



PEDIATRIC EVALUATION AND MANAGEMENT CODING CARD 2019

HISTORY				EXAMINATION			
HPI Elements (Only reporting provider may document.) ☐ Duration (if at, since last night, 1 wk) ☐ Location (right ear, big toe, head, lower abdomen) ☐ Context (occurred when awake from nap, while playing soccer, when fell from tree) ☐ Associated signs/symptoms (blurred vision with headache, cough with runny nose, drowsy with vomiting)		Review of Systems ☐ Constitutional (if vital or general appearance) ☐ Eyes ☐ Ears, nose, and throat ☐ Respiratory ☐ Cardiovascular ☐ Gastrointestinal ☐ Genitourinary ☐ Musculoskeletal ☐ Neurologic ☐ Psychiatric		Past, Family, and Social History ☐ Past (ie, surgery, injuries, illnesses, injuries, treatments) ☐ Family (a history of pertinent family history, including selected traits or disorders) ☐ Social (at age appropriate review of past and current activities)		Body Areas/Organ Systems ☐ Head, face ☐ Neck ☐ Chest/breast/throat ☐ Abdomen ☐ Genitalia, groin/buttocks ☐ Back, spine ☐ Extremities, ears ☐ Constitutional (if vital or general appearance) ☐ Eyes ☐ Ears, nose, and throat ☐ Respiratory ☐ Cardiovascular ☐ Gastrointestinal ☐ Genitourinary ☐ Hematolymphatic/immune ☐ Musculoskeletal ☐ Neurologic ☐ Psychiatric ☐ 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/tent Chest radiograph ECG/ECG Urinalysis Ultrasound	First Cough Elastic bandage 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)	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.	Moderate	1 chronic illness with mild exacerbation 2 stable/chronic illnesses Unexplained new problem, uncertain prognosis Acute illness with multiple symptoms Acute complicated injury	Physologic, 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 neurologic 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 or 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 (face-to-face) and that >50% of total time was dominated by counseling or coordinating care. In less 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 Cheat Guidelines

Anthem



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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 *Coding for Chest Medicine 2009*, 2009 **Understanding Hospital Billing and Coding** Debra P. Ferenc, 2013-02-26 A basic guide to hospital billing and reimbursement Understanding Hospital Billing and Coding 3rd Edition helps you understand complete and submit the UB 04 claim form that is used for all Medicare and privately insured patients It describes how hospitals are reimbursed for patient care and services showing how the UB 04 claim form reflects the flow of patient data from the time of admission to the time of discharge Written by coding expert Debra P Ferenc this book also ensures that you understand the essentials of ICD 10 CM and develop skills in both inpatient coding and outpatient ambulatory surgery coding UB 04 Claim Simulation on the companion Evolve website lets you practice entering information from source documents into the claim form Over 300 illustrations and graphics bring important concepts to life Detailed chapter objectives highlight what you are expected to learn Key terms acronyms and abbreviations with definitions are included in each chapter Concept Review boxes reinforce key concepts Test Your Knowledge exercises reinforce lessons as you progress through the material Chapter summaries review key concepts Practice hospital cases let you apply concepts to real life scenarios Updated Claim Forms chapter covers the UB 04 claim form Updated information covers diagnosis and procedural coding with guidelines and applications Updated claim forms and names are used throughout [PROP - Coding Systems Custom E-Book](#) Anthem, 2014-04-25 PROP Coding Systems Custom E Book

[Conquer Medical Coding 2018](#) Jean Juek, Stacey Mosay, Daphne Neris, 2017-12-25 Take a real world approach to coding that prepares you for the AAPC or AHIMA certification exams and for professional practice in any health care setting The book is also a handy resource you can turn to throughout your career Unique decision trees show you how to logically assign a code It s the only text that breaks down the decision making process into a visual and repeatable process You ll learn exactly how to select the correct ICD 10 CPT and HCPCS codes Each section parallels the Official Coding Guidelines with a special emphasis on commonly used codes A wealth of learning tools and tips along with critical thinking exercises and real life case studies provide the practice you need to master coding Brief reviews of A P and pathophysiology put the codes into perfect context **The Trauma Manual** Andrew B. Peitzman, Michael Rhodes, C. William Schwab, 2008 The thoroughly updated Third Edition of this popular and widely used pocket reference guides the trauma team through every aspect of patient care after injury and before during and after acute care surgery from prehospital care to resuscitation treatment of specific organ injuries priorities in intensive care and management of special situations Designed for rapid on the spot information retrieval this manual will be a staple reference in emergency departments and trauma centers Flow charts algorithms sequential lists and tables throughout facilitate quick clinical decision making More than 200 illustrations

demonstrate specific injuries and procedures Appendices include organ injury scales tetanus prophylaxis recommendations and frequently used forms Adult-Gerontology Acute Care Practice Guidelines Catherine Harris,2023-05-10 Praise for the first edition from Doody's Medical Reviews Score 93 This well developed book provides acute care guidelines for the geriatric population in an easy to follow format that uses structural elements such as numbering and multilevel lists for each system It is an excellent reference for advanced practice prepared clinicians to help identify diagnose and develop a treatment plan for acute health issues in older adults and geriatric patients Tho Nguyen DNP MSN RN Newly updated this evidence based resource the first of its kind provides NPs PAs and other advance practice providers with the essential clinical knowledge they need to effectively practice adult gerontology acute care The second edition covers 10 new conditions and delivers numerous clinical updates on drugs pain management sedation nutritional management and clinical and screening guidelines Along with relevant information on Covid 19 it examines more acid base and neurological disorders and explains the use of Point of Care Ultrasound POCUS New unfolding case scenarios include questions to reinforce knowledge and step by step procedural videos provide clear detailed guidance The addition of a section on Billing provides clinicians with a working understanding of this process In quick reference format this system based text describes more than 100 common conditions health providers are likely to see in their acute care practice With contributions from NPs PAs and physicians it provides expert insight into each condition enabling readers to categorize symptoms be alert to the distinguishing features of disease symptoms and clusters and locate associated diagnoses This handy text also includes perioperative considerations discharge guidelines treatment and disease management algorithms and procedural guidelines Numerous clinical updates and clinical scenarios incorporated throughout the text validate knowledge and competency Purchase includes digital access for use on most mobile devices or computers New to the Second Edition Provides updated information on drugs pain management moderate sedation nutritional management and clinical and screening guidelines Addresses new conditions Offers current information on Covid 19 Includes additional acid base and neurological disorders Covers Point of Care Ultrasound POCUS Provides brief unfolding case scenarios with questions to reinforce knowledge Addresses the basics of Billing Delivers NEW step by step procedural videos demonstrating arterial line placement digital nerve blocks and lumbar puncture Key Features Presents key points for more than 100 acute care conditions in quick reference format Includes considerations for preoperative intraoperative and postoperative evaluation and management Offers discharge guidelines for inpatient conditions Disseminates over 20 procedural guidelines such as central and arterial line insertion bronchoscopy ECMO endotracheal intubation and more *The Next Step: Advanced Medical Coding and Auditing, 2013 Edition* Carol J. Buck,2013 Learning advanced medical coding concepts is easy with Carol J Buck's proven step by step method The Next Step Advanced Medical Coding and Auditing 2013 Edition provides an in depth understanding of physician based medical coding and coding services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Patient

cases reflect actual medical records with personal details changed or removed and give you real world experience coding from physical documentation with advanced material Enhance your clinical decision making skills and learn to confidently pull the right information from documents select the right codes determine the correct sequencing of those codes properly audit cases and prepare for the transition to ICD 10 CM with the help of Carol J Buck Auditing cases in every chapter offer realistic experience with auditing coded reports UNIQUE Evaluation and Management E M Audit Forms developed to determine the correct E M codes simplify the coding process and help you ensure accuracy Dual Coding prepares you for the switch to ICD 10 by accompanying all ICD 9 answers with corresponding codes from ICD 10 CM Realistic patient cases simulate the professional coding experience by using actual medical records with personal patient details changed or removed allowing you to practice coding with advanced material UNIQUE Netter anatomy plates in each chapter help you understand anatomy and how it affects coding From the Trenches boxes in each chapter highlight real life medical coders and provide practical tips advice and encouragement More than 175 illustrations and a full color design make advanced concepts more accessible and visually engaging Stronger focus on auditing cases prepares you to assign correct codes to complicated records as well as audit records for accuracy Updated content presents the latest coding information so you can practice with the most current information available *Cumulated Index Medicus* ,1999 **The Next Step: Advanced Medical Coding and Auditing, 2013 Edition - E-Book** Carol J. Buck,2012-12-14 Stronger focus on auditing cases prepares you to assign correct codes to complicated records as well as audit records for accuracy Updated content presents the latest coding information so you can practice with the most current information available

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