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Speedy Study Guides **EVALUATION & MANAGEMENT**

The descriptions for the levels of most E/M services recognize seven components, three of which are used in defining the level of E/M services.

Key Components

- History
- Examination
- Medical Decision Making

Contributory Components

- Counseling
- Coordination of care
- Nature of presenting problem (illness)
- Time

Most often, the E/M codes are selected based on the documentation of the key components. Information regarding at least two of the three key components (sometimes all three) must be documented in the patient's medical record to substantiate certain levels of E/M codes. The key component requirements for specific categories of E/M codes will be discussed later.

Time is the determining factor for certain E/M codes when counseling and/or coordination of care takes up more than 50 percent of the total visit (face-to-face time in the office or other outpatient setting or floor/court time in the hospital or nursing facility). Time also is the controlling factor in certain E/M codes, such as critical care and discharge day management.

A. Key Components

The Key components in selecting the level of E/M services are History, Examination, and Medical Decision Making. These three key components appear in the descriptors for office or other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services.

1. History

The extent of history documented is dependent upon the physician's clinical judgment and the nature of the presenting illness or problem. The types of history are defined BELOW:

Problem-Focused

- Chief Complaint.
- Brief History of Present Illness (HPI) or Problem

Expanded Problem-Focused

- Chief Complaint.
- Extended History of Present Illness (HPI) or Problem.
- Problem-Relevant System Review

Detailed

- Chief Complaint.
- Extended History of Present Illness (HPI) or Problem.
- Complete System Review.
- Complete Past, Family and Social History

Each type of history includes some or all of the following elements:

a. Chief Complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter. To qualify for a given type of history, a chief complaint must be indicated at all levels.

b. History of Present Illness (HPI) is a chronological description of the development of the patient's presenting illness or problem from the first sign and/or symptom, or from the previous encounter to the present. There are two types of HPIs (brief and extended) which are distinguished by the amount of detail included in the documentation for the following elements:

- **Location** - place, whereabouts, site, position. Where on the body is the patient experiencing signs or symptoms? (e.g., pain in groin)
- **Quality** - A description, characteristics, or statement to identify the type of sign or symptom. (e.g., burning pain in groin)
- **Severity** - Degree, intensity, ability to endure. The patient may describe the severity of their signs or symptoms by using a self-assessment scale to measure subjective levels. (e.g., History of mild burning pain in groin that has become more intense)
- **Duration** - Length of time. How long has patient been experiencing the signs or symptoms? (e.g., History of intermittent mild burning pain in groin that has become more intense and frequent for the last two weeks)
- **Timing** - Regulation of occurrence. A description of when

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