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:

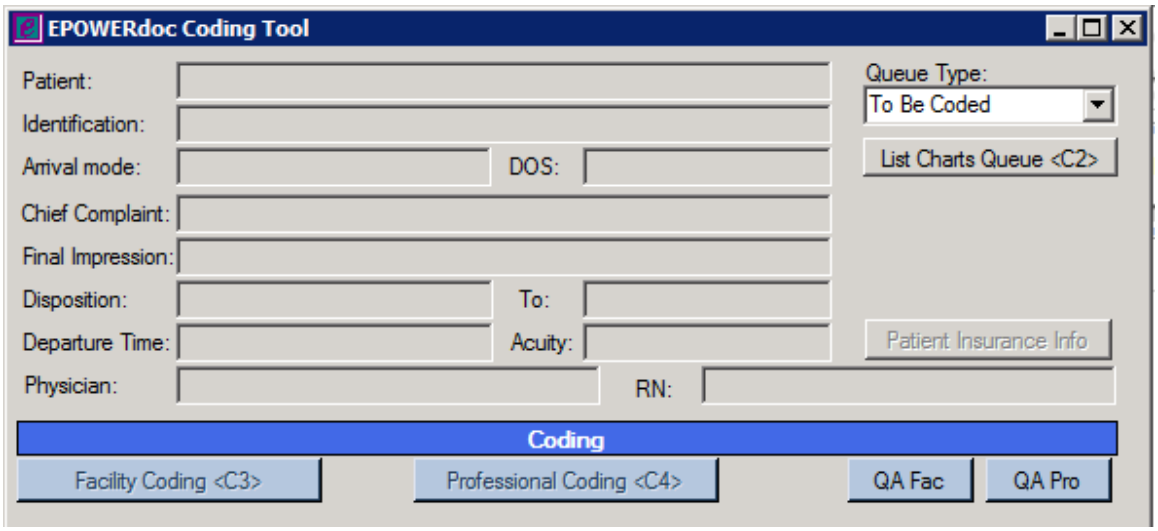
- "Guided" prompts to ensure complete documentation
- Warnings tied to signing off / closing out the record to capture pertinent information (i.e. IV stop times)
- Automatic placement on coding worksheet with CPT and Charge code
- Coding worksheet splits screen with actual visit record
- Easy to read 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

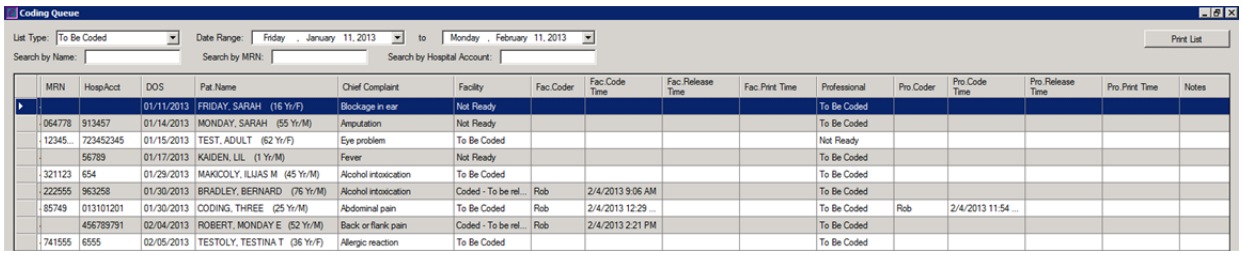
The client has the ability to choose a "leveling", "Point" or "Occurrence" system for the facility coding methodology. Internal client point or occurrence systems can also be placed into the EPOWERdoc Coding module for use as the methodology.

Below is a quick visual "walk" through the coding application:

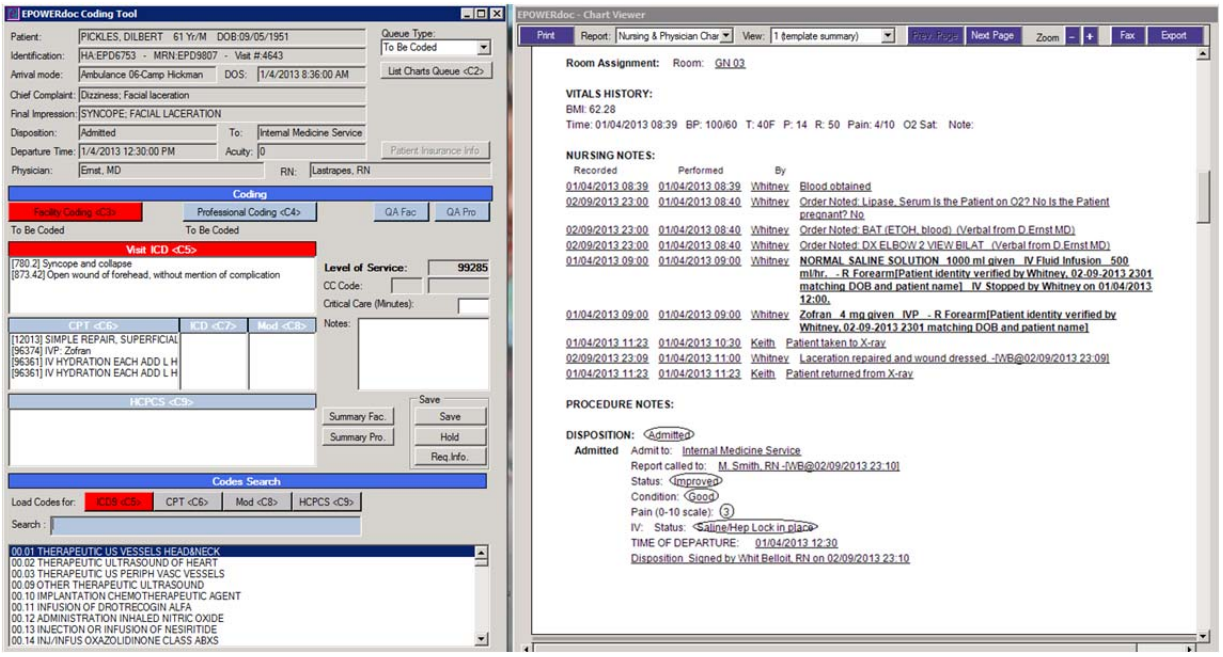
1. Once the coding module is open, the options for the chart selection



2. A Chart is selected from the Queue type



3. Once the chart is selected, the fields will automatically populate:
    a. Demographics
    b. Visit details
4. Selecting “Facility Coding” populates these additional fieds:
    a. CPT / HCPCS
    b. Level of Service (if applicable)



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

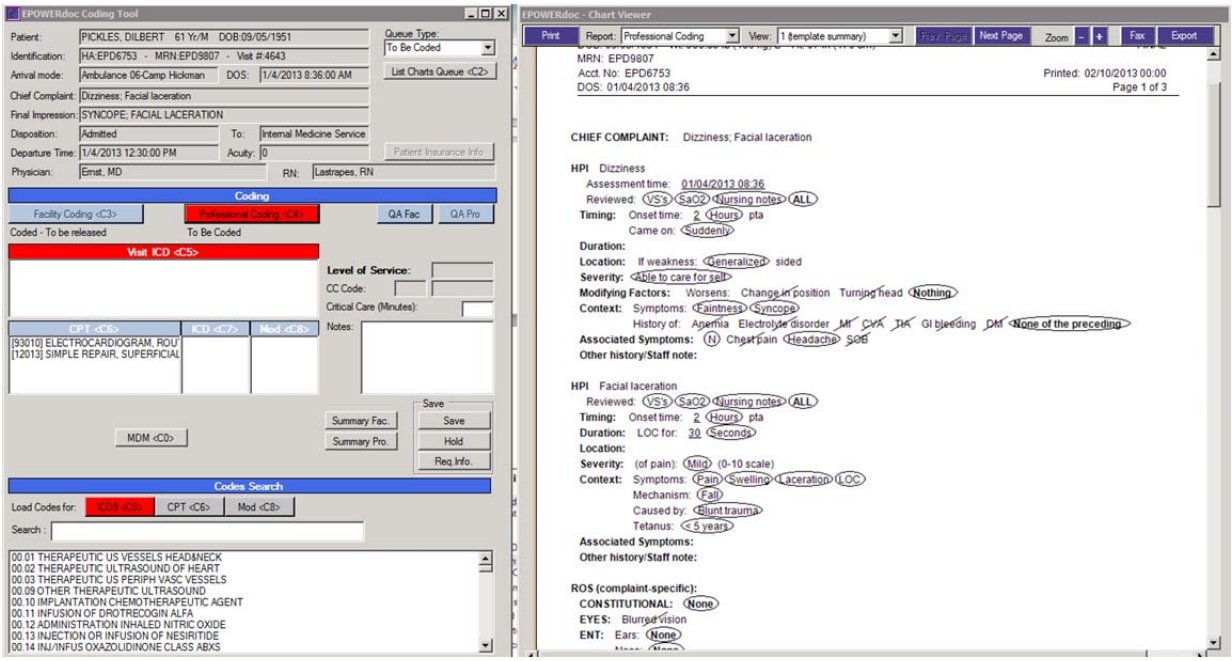
CPT Codes
() - [12013] - SIMPLE REPAIR, SUPERFICIAL WOUNDS, FACE/EARS/EYELIDS/NOSE/LIPS/MUCOUS MEMBRANES; 2.6-5.0 CM
(2305050) - [96374] - IVP: Zofran
(2305083) - [96361] - IV HYDRATION EACH ADD L HOUR
(2305083) - [96361] - IV HYDRATION EACH ADD L HOUR

Professional Coding

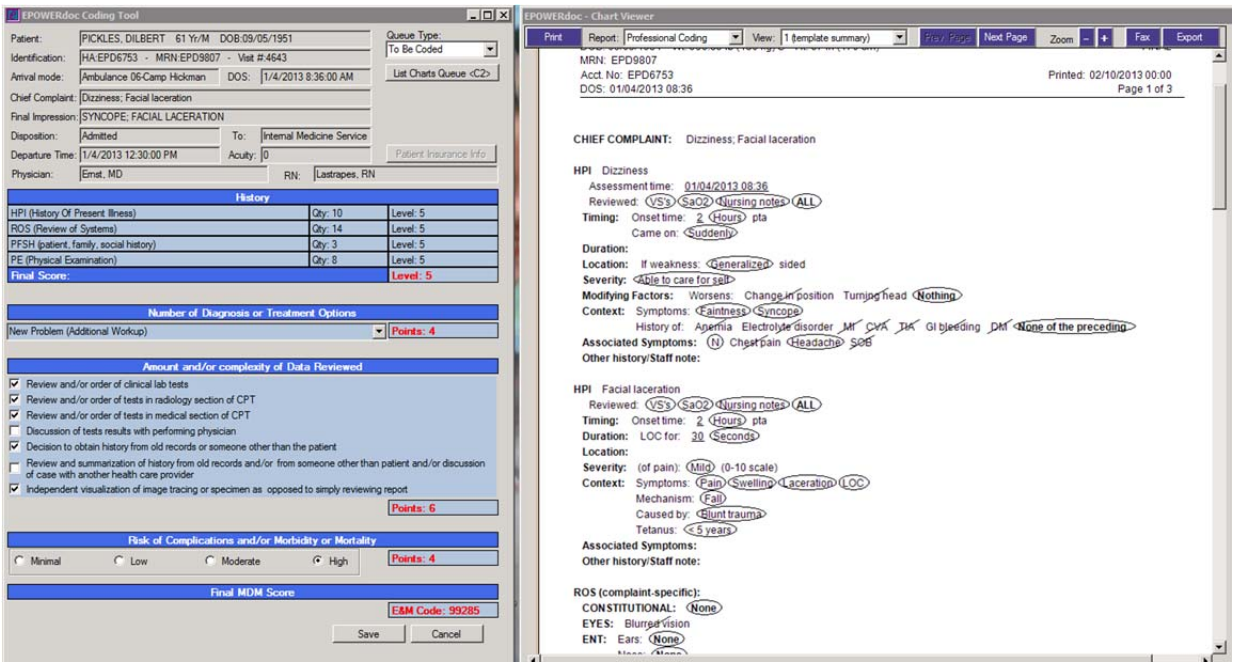
The EPOWERdoc Coding module follows the 95 Guidelines and all CMS standards. There are several areas that are automatically extrapolated from the physician provider documentation (i.e. Histories count, etc) and these are populated into the coding module when it is opened. The Complexity of Medical Decision 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.

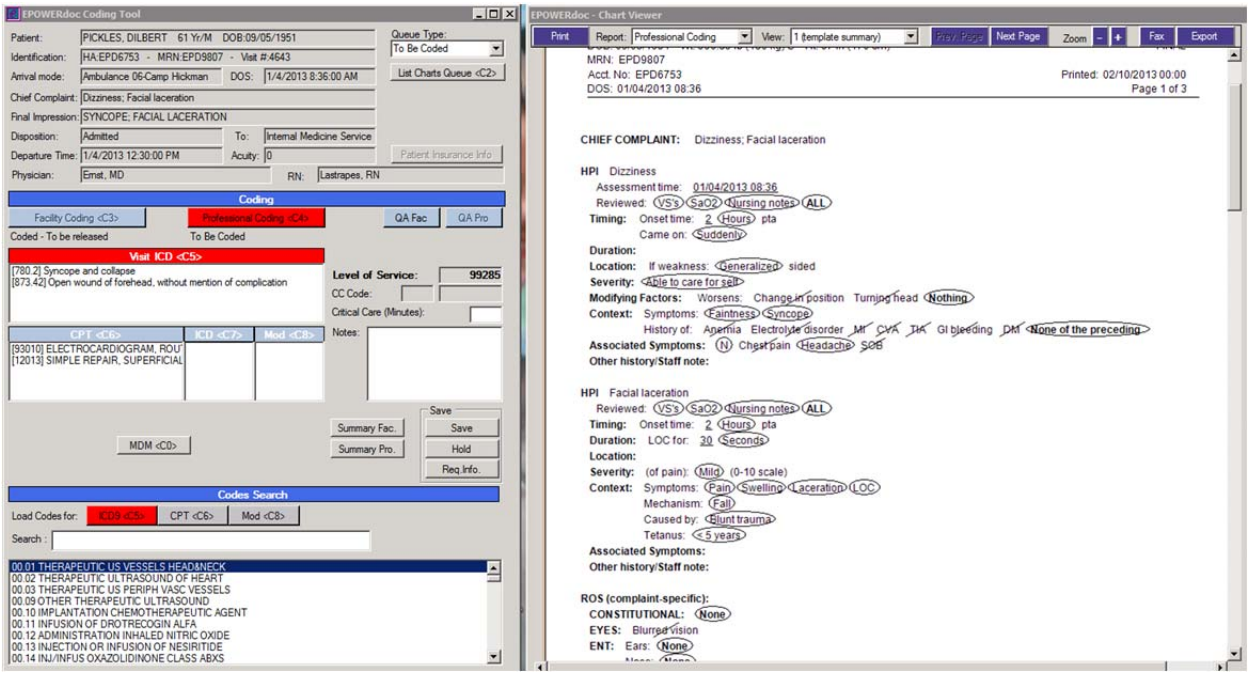
1. Selecting “Professional Coding” populates the following fields:
    a. CPT Procedure codes
    b. ICD codes (if applicable)



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.



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



5. The Final summary is easily viewed in the “Professional Coding Summary”

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

Professional 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] - 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