



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 (at 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, ears <input type="checkbox"/> Constitutional <input type="checkbox"/> (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"/> Hematolymphatic <input type="checkbox"/> Integumentary <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/tone 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	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 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 notation 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 (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 Sheet

Ying Liu



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