



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, right eye, 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, joints ☐ 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 fundi Chest radiograph ECG/BBG Urinalysis Ultrasound	First Cough Elastic bandage Superficial debridement
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/CT)	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 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 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		1	
2	Low	2	Low	Low		2	
3	Moderate	3	Moderate	Moderate		3	
4	High	4	High	High		4	

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

Carol J. Buck



Evaluation And Management Coding Cheat Guidelines:

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 *Evaluation and Management Coding and Documentation Guide* Jillian H. Kuruc, 2003

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

Buck's The Next Step: Advanced Medical Coding and Auditing, 2025/2026 Edition - E-BOOK Elsevier Inc, Jackie Koesterman, 2024-12-26 Master advanced coding skills Buck's The Next Step Advanced Medical Coding and Auditing shows how to code for services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Real world cases cleared of any patient identifiers takes your coding proficiency a step further by providing hands on practice with physician documentation With this guide you ll learn to pull the right information from medical documents select the right codes determine the correct sequencing of those codes and properly audit cases NEW Coding updates include the latest information available including 2026 code updates when released Real world patient cases cleared of any patient identifiers simulate the first year of coding on the job by using actual medical records allowing you to practice coding with advanced material UNIQUE Evaluation and Management E M audit forms include clear coding instructions to help reduce errors in determining the correct level of service More than 150 full color illustrations depict and clarify advanced coding concepts Coverage of CPT E M guidelines changes for office and other outpatient codes From the Trenches boxes highlight the real life experiences of professional medical coders and include photographs quotes practical tips and advice

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Ham's Primary Care Geriatrics E-Book Gregg A. Warshaw,Jane F. Potter,Ellen Flaherty,Matthew K. McNabney,Mitchell T. Heflin,Richard J. Ham,2021-01-05 Selected for Doody's Core Titles 2024 in Geriatrics Written with first line primary care providers in mind Ham's Primary Care Geriatrics A Case Based Approach 7th Edition is a comprehensive easy to read source of practical clinical guidance for this rapidly growing population Using a unique case based approach it covers the patient presentations you're most likely to encounter offering key clinical information expert advice and evidence based medical guidelines throughout This highly regarded text uses a consistent format and an enjoyable writing style to keep you informed engaged and up to date in this increasingly important field Uses a case study format that is ideal for learning retention and rapid recall All case studies are thoroughly up to date with current references Features an interdisciplinary perspective to provide team oriented knowledge on the best diagnosis treatment and management strategies available to address the complex needs of older adults Contains a new chapter on Lesbian Gay Bisexual Transgender LGBT Medicine in Older Adults as well as completely revised or rewritten chapters on rehabilitation infectious disease and urinary incontinence Provides up to date information on key topics such as opioid management and polypharmacy the geriatric emergency room cultural humility in the care of older adults and the five signs of problematic substance abuse Includes key learning objectives and USMLE style questions in every chapter Online extras include dizziness gait and balance video resources a dermatology quiz and a Cognitive Status Assessment with tests and patient teaching guides Enhanced eBook version included with purchase Your enhanced eBook allows you to access all of the text figures and references from the book on a variety of devices

Buck's The Next Step: Advanced Medical Coding and Auditing, 2019/2020 Edition Elsevier,2018-11-03 Master advanced coding skills Buck's The Next Step Advanced Medical Coding and Auditing shows how to code for services such as medical visits diagnostic testing and interpretation treatments surgeries and

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