



PEDIATRIC EVALUATION AND MANAGEMENT CODING CARD 2019

HISTORY				EXAMINATION			
HPI Elements (Only reporting provider may document.) <input type="checkbox"/> Duration (if at, since last night, 1 wk) <input type="checkbox"/> Location (right ear, big toe, head, lower abdomen) <input type="checkbox"/> Context (occurred when awake from nap, while playing soccer, when fell from tree) <input type="checkbox"/> Associated signs/symptoms (blurred vision with headache, cough with runny nose, drowsy with vomiting)		Review of Systems <input type="checkbox"/> Constitutional (if vital or general appearance) <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, and throat <input type="checkbox"/> Respiratory <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genitourinary <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Neurologic <input type="checkbox"/> Psychiatric		Past, Family, and Social History <input type="checkbox"/> Past (ie, surgery, injuries, illnesses, injuries, treatments) <input type="checkbox"/> Family (a history of pertinent family history, including selected traits or disorders) <input type="checkbox"/> Social (an age-appropriate review of past and current activities)		Body Areas/Organ Systems <input type="checkbox"/> Head, face <input type="checkbox"/> Neck <input type="checkbox"/> Chest/breast/throat <input type="checkbox"/> Abdomen <input type="checkbox"/> Genitalia, groin/buttocks <input type="checkbox"/> Back, spine <input type="checkbox"/> Extremities, nails <input type="checkbox"/> Constitutional (if vital or general appearance) <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, and throat <input type="checkbox"/> Respiratory <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genitourinary <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Neurologic <input type="checkbox"/> Psychiatric <input type="checkbox"/> Integumentary (skin or breast)	
No. of HPI Elements _____		No. of ROS _____		No. of PFH _____			
No. of Body Areas/Organ Systems _____							
MEDICAL DECISION-MAKING							
Dx/Mgt		Data Reviewed/Ordered		Risk			
				Presenting Problem	Diagnostic Procedures	Management Options	
1 point (issue 1)	Established problem	1 point Order or review laboratory studies.	Minimal	1 self-limited, minor problem	Wet/dry/tape Chest radiograph ECG/EEG Urinalysis Ultrasound	Pain Cough Dietary changes Superficial dressing	
2 points (issue 2)	Established problem worsening, inadequately controlled, or failing to change as expected	1 point Order or review other studies (eg, ECG, EEG, x-ray, PET) 1 point Decide to obtain old records OR Decide to obtain history from someone other than the patient.	Low	1 self-limited, minor problem 1 stable/chronic illness Acute uncomplicated illness or injury	Physologic, nonstress test Non-cardiovascular imaging study with contrast Needle biopsy Arterial puncture Skin biopsy	OTC drug Minor surgery, no consultation Physical therapy Occupational therapy IV fluids without additives	
3 points (issue 3)	New problem without additional workup	1 point Discuss test with performing physician. 2 points Independently review image, specimen, or testing (documentation tip: "On my review...").	Moderate	1 chronic illness with mild exacerbation 2 stable/chronic illnesses Undiagnosed new problem, uncertain prognosis Acute illness with multiple symptoms Acute complicated injury	Physiologic stress test Diagnostic endoscopy, no consultation Deep needle or incisional biopsy Cardiovascular imaging study with contrast Obtaining fluid from body cavity	Minor surgery with consultation Elective major surgery without consultation Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed fracture treatment	
4 points (issue 4)	New problem with additional workup	2 points Review and summarize old records OR Obtain history from someone other than the patient OR Discuss care with other health-care professionals.	High	Chronic illness with severe exacerbation, progression Illness/injury that poses a threat to life or bodily function Always change in recordings, status	Electrophysiologic study Diagnostic endoscopy with consultation Diagnostic	Elective major surgery with documented consultation Emergency major surgery Parenteral controlled substance Drug therapy requiring intensive monitoring Decision for DNR or do-resuscitation of treatment due to poor prognosis	
Add Points Total Points		Add Points Total Points		Choose Risk Level Based on Highest Risk Noted From Table Above		Overall MDGM Level. Choose on the Basis of Meeting or Exceeding 2 of the 2 (Dx/Mgt, Data, Risk) Elements	
1	Minimal	1	Minimal	Minimal	Minimal	Minimal	
2	Low	2	Low	Low	Low	Low	
3	Moderate	3	Moderate	Moderate	Moderate	Moderate	
4	High	4	High	High	High	High	

HISTORY: Documentation of history includes CC, HPI, ROS, and PFH.

- ☐ **Internal History:** Subsequent hospital care only requires documentation of new history since last encounter.
- ☐ **Unstable/Unstable History:** Document reason. For example, "Further history was unstable/unstable because..."

EXAMINATION: Document specific abnormal, unexpected, and adverse negative findings. A collection of negative or normal is sufficient for normal findings. Extent of exam documented depends on PP.

MEDICAL DECISION-MAKING: MDGM can be viewed as the outcome of a cognitive process that leads to the selection of a course of action to diagnose or treat a patient. There are 3 distinct components to MDGM: number of problems, data reviewed/ordered, and risk. The first 2 are quantified; risk is up to the health-care professional to determine. To qualify for a given type of MDGM, 2 of the 3 elements must be met or exceeded.

TIME: For visits dominated by counseling or coordinating care, document total face-to-face time (disruptive) or visit flow time (disruptive) and that >50% of total time was dominated by counseling or coordinating care. In flow of key components, time can be used to determine L/N level: >10% was spent counseling and coordinating care. Time is counted only by the reporting/health-care professional. Documentation requirements: "I personally spent a total time of <_> minutes in the care of this patient; of that, <_> minutes was spent in counseling and coordinating care face-to-face."

Evaluation And Management Coding Guidelines

Stephen Levinson (MD.)



Evaluation And Management Coding Guidelines :

The New Face of Evaluation and Management Kellie S Hall, 2025 Physicians want to care for patients not spend their time documenting in an electronic medical record Physicians are always complaining about the amount of time they spend documenting patient care in support of medical billing through an evaluation and management coding system E M New guidelines were created to lessen the time a physician provider spends on documentation as many of the mandatory elements are no longer a requirement for calculating a code level Previously an E M evaluation and management note required documentation of history exam and medical decision making with required elements in each component to support a level for payment If an element was missing the level of service was not supported therefore the code was lowered resulting in a lower reimbursement for the physician provider The new guidelines eliminated the requirement of History and Exam as part of the calculation of a code level Yes an appropriate history and exam are required this supports good patient care but when it comes to reimbursement they are no longer part of the picture The overall system is not difficult if time is taken to understand the elements and how they are applied in the documentation Documentation is a word game always has been the authors focus is to show what words to use to lessen the time but still convey the complexity of the patient s condition and how the physician provider determines a treatment plan which includes the risk to the patient to satisfy the Coding guidelines initiated by Medicare and American Medical Association This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement This is not a cumbersome book or complicated but straight to the point The main goal of the book is to educate physicians nurses and coders on what documentation is really required and what has just become habit over the last 30 years

Evaluation and Management Coding Reference Guide - First Edition AAPC, 2020-06-30 Defeat the challenges that threaten your E M claims and compliance success Evaluation and management E M services are the lifeblood of your revenue stream and yet they re the most problematic to report Claim denials remain high E M coding errors in fact rose from 11.9% in 2018 to account for 12.8% of CMS s overall 2019 improper payment rate How much E M revenue are you losing Safeguard your organization from claim denials and audit scrutiny with the Evaluation Management Coding Reference Guide Our experts break down E M coding rules and requirements into simple manageable steps written in everyday language to boost your E M reporting skills Learn how to capture the key components of medical history physical exam and medical decision making and capitalize on real world clinical scenarios to prevent over or under coding The Evaluation Management Coding Reference Guide will help you prep for 2021 E M guideline changes overhauling new and established office and outpatient services and walk you through online digital E M services remote physiologic monitoring and more Master the ins and outs of E M coding CPT guidelines level of service modifiers regulations and documentation guidelines Put an end to avoidable denials and optimize your E M claims for full and prompt reimbursement Benefit from expert

tutorials covering the spectrum of E M reporting concepts and challenges Prep for 2021 guideline changes and their impact on your organization Master the ins and outs of E M guidelines in CPT Capture the seven components of E M services Sort out medical decision making coding Avoid the pitfalls of time based coding Nail down specifics for critical care E M services Clear up modifier confusion Understand NPPs rules for same day E M services Take the guesswork out of complexity determinations Get the details on coding surgery and E M together Learn the principles of E M documentation **Practical Evaluation and Management Coding** Christopher L. Taylor,2008-03-14 This guide explains the Evaluation and Management E M coding process used by physicians and regulated by the American Medical Association In four chapters Dr Christopher Taylor establishes a step by step approach to determining the correct CPT code for the most common patient encounters in the office hospital or nursing home Helpful appendices provide E M coding guide templates and additional information Auditing Evaluation and Management Coding Joe Rivet,Sharon Bolarakis,2006 **E&M Coding Clear & Simple** Terri Ann Brame,2013-09-16 This easy to read text breaks these complex codes into manageable bite sized pieces Practice questions and real world case studies help you apply your knowledge and approach any coding situation with confidence The New Face of Evaluation and Management Kellie Hall,2025-06-30 Physicians want to care for patients not spend their time documenting in an electronic medical record Physicians are always complaining about the amount of time they spend documenting patient care in support of medical billing through an evaluation and management coding system E M New guidelines were created to lessen the time a physician provider spends on documentation as many of the mandatory elements are no longer a requirement for calculating a code level Previously an E M evaluation and management note required documentation of history exam and medical decision making with required elements in each component to support a level for payment If an element was missing the level of service was not supported therefore the code was lowered resulting in a lower reimbursement for the physician provider The new guidelines eliminated the requirement of History and Exam as part of the calculation of a code level Yes an appropriate history and exam are required this supports good patient care but when it comes to reimbursement they are no longer part of the picture The overall system is not difficult if time is taken to understand the elements and how they are applied in the documentation Documentation is a word game always has been the authors focus is to show what words to use to lessen the time but still convey the complexity of the patient s condition and how the physician provider determines a treatment plan which includes the risk to the patient to satisfy the Coding guidelines initiated by Medicare and American Medical Association This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement This is not a cumbersome book or complicated but straight to the point The main goal of the book is to educate physicians nurses and coders on what documentation is really required and what has just become habit over the last 30 years The New Face of Evaluation and Management KELLIE. HALL,2025-04-17 This book evaluates the new

guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement

Evaluation and Management Coding Made Easy Terry

Tropin,2020-11-12 Evaluation and Management Coding Made Easy book has now been updated to include the extensive 2021 changes This book simplifies the language of CPT R E M guidelines and places the guidelines into charts for easy reference The book covers Outpatient and inpatient coding Preventive care Other services such as critical care and prolonged services The book also includes a discussion of modifiers and terms used in E M services Forms are included to guide the reader through the step by step process of determining the level of service This book is designed especially for both students and working coders

Evaluation and Management Coding Made Easy Terry Tropin,2021-11-29

This book simplifies the language of Current Procedural Terminology CPT for Evaluation and Management coding The book includes the updates for 2022 This book was developed by a coding teacher to help both students and working coders The book is updated every year or as needed The book covers The key components history examination and medical decision making Office or other outpatient services Forms to guide the reader through the step by step process to determine level of service Services to patients who are not sick Non Face to Face Services Services based on time Modifiers Definitions of terms CMS 1997

Documentation Guidelines

Evaluation and Management (e&M) Coding Calculator BarCharts, Inc,Theresa

Tropin,2017-01-31 Annotation Quick and easy tool for students and professionals Whether studying for class or a coding certification test Use as a quick go to desk reference for the professional starting out or for the guru that has the ultimate coding toolbox of useful resources 6 page laminated guide includes Standard Steps Codes for E M Diagnosis or Symptom Location of the Service Relationship Between Physician Patient Level of History from Documentation Level of Exam from Documentation Level of Medical Decision Making Choose Code Based on Levels of Key Components When Time Determines the E M Code Modifiers Special Types of E M Services HCPCS Level II E M Services Medicare Documentation Guidelines History Physical Examination Medical Decision Making Suggested uses Students handy reference that is compact and easily reviewed on a daily basis Certification great quick review tool for certification testing Coding Professionals a quick reference memory refresher Medical Administration training tool for coding or non coding staff

Compliance for Coding,

Billing & Reimbursement, 2nd Edition Duane C. Abbey,2008-04-02 While the vast majority of providers never intend to commit fraud or file false claims complex procedures changing regulations and evolving technology make it nearly impossible to avoid billing errors For example if you play by HIPAA s rules a physician is a provider however Medicare requires that the same physician must be referred to as a supplier Even more troubling is the need to alter claims to meet specific requirements that may conflict with national standards Far from being a benign issue differing guidelines can lead to false claims with financial and even criminal implications Compliance for Coding Billing Reimbursement Second Edition A Systematic Approach to Developing a Comprehensive Program provides an organized way to deal with the complex coding

billing and reimbursement CBR processes that seem to force providers to choose between being paid and being compliant Fully revised to account for recent changes and evolving terminology this unique and accessible resource covers statutorily based programs and contract based relationships as well as ways to efficiently handle those situations that do not involve formal relationships Based on 25 years of direct client consultation and drawing on teaching techniques developed in highly successful workshops Duane Abbey offers a logical approach to CBR compliance Designed to facilitate efficient reimbursements that don't run afoul of laws and regulations this resource Addresses the seven key elements promulgated by the OIG for any compliance program Discusses numerous types of compliance issues for all type of healthcare providers Offers access to online resources that provide continually updated information Cuts through the morass of terminology and acronyms with a comprehensive glossary Includes a CD ROM packed with regulations and information In addition to offering salient information illustrated by case studies Dr Abbey provides healthcare providers and administrators as well as consultants and attorneys with the mindset and attitude required to meet this very real challenge with savvy humor and perseverance

Foundations of Clinical Nurse Specialist Practice Janet S. Fulton, Brenda L. Lyon, Kelly A. Goudreau, 2009-10-16 Designated a Doody's Core Title This comprehensive book addresses pertinent issues for clinical nurse specialists from clinical interventions to nursing care delivery and nursing leadership This is a wonderful addition to the field of nursing Score 100 5 stars Doody's Foundations of Clinical Nurse Specialist Practice serves as a comprehensive textbook and practice reference for graduate level CNS students and practitioners Compiled and edited by experts in the field this book discusses every aspect of Clinical Nurse Specialist practice from its historical foundations to chapters on implementing the business of CNS practice With this book readers will gain essential knowledge on delivering client care to the individual patient the family and the community The text includes major sections on designing and evaluating client care interventions promoting innovation change and diffusion in practice client care delivery and a wealth of information on the business aspects of CNS practice Key topics discussed How to use the Clinical Reasoning Model CRM a clinical inquiry guide for problem solving How to use complex adaptive systems theory to influence change Using population based data analysis to improve patient care outcomes Exploring the business aspects of CNS practice with discussions on economics consultation technology management and billing and reimbursement issues Practice Exemplars on hospital based CNS practice collaborative private practice and entrepreneurship Role Exemplars that range from pediatric bariatric and pain management to psychiatric liaison rehabilitation CNS and Emergency CNS

The Physician Assistant's Business Practice and Legal Guide Michele Roth-Kauffman, 2006 This text is offered as a medical legal resource of the physician assistant profession It is intended for use through all phases of the professional development of the physician assistant from the high school student sorting through options in career choices to physician assistant students practicing physician assistants and supervisory physicians or those who are considering practicing with a physician assistant The history and

development of the profession is reviewed allowing an understanding of the role the physician assistant plays in the healthcare team approach to patient care The scope of practice is defined along with the key collaboration between the physician assistant and the supervising physician Regulatory requirements are delineated by state including basic requirements and maintenance of licensure and certification

Coders' Specialty Guide 2025: Cardiology/

Cardiothoracic Surgery AAPC,2025-01-31 Find all the details you need to support each cardiology coding decision How would you like to rule your workload with mastery of the 2025 CPT and HCPCS Level II procedure codes for cardiology Now you can with the Coders Specialty Guide 2025 Cardiology Cardiothoracic Surgery No need to flip through bulky coding books with this specialty specific and intelligently designed resource All the information you need about a code is organized for rapid access ICD 10 cross references RVUs and NCCI edits along with anatomical illustrations Medicare reimbursement details and expert coding and billing guidance Plus a description of the procedure in easy to understand terms so you can confidently translate your providers notes into the correct codes Expedient your cardiology coding with these features Cardiology and cardiothoracic surgery CPT and HCPCS Level II procedure and service codes including 2025 new and revised codes Official descriptors for Category I III CPT codes Easy to follow lay term explanations of how physicians perform each procedure Expert coding and billing tips for assigning specific CPT codes Medicare reimbursement rates for physicians and hospitals with facility and non facility RVUs Modifier crosswalks showing applicable modifiers for CPT codes Pre post and intra operative procedure indicators NCCI edits to check for bundling conflicts ICD 10 CM to CPT crosswalks to pin down medical necessity and reap maximum reimbursement Complete code index to make searches quick and easy Dictionary style headers for fast navigation Detailed anatomical illustrations And more Rely on the Coders Specialty Guide 2025 Cardiology Cardiothoracic Surgery for reporting accuracy and coding speed CPT is a registered trademark of the American Medical Association

Study Guide and Procedure Checklist Manual for Kinn's The Medical Assistant - E-Book Brigitte Niedzwiecki,Julie Pepper,2022-09-08 Designed to support the trusted content in Kinn s The Medical Assistant 15th Edition this study guide is an essential review and practice companion to reinforce key concepts encourage critical thinking and help you apply medical assisting content This robust companion guide offers a wide range of activities to strengthen your understanding of common administrative and clinical skills including certification preparation questions a review of medical terminology and anatomy and application exercises Trusted for more than 65 years as a key part of the journey from classroom to career it also features competency checklists to accurately measure your progress and performance from day one until you land your first job as a medical assistant Comprehensive coverage of all administrative and clinical procedures complies with accreditation requirements Approximately 190 step by step procedure checklists enable you to assess and track your performance for every procedure included in the textbook Chapter by chapter correlation with the textbook allows you to easily follow core textbook competencies Matching and acronym activities reinforce your understanding of medical

terminology anatomy and physiology and chapter vocabulary Short answer and fill in the blank exercises strengthen your comprehension of key concepts Multiple choice questions help you prepare for classroom and board exams Workplace application exercises promote critical thinking and job readiness before you enter practice Internet exercises offer ideas for expanded and project based learning NEW Content aligns to 2022 Medical Assisting educational competencies NEW Advanced Clinical Skills unit features three new chapters on IV therapy radiology basics and radiology positioning to support expanded medical assisting functions NEW Coverage of telemedicine enhanced infection control related to COVID 19 and catheterization NEW Procedures address IV therapy limited scope radiography applying a sling and coaching for stool collection UPDATED Coverage of administrative functions includes insurance coding privacy security and more EXPANDED Information on physical medicine and rehabilitation EXPANDED Content on specimen collection including wound swab nasal and nasopharyngeal specimen collections PEDIATRIC EVALUATION AND MANAGEMENT ,2023 **Practical E/M** Stephen Levinson (MD.),2006 A how to guide that provides a practical and effective new approach for the implementation of compliant evaluation and management E M documentation and coding Provided by publisher **Insurance and Risk Management Strategies for Physicians and Advisors** David Edward Marcinko,2005 This book fulfills its promise as a peerless tool for physicians wanting to make good decisions about the risks they face **Guide to Reference in Medicine and Health** Denise Beaubien Bennett,Christa Modscheidler,2014-04-26 Drawn from the extensive database of Guide to Reference this up to date resource provides an annotated list of print and electronic biomedical and health related reference sources including internet resources and digital image collections United States Code United States,2007

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