



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 (an 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, nails ☐ 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/tan 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 Undiagnosed 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		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 Guidelines

United States. Congress. House



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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

Auditing Evaluation and Management Coding Joe Rivet, Sharon Bolarakis, 2006 **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

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Cardiology: Current Practice Guidelines Demosthenes G. Katritsis, Bernard J. Gersh, A. John Camm, 2016-07-21 Clinical Cardiology Current Practice Guidelines Updated Edition is an essential tool for the busy clinician offering succinct yet detailed access to the most recent trial and guideline data supporting practice and patient management in cardiology ESC and ACC AHA guidelines are continually updated and often overlap in their advice making it difficult for the cardiologist to obtain a clear picture of the right way to diagnose and treat disease according to the latest evidence base Written by leading authorities in the field this book together with its regularly updated online version provides a unique solution The authors have scrutinized all available guidelines and research from both ACC AHA and ESC on every clinical issue The result is a rigorous examination of the implications of published guidance illustrated by more than 600 easy to follow tables and 200 full colour images which reinforce key points and clarify difficult concepts 87 comprehensive chapters explore the definition epidemiology pathophysiology diagnosis and management of cardiac disease Two new chapters examine the univentricular heart and venous thrombembolism Each chapter encompasses the latest published research followed by discussions of possible presentations and investigations offering detailed insights for clinicians into best practice for diagnosis and treatment Providing at a glance access to the best guidance in cardiology this book offers a diagnosis and management toolkit which no practising cardiologist can afford to be without 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 **Guide to Clinical**

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of the House of Representatives of the United States United States. Congress. House, 2012 Some vols include supplemental journals of such proceedings of the sessions as during the time they were depending were ordered to be kept secret and respecting which the injunction of secrecy was afterwards taken off by the order of the House

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