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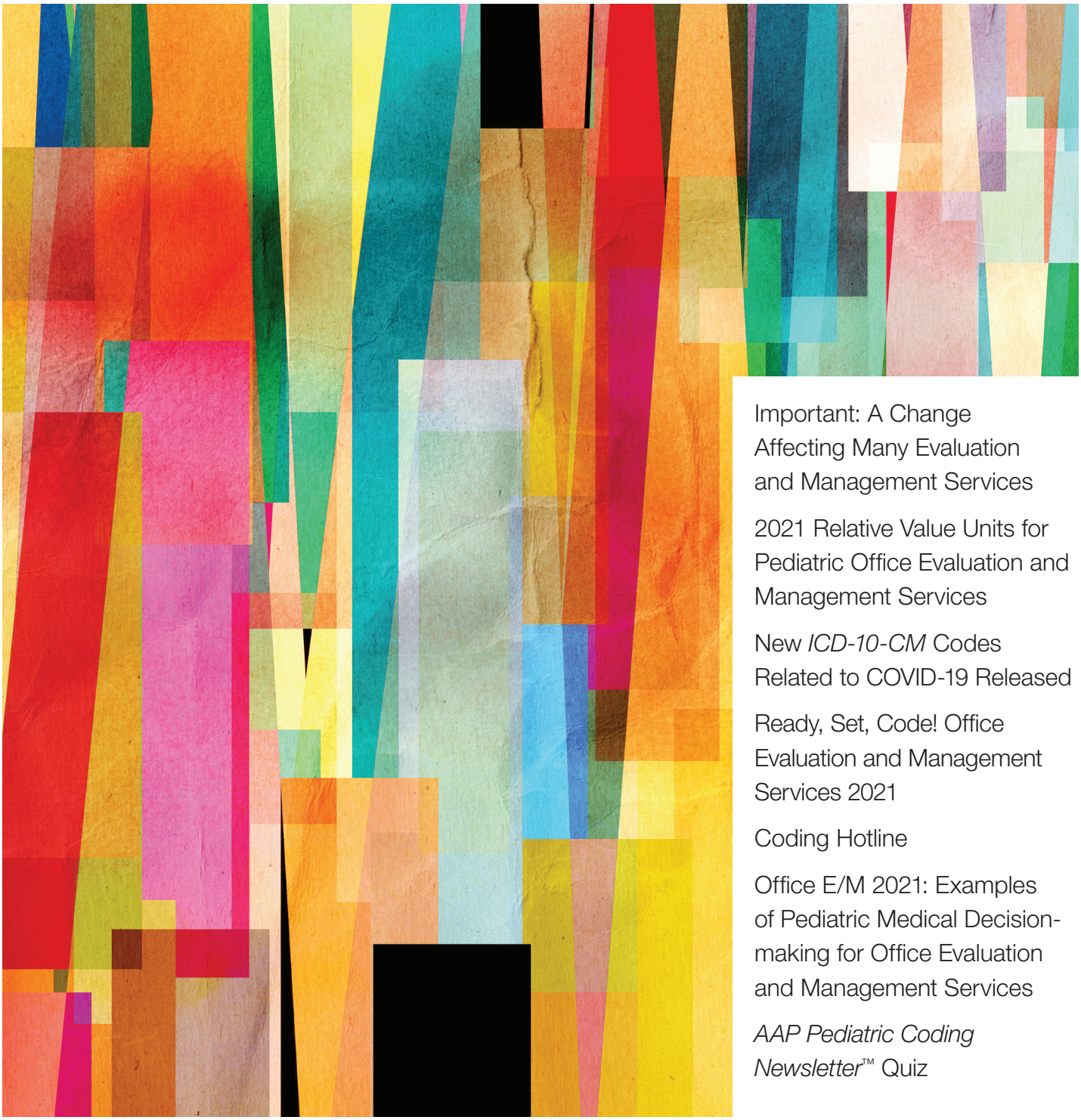

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AAP Pediatric Coding Newsletter™

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CONTENTS

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Coding Symbols
▲ Revised code
● New code
+ Add-on code
⚡ Product pending US Food and Drug Administration approval
Out-of-numerical-sequence code
★ Telemedicine

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Important: A Change Affecting Many Evaluation and Management Services

The 2021 *Current Procedural Terminology*® guidelines for all evaluation and management (E/M) services include the following sentence that changes how any E/M service code is selected based on medical decision-making (MDM) as 1 of the 2 or 3 required key components (ie, history, examination, and MDM) or based solely on the level of MDM (only applicable to office or other outpatient visit codes **99202–99205** and **99212–99215**):

> "The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter *are not included in determining the levels of E/M services when reported separately*."

Important Correction to Prior Advice

The advice in this article has not previously been included in publications by the American Academy of Pediatrics. Our editors have been advised that an order or review of tests that were performed and billed by the physician or other qualified health care professional are not counted in determination of the level of MDM. Previous understanding was that if a test was not valued to include physician work (eg, laboratory tests), it should be counted toward the amount and/or complexity of data reviewed and analyzed. Errata related to this change will be posted to the websites for *AAP Pediatric Coding Newsletter*™ (http://coding.aap.org), *Coding for Pediatrics 2021* (www.aap.org/cfp), and AAP Publishing Errata (www.aap.org/errata).

Based on this instruction, physicians who order and/or review any testing in which they also report that test cannot count the order of the test or review and interpretation of the result toward the level of MDM for the encounter. This includes in-office laboratory tests that have traditionally been counted under the 1995 and 1997 guidelines.

The following examples are intended to illustrate coding instructions only. Appropriate codes for each unique encounter must be based on the documented service provided.

EXAMPLES

1. Dr Hanks sees a new adolescent boy with obesity and type 2 diabetes whose primary care pediatrician has requested a consultation to evaluate and advise on management of hyperlipidemia that was noted on a screening laboratory test performed in conjunction with a preventive medicine service. After reviewing and summarizing health records from the patient's primary care physician, Dr Hanks notes that the last hemoglobin A_{1c} (HbA_{1c}) result for this patient was more than 90 days prior to this visit. Dr Hanks orders an in-office glucose and HbA_{1c} test to help determine the current control of the patient's diabetes. The patient's glucose is at the high end of the normal range and the HbA_{1c} of 7.5 is unchanged from prior results. Dr Hanks recommends aggressive dietary and lifestyle changes to improve diabetic control, which may concurrently improve the patient's lipid profile. Dr Hanks sends a consultation report to the primary care pediatrician, who will continue patient management, and recommends another consultation if the hyperlipidemia remains after the patient's diabetes is better controlled. Diagnoses are type 2 diabetes, hyperlipidemia, and obesity. A comprehensive history and comprehensive examination are documented.

   The E/M code reported to a payer that accepts consultation codes is based on the 1995 or 1997 documentation guidelines. MDM is determined based on the following:

   - A moderate number of diagnosis and management options were addressed. Dr Hanks addressed problems that were new to this examiner with no additional workup planned.
   - A low amount and/or complexity of data is supported based on Dr Hanks' review and summarization of the health records from the primary care pediatrician. Dr Hanks does not receive credit for ordering and reviewing the result of the in-house laboratory tests.
   - Moderate risk of complications and/or morbidity or mortality is supported based on management of poorly controlled type 2 diabetes, hyperlipidemia, and obesity.

   The level of MDM is moderate based on 2 of 3 elements of MDM. The combination of comprehensive history, comprehensive examination, and moderate MDM supports code **99244**, meeting the required 3 of 3 key components to support code selection for consultation services. In this example, not counting the in-office test did not affect the level of service reported. Had the in-office test been counted, the amount and/or complexity of data reviewed would be moderate but would not change the overall level of MDM.

2. Dr Parker, who requested the consultation for the patient in Example 1, sees the patient 1 month later for a follow-up office visit for the patient's diabetes and hyperlipidemia. Dr Parker reviews Dr Hanks' consultation report, including the result of the HbA_{1c} test performed by Dr Hanks. The patient has lost 5 pounds since his last visit. The patient's parents report that the family is making a joint effort to exercise and eat less since seeing Dr Hanks. Dr Parker spends 10 minutes counseling the patient and parents about the need for continued compliance to bring the diabetes under control and potentially eliminate hyperlipidemia without additional treatment. Dr Parker orders testing for glucose, albumin, and creatinine, which is performed in the office. The test results are slightly elevated

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2021 Relative Value Units for Pediatric Office Evaluation and Management Services

Despite movement toward other payment methodologies, payment for pediatricians' services is still largely fee-for-service, meaning that the amounts paid and/or used to attribute the cost of care are based on the relative value units (RVUs) assigned to the procedure code for each service. Although they were developed for the Medicare program, the RVUs and an associated monetary conversion factor (CF) (estimated at $32.4085 per RVU for 2021 at time of publication) often affect payment by Medicaid plans and other payers.

For 2021, key changes of interest to pediatricians include

- Revisions to the office and other outpatient evaluation and management (E/M) codes **99202–99205** and **99211–99215** resulted in revaluing these codes as shown in Tables 1 and 2.
- RVUs for other E/M services, such as emergency department (ED) and transitional care management (TCM) services, were assigned based on a comparison to the office E/M codes and are updated accordingly.

Individual payers may base their fee schedules on the current or a past year's Medicare RVUs. The fee schedules and CFs are often stated in contracts between physician practices or health systems and the payers. Be sure to know the fee schedules individual payers use prior to entering into contracts with them.

Pediatric Evaluation and Management Services With Changes in Relative Value Units in 2021

Tables 1 through 5 show the RVUs and changes from 2020 to 2021 for office E/M (**99202–99205** and **99212–99215**), ED E/M (**99281–99285**), and TCM (**99495**, **99496**) services. Work, practice expense, and malpractice RVUs are combined to arrive at the total facility (eg, outpatient hospital clinic) and total non-facility (NF) (eg, office practice) RVUs for each code. Work RVUs are often used in calculating payments and productivity of employed physicians.

Payment rates vary based on each payer's CF and geographic adjustments used to reflect differences in practice expenses. To estimate allowed amounts, multiply the appropriate total facility or NF RVUs by your typical payer's CF (eg, **99213** = 2.69 total NF RVUs × $32.4085 CF, or $87.18).

How Are Relative Values Assigned?

As *Current Procedural Terminology* (*CPT*®) codes are added or revised, and periodically for established codes, the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) conducts surveys of practicing physicians to determine the typical resources used to provide the services described by each code. The RUC then recommends RVUs for each code to the Centers for Medicare & Medicaid Services (CMS) for inclusion in the Medicare Physician Fee Schedule for the following year. The CMS may accept or revise the RUC recommendations based on additional considerations. RVUs are adjusted to account for practice expenses in differing geographic areas and then multiplied by a monetary conversion factor (estimated at $32.4085 per RVU for 2021 at time of publication) to determine allowed amounts for each service.

Additional 2021 RVU Information

For up-to-date information on the 2021 RVUs and Medicare CF, please see www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Code-Valuation-and-PaymentRBRVS.aspx.

Table 1. 2021 Non-facility Office and Other Outpatient Evaluation and Management Code Relative Value Units

Code	Work RVUs	Change From 2020[a]	Non-facility PE RVUs	Change From 2020[a]	MP RVUs	Change From 2020[a]	Total Non-facility RVUs	Total Change From 2020[a]
99202	0.93	0.00	1.12	0.00	0.08	–0.01	2.13	–0.01
99203	1.60	0.18	1.53	0.05	0.15	0.02	3.28	0.25
99204	2.60	0.17	2.09	0.11	0.24	0.02	4.93	0.30
99205	3.50	0.33	2.69	0.29	0.32	0.04	6.51	0.66
99211	0.18	0.00	0.49	0.03	0.01	0.00	0.68	0.03
99212	0.70	0.22	0.90	0.15	0.07	0.02	1.67	0.39
99213	1.30	0.33	1.28	0.22	0.10	0.02	2.68	0.57
99214	1.92	0.42	1.76	0.31	0.13	0.02	3.81	0.75
99215	2.80	0.69	2.32	0.47	0.21	0.06	5.33	1.22

Abbreviations: MP, malpractice; PE, practice expense; RVU, relative value unit.

[a]The total RVUs for **99202** are decreased by –0.01 from 2020. Because services in 2020 may have been reported with **99201** (deleted in 2021), additional increases in RVUs may be seen as services are reported in 2021 using **99202**.

Table 2. 2021 Facility Office and Other Outpatient Evaluation and Management Code Relative Value Units

Code	Work RVUs	Change From 2020[a]	Facility PE RVUs	Change From 2020[a]	MP RVUs	Change From 2020[a]	Total Facility RVUs	Total Change From 2020[a]
99202	0.93	0.00	0.41	0.00	0.08	–0.01	1.42	–0.01
99203	1.60	0.18	0.67	0.08	0.15	0.02	2.42	0.28
99204	2.60	0.17	1.12	0.11	0.24	0.02	3.96	0.30
99205	3.50	0.33	1.56	0.23	0.32	0.04	5.38	0.60
99211	0.18	0.00	0.08	0.01	0.01	0.00	0.27	0.01
99212	0.70	0.22	0.29	0.09	0.07	0.02	1.06	0.33
99213	1.30	0.33	0.55	0.15	0.10	0.02	1.95	0.50
99214	1.92	0.42	0.83	0.21	0.13	0.02	2.88	0.65
99215	2.80	0.69	1.26	0.37	0.21	0.06	4.27	1.12

Abbreviations: MP, malpractice; PE, practice expense; RVU, relative value unit.

[a]The total RVUs for **99202** are decreased by –0.01 from 2020. Because services in 2020 may have been reported with **99201** (deleted in 2021), additional increases in RVUs may be seen as services are reported in 2021 using **99202**.

Table 3. 2021 Emergency Department Code Relative Value Units

Code	Work RVUs	Change From 2020	Facility PE RVUs	Change From 2020	MP RVUs	Change From 2020	Total Facility RVUs	Total Change From 2020
99281	0.48	0.00	0.11	0.00	0.05	0.00	0.64	0.00
99282	0.93	0.00	0.21	0.00	0.10	0.01	1.24	0.01
99283	1.60	0.18	0.33	0.04	0.17	0.04	2.10	0.26
99284	2.74	0.14	0.54	0.03	0.29	0.02	3.57	0.19
99285	4.00	0.20	0.74	0.03	0.42	0.02	5.16	0.25

Abbreviations: MP, malpractice; PE, practice expense; RVU, relative value unit.

Table 4. 2021 Non-facility Transitional Care Management Code Relative Value Units

Code	Work RVUs	Change From 2020	Non-facility PE RVUs	Change From 2020	MP RVUs	Change From 2020	Total Non-facility RVUs	Total Change From 2020
99495	2.78	0.42	3.14	0.43	0.18	0.05	6.10	0.90
99496	3.79	0.69	4.21	0.63	0.24	0.05	8.24	1.37

Abbreviations: MP, malpractice; PE, practice expense; RVU, relative value unit.

Table 5. 2021 Facility Transitional Care Management Code Relative Value Units

Code	Work RVUs	Change From 2020	Facility PE RVUs	Change From 2020	MP RVUs	Change From 2020	Total Facility RVUs	Total Change From 2020
99495	2.78	0.42	1.24	0.25	0.18	0.05	4.20	0.72
99496	3.79	0.69	1.69	0.39	0.24	0.05	5.72	1.13

Abbreviations: MP, malpractice; PE, practice expense; RVU, relative value unit.

NEW *ICD-10-CM* CODES RELATED TO COVID-19 RELEASED

As a result of the urgent and ongoing need to capture more information related to the current public health emergency, *International Classification of Diseases, 10th Revision, Clinical Modification* deviated from its regular release schedule to issue 6 new codes related to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)/coronavirus disease 2019 (COVID-19) that go into effect January 1, 2021. Please visit https://coding.solutions.aap.org/ss/news.aspx for details.

Ready, Set, Code! Office Evaluation and Management Services 2021

January 1, 2021, brought about the biggest changes to code selection for office and other outpatient evaluation and management (E/M) services since the 1997 *Documentation Guidelines for Evaluation and Management Services.* There have been many newly defined terms and details to learn in the guidelines for these services as published in *Current Procedural Terminology*®. As we put the revised codes and guidelines into practice, it might be helpful to reflect on the key simplifications offered by this change. These simplifications are intended to reduce the administrative burdens that were seen with previous code descriptors and guidelines.

Remember, you now have 2 code selection options and can choose the one most favorable to you.

1. Select the code based on your *total time on the date of the encounter* that is spent on work directed to the individual patient. This includes face-to-face and non–face-to-face time, such as time documenting the service, reviewing test results before or after the visit, and discussing and/or coordinating care with other health care professionals. Time ranges are assigned to each code as shown in Table 1.
2. Determine your level of medical decision-making (MDM) based on meeting any 2 of 3 elements, as shown in Table 1.

The steps to code selection are as follows:

1. Determine if your patient is a new or established patient (unchanged from 2020). The patient is new if you or another physician or other qualified health care professional in your same specialty and subspecialty and same group practice (billing under the same tax identification number) have not provided a face-to-face professional service within the past 3 years. Any patient who has received a face-to-face professional service within the past 3 years is established.
2. Determine the total amount of time spent directed to the care of the individual patient, not including any time spent by clinical staff or any time in activities not directed to care of the individual patient. Time spent providing services that are separately reported (eg, interpreting an electrocardiogram and creating a report of the findings) is not included in the time of the office or other outpatient E/M service.

EXAMPLE

A pediatrician spends 5 minutes on the morning of an established patient's office visit reviewing notes made by the practice's chronic care coordinator since the patient's last visit for management of intermittent asthma. The pediatrician notes that the care coordinator has had several discussions with the patient's parents about continuation of the asthma control medication. Later that day, the pediatrician provides a face-to-face E/M service that includes history and examination necessary to address stable intermittent asthma (low-complexity problem), requiring an independent historian (low amount and complexity of data), and recommends continuation of asthma medication (moderate risk of morbidity from treatment). The pediatrician counsels the patient and parents about the importance of continuing the asthma control medication despite lack of symptoms. The total face-to-face time of the visit is 26 minutes. The pediatrician spends another 5 minutes documenting the service, checking the patient's health plan formulary and ordering control and rescue medications, and updating the patient's care plan. The pediatrician selects code **99214**, based on the total time spent on the day of the visit (36 minutes, illustrated in ***bold and italic*** font in Table 2), in lieu of code **99213**, which is supported by 2 of 3 elements of MDM (illustrated in **bold and underlined** font in Table 2).

3. Determine the level of MDM supported by your documented history, examination, assessment, and plan of care for the patient based on 2 of 3 elements of MDM.
   a. Determine the number and complexity of the problems addressed at the encounter.
   b. Determine the amount and complexity of data to be reviewed and analyzed.
   c. Determine the risk of complications and/or morbidity or mortality of patient management.

Table 1. Office and Other Outpatient Evaluation and Management Service Code Requirements

Code and Total Time ***New patient*** **(99202–99205)** ***Established patient*** **(99212–99215)**	Number and Complexity of Problems Addressed at the Encounter	Amount and Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 15–29 min **99212** 10–19 min	Minimal	Minimal or none	Minimal
99203 30–44 min **99213** 20–29 min	Low	Limited	Low
99204 45–59 min **99214** 30–39 min	Moderate	Moderate	Moderate
99205 60–74 min **99215** 40–54 min	High	Extensive	High

EXAMPLE

An established patient receives an E/M service, including history and examination necessary to address stable intermittent asthma (low-complexity problem), requiring an independent historian (limited amount and complexity of data), and review and analysis of the score of an asthma control test administered by clinical staff (separately reported and not counted toward MDM), with refill of asthma medication (moderate risk of morbidity from treatment). The patient and parents agree with the plan of care. The pediatrician's total time on the date of the visit was 18 minutes, including time spent ordering the medication refill and documenting the service. The pediatrician reports code **99213** based on the level of MDM supported by the number and complexity of problems and amount and/or complexity of data (illustrated in **bold and underlined** font in Table 3) rather than the total time (18 minutes, illustrated in ***bold and italic*** font in Table 3), which supports code **99212**. Code **96160** (administration of patient-focused health risk assessment instrument with documentation and scoring) is also reported for the administration and scoring of the asthma control test.

Getting Help

As you use the revised office E/M codes, you may have questions. The American Academy of Pediatrics (AAP) has worked to develop educational resources and assistance since the announcement of the revised codes and guidelines. Many questions have been raised in the process, and we may yet see additional clarifications or changes to the new guidelines for these services. This newsletter and other resources produced by the AAP will continue to provide the most correct and complete information and guidance available at the time each issue is developed.

For more resources, including answers to frequently asked questions, please see

- The Office E/M 2021 collection of articles under Coding Resources at http://coding.aap.org
- "2021 Office-Based E/M Changes" at https://services.aap.org/en/practice-management/2021-office-based-em-changes
- Chapter 7 of *Coding for Pediatrics 2021,* which includes many examples of code selection using the revised codes and guidelines

Table 2. Time Versus Medical Decision-making

Code and Total Time ***New patient*** **(99202–99205)** ***Established patient*** **(99212–99215)**	Number and Complexity of Problems Addressed at the Encounter	Amount and Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 15–29 min	Minimal	Minimal or none	Minimal
99212 10–19 min			
99203 30–44 min	**Low**	**Limited**	Low
99213 20–29 min			
99204 45–59 min	Moderate	Moderate	**Moderate**
99214 *30–39 min*			
99205 60–74 min	High	Extensive	High
99215 40–54 min			

Table 3. Medical Decision-making Versus Time

Code and Total Time ***New patient*** **(99202–99205)** ***Established patient*** **(99212–99215)**	Number and Complexity of Problems Addressed at the Encounter	Amount and Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 15–29 min	Minimal	Minimal or none	Minimal
99212 *10–19 min*			
99203 30–44 min	**Low**	**Limited**	Low
99213 20–29 min			
99204 45–59 min	Moderate	Moderate	**Moderate**
99214 30–39 min			
99205 60–74 min	High	Extensive	High
99215 40–54 min			

Coding Hotline

Billing: Resubmitting Unpaid Claims

Our practice has had a turnover in the billing department and new staff are tasked with recovering a large amount of revenue due to unpaid claims. I have suggested that all unpaid claims be resubmitted to the payers as an initial step in recovery. The new billing manager is resisting, stating that it is important to investigate whether the payer has already received and/or processed the claims. Should I insist that all unpaid claims be resubmitted?

No, a blanket rebilling of all unpaid claims may produce a large volume of denials and may delay submission of information or corrected claims that are necessary for payment. This is true for several reasons.

- Unpaid claims are often unpaid due to simple errors such as incorrect patient date of birth or gender or outdated information (eg, change of insurance or home address). Each batch of electronically submitted claims results in a report from the claims clearinghouse and/or payer that provides information on which claims were accepted and which were rejected, with codes identifying the reasons for rejections. Rejected claims can be worked through quickly, while resubmitting the uncorrected claims will likely result in the same rejection. (This is especially true if there is an error in a physician's information, such as an incorrect National Provider Identifier or practice address that caused rejections of multiple batches of claims.)
- Claims that were accepted by a payer but denied have been assigned a claim identification number that, when included on resubmissions, avoids denial as a duplicate claim. Usually, these claims also require correction of information, such as an invalid diagnosis or procedure code, or are pending information requested from the physician or patient. While this work takes time, identifying the reason for denial and submitting a corrected claim or an appeal is essential to receiving payment.
- Many patients are now covered under high-deductible health plans, and it is possible that the claims, though unpaid, were correctly processed and should be filed to a secondary insurance or billed to the patient or other guarantor of the account. If the billing system is not correctly updating to transfer responsibility from the primary payer, resubmission to the primary payer will result in a duplicate claim denial and delay billing to the appropriate party.

If your practice does not currently use a claims scrubber, these automated programs can be used to detect and fix errors on claims prior to submission or alert staff to do so. However, it is best to investigate and get local references for these products, as a claims scrubber that fails to reflect up-to-date billing and payment policies of local plans may result in more work by your staff and slower payment.

Have a coding question? Visit **https://form.jotform.com/Subspecialty/aapcodinghotline** to connect with our coding specialists.

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blood glucose and normal albumin and creatinine levels. Dr Parker advises to continue the same medications and continue lifestyle changes to improve control of diabetes and hyperlipidemia. Dr Parker's total time on this date is not documented. The diagnoses documented are type 2 diabetes with hyperglycemia, hyperlipidemia, and morbid obesity.

The office E/M service is determined based on MDM because of a lack of documentation to support time-based billing. The level of MDM for Dr Parker's office E/M service is based on the following:

- A moderate number and complexity of problems addressed is supported by the type 2 diabetes with hyperglycemia, hyperlipidemia, and obesity (1 chronic illness with poor control and 2 stable chronic illnesses).
- A low amount and complexity of data is supported by the review of the notes from 1 external source (Dr Hanks) and obtaining history from an independent historian (parent). The tests ordered do not count toward the level of MDM because they are performed in the office and reported separately by Dr Parker.
- Moderate risk of morbidity from additional diagnostic testing or treatment is supported by the prescription drug management (decision to continue current medications).

Dr Parker reports code **99214** for a level 4 office visit based on the moderate number and complexity of problems and the moderate risk.

In both examples, the inability to count tests performed and separately reported did not affect code selection because the MDM for each visit was moderate based on risk and the problems addressed. However, it is important that pediatricians are aware of the *CPT* instruction and are careful to avoid any increase in the level of MDM based on tests that are performed and separately reported by the pediatrician. In addition, you may not forego reporting a test or study to count it toward your MDM level.

Office E/M 2021: Examples of Pediatric Medical Decision-making for Office Evaluation and Management Services

The 2021 office and other outpatient evaluation and management (E/M) service codes and guidelines were implemented on January 1, 2021. In the coming months, there will undoubtedly be uncertainty about the levels of medical decision-making (MDM) for specific encounters. Each encounter must be evaluated based on the MDM elements of the number and complexity of problems addressed, amount and/or complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management.

The Table is intended to help pediatricians and coders gain familiarity with the types of visits that may result in each level of MDM. As always, these are only examples and the level of MDM for actual visits must be based on the actual problems addressed, data reviewed and analyzed, and risks to the patient associated with the decisions made regarding management or treatment. In other words, real code selection must reflect the actual nature of the patient presentation and the documented time or MDM required to address the patient's health care needs.

The total time assigned to each code is included in the Table to provide a comparison of how code selection based on the total time spent by a pediatrician or other qualified health care professional in care of the individual patient on the date of the encounter contrasts with code selection based on MDM. Select the highest code supported by either time or MDM. Time is not a validator of MDM or vice versa (eg, total time of 30 minutes does not prohibit reporting of **99215** [total time 40–54 minutes] when MDM supports **99215**). See the end notes for definitions of terms used in the Table.

Additional information on selecting office E/M codes can be found in Chapter 7 of *Coding for Pediatrics 2021* as well as previous articles in the Office E/M 2021 collection at https://coding.solutions.aap.org/ss/resources.aspx.

Medical Decision-making Table With Pediatric Examples[a]

Level/Codes (Times included for comparison to selection based on MDM. Time is the pediatrician's or other QHP's total time directed to the patient's care on the date of the encounter.)	**Medical Decision-making** (2 of 3 required: problems, data, risk)		
	Problems Addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other QHP reporting the service.	*Data Reviewed and Analyzed:* Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 (eg, a urinalysis is counted only once when test is ordered and result is reviewed on the date of the encounter). Do not count tests performed during the encounter and separately reported.	*Risk of Complications and/or Morbidity or Mortality of Patient Management*[b]: Risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.
Straightforward New patient **99202** 15–29 min Established patient **99212** 10–19 min	*Problems Addressed:* **Self-limited or minor** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status	*Data Reviewed and Analyzed:* **Minimal or none** Often, data is limited to need for an independent historian with no ordered tests and no reviewed records or test results.	*Risk of Additional Testing or Treatment:* **Minimal** • Apply ice pack or warm compress. • Drink fluids and rest. • Gargle with salt water.
	• *Erythema toxicum with advice that condition is self-limiting and will resolve without treatment* • *Cold or mild upper respiratory infection with advice for home care and infection control* • *Sore throat without fever or inflammation, independent historian, advice for home care* • *Uncomplicated viral conjunctivitis with instructions for home care and infection control* • *Mild diaper or heat rash with advice for over-the-counter medication* • *Resolving acute condition with parental concern about remaining symptoms; advice to complete course of treatment*		
Low New patient **99203** 30–44 min Established patient **99213** 20–29 min	*Problems Addressed:* **Low** • 2 or more self-limited or minor problems or • 1 stable chronic[c] illness (treatment goal for problem is met [eg, asymptomatic asthma]) or • 1 acute, uncomplicated illness or injury (Recent or new short-term problem with low risk of morbidity and treatment is considered. Full recovery without functional impairment is expected. A problem that is normally self-limited or	*Data Reviewed and Analyzed:* **Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1:** Tests[d] and documents Any combination of 2 from the following: • Review of prior external note(s) from each unique source[e] • Review of the result(s) of each unique test[d] • Ordering of each unique test[d] or	*Risk of Additional Testing or Treatment:* **Low** • Over-the-counter medication (As labeled; off-label use may increase risk.) • Physical, occupational, or speech/language therapy • Removal of sutures

...continued on page 10

Office E/M 2021: Examples of Pediatric Medical Decision-making for Office Evaluation and Management Services...*continued from page 9*

Medical Decision-making Table With Pediatric Examples[a] (*continued*)

Low (*continued*)	minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.)	**Category 2:** Assessment requiring independent historian(s) (eg, parent, guardian, surrogate, spouse, witness who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history)	
	• *Mild upper respiratory infection and mild diaper rash, home care recommendations* • *Pharyngitis with negative streptococcal test with independent historian* • *Uncomplicated otitis externa or otitis media with independent historian* • *Acute gastroenteritis, independent historian, instructions for symptom management* • *Follow-up of stable ADHD, limited data, with prescription drug management* • *Follow-up of stable asthma, limited data, prescription drug management* • *Impetigo with instructions for over-the-counter antibiotic ointment and recheck by nursing staff* • *Uncomplicated hand-foot-and-mouth disease with advice for home care and infection control* • *Allergic rhinitis due to pollen with advice for over-the-counter medication* • *Minor sprain with recommendation for use of soft brace* • *Wound repaired in emergency department or urgent care requiring evaluation and suture removal* • *Overuse injury requiring order for physical therapy*		
Moderate New patient **99204** 45–59 min Established patient **99214** 30–39 min	*Problems Addressed:* **Moderate** Any 1 of the following: • ≥1 chronic[c] illness(es) with exacerbation, worsening, poor control, or progressing with an intent to control progression, or attention to side effects of treatment • ≥2 stable chronic illnesses[c] • 1 undiagnosed new problem with uncertain prognosis (differential diagnosis representing a condition likely to result in a high risk of morbidity if untreated) • 1 acute illness with systemic symptoms[f] and has a high risk of morbidity without treatment (may be single system) • 1 acute complicated injury[g]	*Data Reviewed and Analyzed:* **Moderate** (Meet 1 of 3 categories.) **Category 1:** Any 3 of the following: • Review of prior external note(s)—each unique source[e] • Review of the result(s) of each unique test[d] • Ordering each unique test[d] • Assessment requiring independent historian(s) (eg, parent, guardian, surrogate, spouse, witness who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history) **Category 2:** Independent interpretation of a test performed by another physician/other QHP[h] **Category 3:** Discuss management or test interpretation with external physician/other QHP/appropriate source.[i]	*Risk of Additional Testing or Treatment:* **Moderate** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery; no identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health[j] (eg, housing or food insecurity)
	• *Hypertrophic adenoids with decision for adenoidectomy in a child with no systemic disease or anomalies* • *Infant presents with fever, cough, and third episode of otitis media within 3 months, antibiotics prescribed* • *Acute gastroenteritis with dehydration, administration of antiemetic drug, oral rehydration plan* • *Follow-up of stable ADHD, discussion with school nurse, with medication management* • *Asthma with exacerbation but not respiratory distress requiring prescription drug management* • *Asthma with report of increased symptoms requiring a change in medication* • *Follow-up for stable asthma and stable anxiety disorder with medication management* • *Patient with symptoms and findings supporting strep throat, positive streptococcal test, antibiotic prescribed* • *Unexplained bruising with independent historian and 2 or more laboratory tests ordered and/or results reviewed* • *Follow-up of stable type 1 diabetes with orders for 5 unique tests sent to outside laboratory and insulin management* • *Follow-up of head injury with brief loss of consciousness with intermittent headaches and confusion, order for cognitive testing, review of radiology report from initial treatment at hospital, and independent historian* • *Foreign body of ear with decision regarding removal of foreign body under anesthesia* • *Caregiver refusal of testing or consultation for an undiagnosed new problem due to out-of-pocket costs*		

Medical Decision-making Table With Pediatric Examples[a] (*continued*)

High New patient **99205** 60–74 min Established patient **99215** 40–54 min	*Problems Addressed:* **High**– 1 of the following: • ≥1 chronic[c] illness(es) with severe exacerbation, progression, or side effects of treatment that have significant risk of morbidity and may require hospital level of care • Threat to life or bodily function in the near term without treatment due to an acute illness with systemic symptoms; chronic illness with exacerbation and/or side effects of treatment; or injury	*Data Reviewed and Analyzed:* **Extensive** (Meet 2 of 3 categories.) **Category 1:** Any 3 of the following: • Review of prior external note(s) from each unique source[e] • Review of the result(s) of each unique test[d] • Ordering of each unique test[d] • Assessment requiring independent historian(s) (eg, parent, guardian, surrogate, spouse, witness who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history) **Category 2:** Independent interpretation of a test performed by another physician/other QHP[h] **Category 3:** Discuss management or test interpretation with external physician/other QHP/appropriate source.[i]	*Risk of Additional Testing or Treatment:* **High** • Drug therapy requiring intensive monitoring for toxicity[k] • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis
	• *Decision for or against hospital admission in a patient who is in acute respiratory distress (eg, status asthmaticus).* • *Decision for hospitalization for acute mastoiditis.* • *In-office hydration therapy for dehydration with plan for hospitalization if not able to tolerate oral rehydration before leaving office.* • *Infant with fever, tachycardia, lethargy, and dehydration with decision to admit to hospital.* • *A patient is seen for recent seizures that required hospital management. The physician reviews hospital records including recent video EEG test results read by another physician, obtains history from caregivers who witnessed seizures, and also monitors for toxicity due to long-term use of an antiepileptic drug.* • *Parents seek hospitalization of their child who planned suicide but was stopped before injury occurred.* • *Decision for emergency surgery or for trial of antibiotic treatment followed later by non-emergent appendectomy.* • *Shared decision-making with a patient/family regarding treatment failure and decision for palliative care.* • *Decision for scoliosis repair in a patient with cerebral palsy and respiratory compromise.*		

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; *CPT, Current Procedural Terminology*®; EEG, electroencephalogram; MDM, medical decision-making; QHP, qualified health care professional.

[a] Examples included in *italic text* are not included in *CPT* and are intended only to illustrate how the level of MDM might be met. The elements of MDM may vary across individual patient services, and code selection for each service should reflect the extent of MDM by the physician or other QHP on the date of the visit.

[b] Risk includes the possible management options selected and those considered but not selected after shared MDM with the patient and/or family. For example, a decision regarding hospitalization includes consideration of alternative levels of care.

[c] Chronic conditions are problems that are expected to last at least 1 year or until the death of the patient.

[d] Tests are imaging, laboratory, psychometric, or physiologic data. One *CPT* code equals 1 test (eg, laboratory panel reported with 1 code is 1 test). Ordering a test is included in the category of test result(s), and the review of the test result is part of the encounter and not a subsequent encounter.

[e] External records, communications, and/or test results are from an external physician, external other QHP, facility, or health care organization.

[f] For systemic general symptoms such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or prevent complications, see the definitions for *self-limited or minor* or *acute, uncomplicated*.

[g] An injury requiring treatment that includes evaluation of body systems that are not directly part of the injured organ is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

[h] The interpretation of a test for which there is a code and an interpretation or report is customary. This does not apply when the physician or other QHP is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

[i] An external physician or other QHP is an individual who is not in the same group practice or is a different specialty or subspecialty. The category includes licensed professionals that are practicing independently. An external physician may also be a facility or organizational provider, such as a hospital, nursing facility, or home health care agency. When the physician or other QHP is reporting a separate service for discussion of management with a physician or other QHP, the discussion is not counted in the MDM when selecting a level of office or other outpatient service.

[j] Economic and social conditions that influence the health of people and communities.

[k] A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. Monitoring by history or examination does not qualify. The monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a laboratory test, a physiologic test, or imaging. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient.

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0.5 Continuing Education Units

1. **Which of the following is not a factor in selecting codes for office evaluation and management (E/M) services in 2021?**
   a. Whether the patient is new or established
   b. The level of medical decision-making (MDM)
   c. The level of history obtained
   d. The pediatrician's total time on a date of service

2. **Which is a potential cause of unpaid claims in a physician practice?**
   a. Errors in patient information, such as date of birth or insurance plan information
   b. Errors in the billing physician's information (eg, billing address) included on the claim
   c. Claims processed and applied to the patient's out-of-pocket expenses (eg, deductible)
   d. All of the above

3. **Which of the following is true of MDM for office E/M services?**
   a. The physician's time is not a validator of the level of MDM.
   b. Risk is based on consequences of the problem(s) addressed at the encounter when untreated.
   c. A chronic condition with poor control is a stable chronic illness.
   d. An acute illness with systemic symptoms is an illness with systemic general symptoms, such as fever, body aches, or fatigue in a minor illness.

4. **Which is true for code 33741, transcatheter atrial septostomy for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method?**
   a. Modifier **63** (procedure performed on infant ≤4 kg) is typically appended to code **33741**.
   b. Modifier **63** is never appended to code **33741**.
   c. Does not include ultrasound guidance for vascular access or fluoroscopic guidance for the intervention
   d. Includes diagnostic cardiac catheterization for congenital anomalies when a clinical change during the procedure requires more thorough evaluation

5. **What codes are reported for placement of a single stent in a primary location and multiple stents in a single secondary location during transcatheter intracardiac shunt creation by stent placement for congenital cardiac anomalies (33745, 33746)?**
   a. Report **33746** with 2 units of service.
   b. Report only **33745**, which includes all intracardiac shunts.
   c. Report **33745** and **33746** with 1 unit of service each.
   d. Report **33745** with 1 unit of service and **33746** with 2 units of service.

MIXED SOURCES