American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

PEDIATRIC EVALUATION AND MANAGEMENT CODING CARD 2019

HISTORY

HPI Elements (Only reporting provider may document.)

☐ Duration (2 d, 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, nausea with vomiting)
☐ Severity (moderate, pain scale [1–10], low-grade, progressive, improving, worsening)
☐ Quality (dull, clear, cloudy, thick, throbbing)
☐ Timing (persistent, occasionally, twice weekly, daily, 15 min after)
☐ Modifying factors (took ibuprofen without relief, improved with nebulizer treatment)

No. of HPI Elements: ________

Review of Systems

☐ Constitutional (2 vitals or general appearance)
☐ Eyes
☐ Ears, nose, and throat
☐ Respiratory
☐ Cardiovascular
☐ Gastrointestinal
☐ Genitourinary
☐ Musculoskeletal
☐ Neurologic
☐ Psychiatric

No. of ROS: ________

Past, Family, and Social History

☐ Past (ie, allergies, surgeries, illnesses, injuries, treatments)
☐ Family (a review of pertinent family history, including inherited traits or diseases)
☐ Social (an age-appropriate review of past and current activities)

No. of PFSH: ________

EXAMINATION

Body Areas/Organ Systems

☐ Head, face
☐ Neck
☐ Chest, breast/axillae
☐ Abdomen
☐ Genitalia, groin/buttocks
☐ Back, spine
☐ Extremities, each
☐ Constitutional (2 vitals or general appearance)
☐ Eyes
☐ Ears, nose, and throat
☐ Respiratory
☐ Cardiovascular
☐ Gastrointestinal
☐ Genitourinary
☐ Hemo/lymphatic/immune
☐ Musculoskeletal
☐ Neurologic
☐ Psychiatric
☐ Integumentary (skin or breast)

No. of Body Areas/Organ Systems: ________

MEDICAL DECISION MAKING

D_x/Mgt		Data Reviewed/Ordered		Risk			
				Presenting Problem		Diagnostic Procedures	Management Options
1 point (max 4)	Established problem	1 point 1 point	Order or review laboratory studies. Order or review radiology, nuclear medicine studies.	Minimal	1 self-limited, minor problem	Venipuncture Chest radiograph ECG/EEG Urinalysis Ultrasound	Rest Gargle Elastic bandage Superficial dressing
2 points (max 2)	Established problem worsening, inadequately controlled, or failing to change as expected	1 point 1 point	Order or review other studies (eg, ECG, EEG, cath, PFTs). Decide to obtain old records OR Decide to obtain history from someone other than the patient.	Low	≥2 self-limited, minor problems 1 stable chronic illness Acute uncomplicated illness or injury	Physiologic nonstress test Non-cardiovascular imaging study with contrast Needle biopsy Arterial puncture Skin biopsy	OTC drug Minor surgery, no comorbidities Physical therapy Occupational therapy IV fluids without additives
3 points (max 1)	New problem without additional workup	1 point 2 points	Discuss test with performing physician. Independently review image, specimen, or tracing (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	Physiologic stress test Diagnostic endoscopy, no comorbidities Deep needle or incisional biopsy Cardiovascular imaging study with contrast Obtaining fluid from body cavity	Minor surgery with comorbidities Elective major surgery without comorbidities Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed fracture treatment
4 points (max 1)	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 Abrupt change in neurologic status	Electrophysiology study Diagnostic endoscopy with comorbidities Discography	Elective major surgery with documented comorbidities Emergency major surgery Parenteral controlled substance Drug therapy requiring intensive monitoring Decision for DNAR 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	Overall MDM Level: Choose on the Basis of Meeting or Exceeding 2 of the 3 (D_x/Mgt, Data, Risk) Elements
1	Minimal	1	Minimal	Minimal	SF
2	Low	2	Low	Low	Low
3	Moderate	3	Moderate	Moderate	Moderate
4	High	4	High	High	High

HISTORY: Documentation of history includes CC, HPI, ROS, and PFSH.

☐ **Interval history:** Subsequent hospital care only requires documentation of new history since last encounter.

☐ **Unobtainable history:** Document reason. For example, "Further history was unobtainable because <_>."

EXAMINATION: Document specific abnormal, unexpected, and relevant 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, and risk. 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 (outpatient) or unit/floor time (inpatient) and that >50% of total time was dominated by counseling or coordinating care. In lieu of key components, time can be used to determine E/M level if >50% 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."

Audit Form For Coding Evaluation And Management

Sebastian Brünink

Audit Form For Coding Evaluation And Management:

This book delves into Audit Form For Coding Evaluation And Management. Audit Form For Coding Evaluation And Management is a crucial topic that must be grasped by everyone, ranging from students and scholars to the general public. The book will furnish comprehensive and in-depth insights into Audit Form For Coding Evaluation And Management, encompassing both the fundamentals and more intricate discussions.

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    - Chapter 2: Essential Elements of Audit Form For Coding Evaluation And Management
    - Chapter 3: Audit Form For Coding Evaluation And Management in Everyday Life
    - Chapter 4: Audit Form For Coding Evaluation And Management in Specific Contexts
    - Chapter 5: Conclusion
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