



PEDIATRIC EVALUATION AND MANAGEMENT CODING CARD 2019

HISTORY			EXAMINATION		
HPI Elements (Only reporting provider may document.)		Review of Systems	Past, Family, and Social History		Body Areas/Organ Systems
<input type="checkbox"/> Duration (if it, since last night, 1 wk)	<input type="checkbox"/> Location (right ear, big toe, head, lower abdomen)	<input type="checkbox"/> Constitutional (if vital or general appearance)	<input type="checkbox"/> Past (ie, allergies, surgeries, illnesses, injuries, treatments)	<input type="checkbox"/> Family (a relative of pertinent family history including inherited traits or disorders)	<input type="checkbox"/> Head, face
<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, rashes with vomiting)	<input type="checkbox"/> Eyes	<input type="checkbox"/> Social (an age appropriate review of past and current activities)	<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Neck
<input type="checkbox"/> Severity (moderate, pain scale [1–10], low-grade, progressive, improving, worsening)	<input type="checkbox"/> Quality (stiff, chise, cloudy, thick, frothy)	<input type="checkbox"/> Ears, nose, and throat		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Chest, breast/axilla
<input type="checkbox"/> Timing (precise, occasionally, twice weekly, daily, 15 min after)	<input type="checkbox"/> Modifying factors (ask: improves without relief, improved with antibiotic treatment)	<input type="checkbox"/> Respiratory		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Abdomen
		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Genitalia, groin
		<input type="checkbox"/> Gastrointestinal		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Neck, spine
		<input type="checkbox"/> Hematologic		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Extremities, feet
		<input type="checkbox"/> Musculoskeletal		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Constitutional
		<input type="checkbox"/> Neurologic		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> (if vital or general appearance)
		<input type="checkbox"/> Psychiatric		<input type="checkbox"/> (if vital or general appearance)	<input type="checkbox"/> Eyes
No. of HPI Elements _____		No. of ROS _____		No. of P/F/H _____	No. of Body Areas/Organ Systems _____

MEDICAL DECISION MAKING							
D ₁ /Mgt	Data Reviewed/Ordered	Risk			Overall MDM Level: Choose on the Basis of Meeting or Exceeding 2 of the 2 (D ₁ /Mgt, Data, Risk) Elements		
		Presenting Problem	Diagnostic Procedures	Management Options			
1 point (max 1)	Established problem	1 point	Order or review laboratory studies.	Minimal	1 self-limited, minor problem	Wegeners Chest radiograph ECG/BBG Urinalysis Ultrasound	Rest Cough Dress bandage Superficial debridement
2 points (max 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	1/2 self-limited, minor problems 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 anesthesia Physical therapy Occupational therapy IV fluids without additives
		1 point	Decide to obtain vitals records OR Decide to obtain history from someone other than the patient.				
3 points (max 3)	New problem without additional workup	1 point	Discuss test with performing physician.	Moderate	1/1 chronic illness with mild exacerbation 2 stable (chronic) illnesses Undiagnosed new problems, uncertain prognosis Acute illness with multiple symptoms Acute complicated injury	Physiologic stress test Diagnostic endoscopy, no anesthesia Deep needle or incisional biopsy Cardiovascular imaging study with contrast Obtaining fluid from body cavity	Minor surgery with anesthesia Elective major surgery without anesthesia Prescription drug management Therapeutic major medicine IV fluids with additives Closed fracture treatment
		2 points	Independently review image, specimen, or testing (documentation tip: "On my review...").				
4 points (max 4)	New problem with additional workup	2 points	Review and summarize vitals 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	Elective major surgery with documented anesthesia Emergency major surgery Parenteral controlled substance Drug therapy requiring intensive monitoring Decisions for DNR or de-escalation 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			
1	Minimal	1	Minimal	Minimal	M		
2	Low	2	Low	Low	L		
3	Moderate	3	Moderate	Moderate	M		
4	High	4	High	High	H		

HISTORY: Documentation of history includes CC, HPI, ROS, and P/F/H.

- Internal history:** Subsequent hospital care only requires documentation of new history since last encounter.
- Medically stable history:** Document cases. For example, "Further history was unremarkable 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: MDM 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 MDM: number of problems, data reviewed/ordered, analysis. The first 2 are quantified; risk is up to the health-care professional to determine. To qualify for a given type of MDM, 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 (in-person) or visit (face-to-face) and that >50% of total time was dominated by counseling or coordinating care. In lieu of log components, time can be used to determine E/M level. >10% was spent counseling and coordinating care. Time is counted only by the reporting health-care professional. Documentation requirement: "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

DJ Losen



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Table of Contents Evaluation And Management Coding Cheat Sheet

1. Understanding the eBook Evaluation And Management Coding Cheat Sheet
 - The Rise of Digital Reading Evaluation And Management Coding Cheat Sheet
 - Advantages of eBooks Over Traditional Books
2. Identifying Evaluation And Management Coding Cheat Sheet
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Evaluation And Management Coding Cheat Sheet
 - User-Friendly Interface
4. Exploring eBook Recommendations from Evaluation And Management Coding Cheat Sheet
 - Personalized Recommendations
 - Evaluation And Management Coding Cheat Sheet User Reviews and Ratings
 - Evaluation And Management Coding Cheat Sheet and Bestseller Lists
5. Accessing Evaluation And Management Coding Cheat Sheet Free and Paid eBooks
 - Evaluation And Management Coding Cheat Sheet Public Domain eBooks
 - Evaluation And Management Coding Cheat Sheet eBook Subscription Services
 - Evaluation And Management Coding Cheat Sheet Budget-Friendly Options

6. Navigating Evaluation And Management Coding Cheat Sheet eBook Formats
 - ePub, PDF, MOBI, and More
 - Evaluation And Management Coding Cheat Sheet Compatibility with Devices
 - Evaluation And Management Coding Cheat Sheet Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Evaluation And Management Coding Cheat Sheet
 - Highlighting and Note-Taking Evaluation And Management Coding Cheat Sheet
 - Interactive Elements Evaluation And Management Coding Cheat Sheet
8. Staying Engaged with Evaluation And Management Coding Cheat Sheet
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Evaluation And Management Coding Cheat Sheet
9. Balancing eBooks and Physical Books Evaluation And Management Coding Cheat Sheet
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Evaluation And Management Coding Cheat Sheet
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Evaluation And Management Coding Cheat Sheet
 - Setting Reading Goals Evaluation And Management Coding Cheat Sheet
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Evaluation And Management Coding Cheat Sheet
 - Fact-Checking eBook Content of Evaluation And Management Coding Cheat Sheet
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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