



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 (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 system <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 P/F/S _____ | | | |
| 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 throat Chest radiograph ECG/ECG 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) | 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 | 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 MD/M 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 P/F/S.

- ☐ **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: MD/M 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 MD/M: 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 MD/M, 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/M 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."

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BarCharts, Inc, Theresa Tropin

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