Level of Service' field set to 99285. A list of codes is visible at the bottom, including 99285, 93010, and 12013. The right window, 'EPOWERdoc - Chart Viewer', displays a 'Professional Coding' report. It lists the chief complaint as 'Dizziness; Facial laceration' and provides a detailed HPI. The HPI for dizziness includes assessment time (01/04/2013 08:36), reviewed notes (VS, SaO2, Nursing notes, ALL), timing (onset 2 hours pta, sudden), location (generalized, sided), severity (able to care for self), and modifying factors (change in position, turning head, nothing). The HPI for facial laceration includes reviewed notes (VS, SaO2, Nursing notes, ALL), timing (2 hours pta), duration (30 seconds), location, severity (mild, 0-10 scale), context (pain, swelling, laceration, LOC), mechanism (fall), and cause (blunt trauma). Associated symptoms include chest pain, headache, SOB, and none of the preceding. The report also includes ROS (constitutional: none, eyes: blurry vision, ENT: ears: none).

- The Final summary is easily viewed in the "Professional Coding Summary"

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Coding Summary - Emergency Department  
97 Administrative Drive  
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**Professional Coding**

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Disposition: Admitted      To: Admitted  
Arrival Mode: Ambulance 06-Camp Hickman      Acuity: 0  
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Physician: David Ernst, MD      Nurse: Keith Lastrapes, RN

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**Level Of Service**

(2300044) - [99285] - EMERGENCY CARE LEVEL 5

**CPT Codes**

() - [93010] - ELECTROCARDIOGRAM, ROUTINE W/AT LEAST 12 LEADS; INTERPRETATION & REPORT ONLY  
() - [12013] - SIMPLE REPAIR, SUPERFICIAL WOUNDS, FACE/EARS/EYELIDS/NOSE/LIPS/MUCOUS MEMBRANES; 2.6-5.0 CM