

staff. In daily practice and when using paper-based systems, clinicians may fail to depict the extent of the work they performed in the care of the patient because of the time required to complete the paperwork.

In addition to meeting documentation needs, correctly designed EHRs are capable of performing internal, real time chart audits and calculating the appropriate level of service based on the documentation present in the EHR. This capability provides reliable and reproducible E/M coding, in comparison to the demonstrably inaccurate method of allowing clinicians to make their best guess.

Conclusion

Although both the physician and the facility utilize the same E/M codes, the level-of-service calculations are based on entirely different rule sets, as mandated by the CMS. As a result, physician and facility E/M level of service do not and should not have any mathematical correlation among patients seen in hospital-based outpatient wound centers. The results of this prospective study comprising 9,985 patient visits at three different hospital-based outpatient wound clinics showed a weak correlation between physician and hospital E/M levels of service. The finding that initial visit physician level of service coding was higher than both hospital E/M levels of service and follow-up visit levels of service is not unexpected, considering the high number of comorbidities in many wound patients and general risk of their presenting problems. In addition to documentation needs, capturing accurate service level codes and automated E/M coding

within a wound care specific EHR can ensure compliant and accurate billing practices for both the hospital and the facility even though the rule sets for each are different. n

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