Office-Based Evaluation and Management Services: 1 Year In

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February 15, 2022

Disclosures

Dr. Slade has no relevant financial disclosures.

This webinar is supported by an industry sponsor. They did not review or influence the content.

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Objectives

- Understand the 2021 office and other outpatient E/M coding guidelines.
- Understand when to select code based on MDM vs time.
- Answer FAQs related to the MDM table.

Why the Change?

- 1995/1997 CMS E/M documentation and coding guidelines
  - Burdensome and difficult to understand
- Mounting pressure
  - Electronic health records: “note bloat”
  - Physician burnout

Guiding Principles for the E/M Updates

- Decrease documentation burden and note bloat.
- Make code level selection more intuitive.
- Decrease the need for audits through the addition and expansion of key definitions.
- Retain current code distribution.

Code level selection is based on **physician work** in managing the patient's problem(s) with focus on decision-making, not on volume of tests/treatments.

Summary of 2021 Changes

- Eliminated history and physical exam as elements for code selection (still important for medical liability)
- Deleted **99201**
- MDM *or* time to select code
- Revised MDM
- Revised time
- New prolonged services code

E/M Office Visits

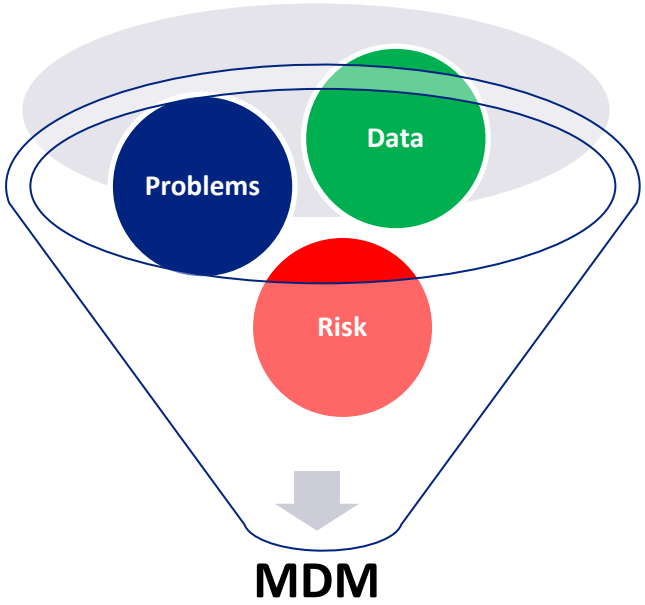
MDM	New Patient	Established Patient
None	~~99201~~	99211
Straightforward	99202	99212
Low	99203	99213
Moderate	99204	99214
High	99205	99215

Medical Decision-Making

(MDM)

Medical Decision-Making

The cognitive process required to manage the patient's problems at that point in time



3 Elements of MDM

Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management

- 2 out of the 3 elements required to reach a level
- Goes for *both* new and established patients

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• 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

Internet search: AMA table of risk 2021

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Problems Addressed

Office Visit E/M Code	Number and Complexity of Problems Addressed
99211	N/A
99202 99212	**Minimal** • 1 self-limited or minor problem
99203 99213	**Low** • 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury
99204 99214	**Moderate** • 1 or more chronic illnesses w/ exacerbation, progression, or side effects of treatment or • 2 or more stable chronic illnesses or • 1 undiagnosed new problem w/ uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury
99205 99215	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function

"Problem" Definitions

- ***Self-limited or minor problem:*** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. *Example:* mild diaper rash.

- ***Undiagnosed new problem with uncertain prognosis:*** A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. *Example:* mass in the abdomen.

- ***Illness or injury that poses a threat to life or bodily function:*** An illness or injury that poses a threat to life or bodily function in the near term without treatment. *Example:* respiratory distress with RSV bronchiolitis.

- ***Acute, uncomplicated illness or injury:***
  - A recent or new short-term problem with low risk of morbidity for which treatment is considered. *Example:* ankle sprain.
  - A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course becomes an acute uncomplicated illness. *Example:* worsening diaper rash.

- ***Acute illness with systemic symptoms:*** An illness that causes systemic symptoms and has a *high risk of morbidity without treatment*. Systemic symptoms may not be general but may be single system. *Examples:* pyelonephritis, gastroenteritis, new onset panic disorder.

- ***Acute, complicated injury:*** An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. *Example:* head injury with brief loss of consciousness.

Chronic: expected duration of at least a year or until death

- ***Stable, chronic illness:*** *Stable* is defined as the individual patient being at their specific treatment goals. *Example:* well-controlled ADHD.

- ***Chronic illness with exacerbation, progression, or side effects of treatment:*** A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or attention to treatment for side effects but not requiring consideration of hospital level of care. *Example:* ADHD with weight loss.

- ***Chronic illness with severe exacerbation, progression, or side effects of treatment:*** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care. *Example:* severe depression with potential threat to self or others.

Data

“Data” Categories

– External notes; tests reviewed or ordered

– Independent historian(s)

– Independent interpretation of tests

– Discussion of management or test interpretation

Office Visit E/M Code	Amount/Complexity of Data to Be Reviewed/Analyzed
99211	N/A
99202 99212	**Minimal or none**
99203 99213	**Limited** (*Must meet the requirements of at least **1 of the 2 categories***) <u>Category 1: Tests and documents</u> Any combination of **2** from the following: • Review of prior **external note(s)** from each unique source* • Review of the **result(s)** of each unique test* • Ordering of each unique **test*** or <u>Category 2: Assessment requiring an independent historian(s)</u> * *Each unique test, order, or document contributes to the combination of 2 in Category 1.*

Office Visit E/M Code	Amount/Complexity of Data to Be Reviewed/Analyzed
99204 99214	**Moderate** (*Must meet the requirements of at least **1 out of 3** categories*) <u>Category 1: Tests, documents, or independent historian(s)</u> Any combination of **3** from the following: • Review of prior external **note(s)** from each unique source* • Review of the **result(s)** of each unique test* • **Ordering** of each unique test* • Assessment requiring an **independent historian(s)** or <u>Category 2: Independent interpretation of tests</u> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or <u>Category 3: Discussion of management or test interpretation</u> • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) **Each unique test, order, or document contributes to the combination of 3 in Category 1*

Office Visit E/M Code	Amount/Complexity of Data to be Reviewed/Analyzed
99205 **99215**	**Extensive** *(Must meet the requirements of at least **2 out of 3** **categories**)* <u>Category 1: Tests, documents, or independent historian(s)</u> Any combination of 3 from the following: • Review of prior external **note(s)** from each unique source*; • Review of the **result(s)** of each unique test*; • **Ordering** of each unique test*; • Assessment requiring an **independent historian(s)** or <u>Category 2: Independent interpretation of tests</u> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or <u>Category 3: Discussion of management or test interpretation</u> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) * *Each unique test, order, or document contributes to the combination of 3 in Category 1.*

"Data" Definitions

- *Test:* imaging, laboratory, psychometric, or physiologic data
  - A clinical laboratory panel (eg, basic metabolic panel [**80047**]) is a single test. The differentiation between single or multiple unique tests is defined per the *CPT*® code set.

- *External physician or other qualified health care professional:* an individual who is not in the same group practice or is a different specialty or subspecialty
  - Includes licensed professionals who are practicing independently
  - May also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency

- *Appropriate source:* professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher)
  - Does not include discussion with family or informal caregivers

Independent historian(s): An individual (eg, parent, guardian) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

Independent interpretation: The interpretation of a test for which there is a *CPT*® code and an interpretation or report is customary, but the physician or other qualified health care professional will not be reporting a separate code for the interpretation. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Risk

Office Visit E/M Code	*Risk* of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A
99202 99212	**Minimal** risk of morbidity from additional diagnostic testing or treatment
99203 99213	**Low** risk of morbidity from additional diagnostic testing or treatment
99204 99214	**Moderate** risk of morbidity from additional diagnostic testing or treatment *Examples only* •Prescription drug management •Decision regarding minor surgery with identified patient or procedure risk factors •Decision regarding elective major surgery without identified patient or procedure risk factors •Diagnosis or treatment significantly limited by social determinants of health
99205 99215	**High** risk of morbidity from additional diagnostic testing or treatment *Examples only* •Drug therapy requiring intensive monitoring for toxicity •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

"Risk" Definitions

- ***Morbidity:*** state of illness or functional impairment; substantial duration
  - Function is limited, or
  - Quality of life is impaired.

  Example: GAD, not able to attend school for 3 months

- ***Social determinants of health:*** economic and social conditions that influence health

  Example: food or housing insecurity

"Risk" Definitions

- ***Intensive monitoring for toxicity:*** 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. The monitoring may be by a lab test, a physiologic test, or imaging. Monitoring by history or examination does not qualify.

  Example: methotrexate, monitor CBC, renal function, LFTs q2–4 weeks

Office Visits Level of Medical Decision-making (MDM)

	Problems	Data	Risk
99202 **99212**	1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 **99213**	• 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury	<u>Category 1: Tests and documents</u> • Any combination of 2 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test or <u>Category 2: Assessment requiring an independent historian(s)</u>	Low risk of morbidity from additional diagnostic testing or treatment
99204 **99214**	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment or • 2 or more stable chronic illnesses or • 1 undiagnosed new problem with uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury	(Must meet the requirements of at least **1 out of 3** categories) <u>Category 1: Tests, documents, or independent historian(s)</u> • Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) or <u>Category 2: Independent interpretation of tests</u> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or <u>Category 3: Discussion of management or test interpretation</u> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 **99215**	• 1 chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 illness or injury that poses a threat to life or bodily function	(Must meet the requirements of at least **2 out of 3** categories) As for **99204**/**99214** above	High risk of morbidity from additional diagnostic testing or treatment *Examples only* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Time

Using Time for Code Selection

- Based on *total time* (both face-to-face **and** non–face-to-face time *on date of encounter*)
- Does not have to be continuous on that day
- Must be in defined time range for the code

Total Time on the Date of the Encounter

- Includes time in activities that require the *physician or other qualified health care professional* and does not include time in activities normally performed by clinical staff
- Includes the following activities, when performed:
  - Preparing for the visit (eg, review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Communicating with other health care professionals (not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

Time Ranges for E/M Selection

New Patient	Total Time Range (min)	Established Patient	Total Time Range (min)[a]
99202	15–29	**99212**	10–19
99203	30–44	**99213**	20–29
99204	45–59	**99214**	30–39
99205	60–74	**99215**	40–54

[a] **99211** is typically a clinical staff only service—time is not used in this code selection.

Prolonged Services

Prolonged Services Code

- Prolonged services code **99417** captures extended time for office visits (**99205**, **99215**).
- Includes both face-to-face (F2F) and non-F2F prolonged time only **on day of encounter.**
- Can only be used when coding based on time.
- Time increment is 15 minutes.
- Do ***not*** use F2F (99354, 99355) or non-F2F (99358, 99359) prolonged services with **99202–99215**.

Prolonged Services: Clarification

Use after exceeding 15 minutes from the *minimum* time in the range of **99205** or **99215**.

New Patient	Total Time Range (mis)	Established Patient	Total Time Range (min)
99205	60–74	**99215**	40–54
99205 + **99417**	75–89	**99215** + **99417**	55–69
99205 + **99417** x2	90–104	**99215** + **99417** x2	70–84
99205 + **99417** x3	105–119	**99215** + **99417** x3	85–99

Problems Stemming From **99417**

- CMS and *CPT*® differ on the interpretation of when **99417** starts.
- CMS has placed a "per day" limit or a Medically Unlikely Edit that has caused issues for extended services.
  - Per day limit (ie, per 15 mins) is set at 4.
- Some payers have yet to load this code and instead use CMS code **G2212**.

FAQs

What do I code for acute otitis media?

It depends!

Vignette 1

- 8-year-old established patient presents with right ear pain of 3 days' duration.
  -Pain not improving.
  -Had fever for 1 day, which is resolved.
  -Patient says hearing seems diminished on right side only.
- On exam, erythematous, bulging, opaque, nonmobile right TM.
- Assessment: right AOM.
- Plan: prescription antibiotic and OTC pain med.

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low 1 acute uncomplicated illness	Limited Independent historian	Low risk	**Low**
99204 99214	Moderate	Moderate	Moderate risk Prescription drug management	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Vignette 2

- 6-month-old established patient presents with fever of 2 days' duration.
  -Increased crying and fussiness
  -Poor feeding
  -Poor sleeping
  -Emesis
- On exam, erythematous, bulging, opaque, nonmobile right TM.
- Assessment: right AOM.
- Plan: prescription antibiotic and OTC pain med. Follow up in 2–3 days if not improving.

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low	Limited Independent historian	Low risk	**Low**
99204 99214	Moderate 1 acute illness with systemic symptoms	Moderate	Moderate risk Prescription drug management	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Vignette 3

- 18-month-old established patient presents with fever of 2 days' duration.
  -Increased crying and fussiness.
  -Poor feeding and poor sleeping.
  -PMH includes 5 prior AOMs in past 6 months.
- On exam, erythematous, bulging, opaque, nonmobile right TM with tenderness and swelling posterior auricular area.

- Assessment: right AOM, concern for right mastoiditis.
- Plan: Discuss with ENT; hospitalization for IV antibiotics.

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low	Limited	Low risk	**Low**
99204 99214	Moderate	Moderate Meet 1 of 3 categories: • Discussion of management with appropriate source [Did not meet Category 1 as only had 1 item (independent historian)]	Moderate risk	**Moderate**
99205 99215	High 1 acute illness that poses a threat to bodily function	Extensive	High risk Decision regarding hospitalization	**High**

What is a **systemic** symptom?

Revisiting Vignette 1

- 8-year-old established patient presents with right ear pain of 3 days' duration.
  -Not improving.
  -Had **fever** for 1 day, which is resolved.
  -Patient says hearing seems diminished on right side only.
- On exam, erythematous, bulging, opaque, nonmobile right TM.
- Assessment: right AOM.
- Plan: prescription antibiotic and OTC pain med.

Revisiting Vignette 2

- 6-month-old established patient presents with **fever** of 2 days' duration.
  -Increased crying and **fussiness**
  -Poor **feeding**
  -Poor **sleeping**
  -Emesis
- On exam, erythematous, bulging, opaque, nonmobile right TM.
- Assessment: right AOM.
- Plan: prescription antibiotic and OTC pain med. Follow up in 2–3 days if not improving.

- *CPT*® defines an *illness with systemic symptoms* as one with a **high risk of morbidity without treatment.**

- May be general symptoms such as malaise or low appetite.

- May be a single system such as pyelonephritis or gastroenteritis.

- Fever/chills/body aches alone are not necessarily considered systemic symptoms in *CPT* when the condition is considered acute and uncomplicated (eg, viral URI).

What is **review of prior notes**?

Revisiting Vignette 3

- 18-month-old established patient presents with fever of 2 days' duration.
  -Increased crying and fussiness.
  -Poor feeding and poor sleeping.
  -**PMH includes 5 prior AOMs** in past 6 months.
- On exam, erythematous, bulging, opaque, nonmobile right TM with tenderness and swelling posterior auricular area.

- Assessment: right AOM, concern for right mastoiditis.
- Plan: Discuss with ENT; hospitalization for IV antibiotics.

4 Scenarios

- You reviewed **your own** prior notes.
  - This does *not* count toward "Review of prior *external* notes from each unique source," as it was *not* an external source.
- You reviewed your **covering colleague's** prior notes (colleague in same specialty and same practice).
  - This does *not* count toward "Review of prior *external* notes from each unique source," as it was *not* an external source.
- You reviewed your office notes as well as specialist notes from **ENT** on 2 different visits over past 6 months.
  - Although it was from 2 different visits, this counts as 1 item for Category 1, as you reviewed external notes from *1* unique source.
- You reviewed your office notes as well as **ENT** specialist notes from 2 different visits and **ED** notes from 1 visit over past 6 months.
  - This counts as 2 items for Category 1, as you reviewed external notes from *2* unique sources (ENT and ED).

What is a ***unique*** test?

Vignette 4

- 3-year-old established patient presents for follow-up of elevated lead with associated anemia.
- You review patient's past 5 lead and CBC tests from the previous 3 months.

- This counts as 2 *unique* tests: lead and CBC.
  - Although you reviewed 10 separate tests, they were serial studies of 2 tests.

Tip

- *CPT*® defines *1 unique test* as that which is based on the *CPT* code set.
- For example, although a CMP reports 14 different chemistries, because you can order it as a panel, it counts as *1 unique test*.
- Other common examples of 1 unique test include
  - BMP
  - CBC
  - Food allergy panel
  - Lipid panel
  - Thyroid panel
  - Viral panel

What is **independent interpretation** of test?
And when can I use it?
And when can I not use it???

Vignette 5

- 11-year-old established patient presents with fever and sore throat for 2 days.
- On exam, throat erythematous, tonsils 2+ bilaterally, palatal petechiae, tender LAD.
- Rapid strep test in the office is negative.
- Collect and send a COVID-19 PCR nasal swab and throat culture to the lab.
- Assessment: pharyngitis, viral vs strep.
- Plan: Supportive care. Await labs to determine if antibiotics are indicated.

- **87880** Rapid strep test
  - Done in office
  - “Credit” for ordering (or interpreting) **1** test
    - Although you ordered the test, interpreted the result, and reviewed the result with the patient, you get “credit” for only **1** test.
- **87081** Group A strep throat culture
  - Sent out to lab
  - “Credit” for ordering 1 test
- **87635** COVID-19 PCR nasal swab
  - Sent out to lab
  - “Credit” for ordering 1 test

Office Visits Level of Medical Decision-making (MDM) Table

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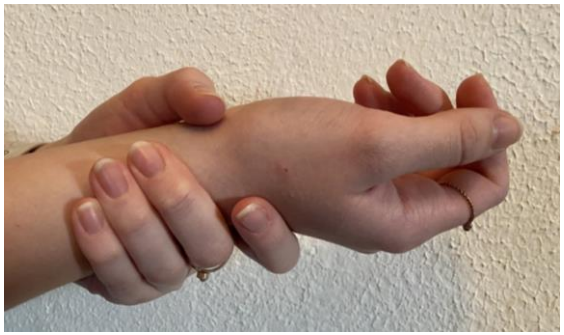
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low 1 acute, uncomplicated illness	Limited	Low risk Low risk from additional testing or treatment	**Low**
99204 99214	Moderate	Moderate Category 1: Ordering of (3) unique tests Independent historian	Moderate risk	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Vignette 6

- 15-year-old established patient presents after a skateboarding injury. Patient fell onto an outstretched hand; has pain in right wrist.
- On exam, there is tenderness and ecchymosis over right wrist.
- Assessment: sprain vs contusion vs fracture.
- Radiograph of the right wrist ordered.



What happens next might alter the service that you submit.

Await radiologist interpretation of radiograph.

Then inform patient of result and plan.

Review the radiograph.

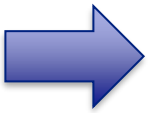
Document your interpretation.

Inform patient of result and plan.

Office Visits Level of Medical Decision Making (MDM) Table	
	Amount/Complexity of Data to be reviewed/ analyzed
99211	N/A
99202 **99212**	Minimal or none Ordered one test (X-ray)
99203 **99213**	Limited
99204 **99214**	Moderate
99205 **99215**	Extensive

Await radiologist interpretation of X-ray

Office Visits Level of Medical Decision-making (MDM) Table	
	Amount/Complexity of Data to Be Reviewed/Analyzed
99211	N/A
99202 **99212**	Minimal or none
99203 **99213**	Limited
99204 **99214**	Moderate Category 2: Independent interpretation of test (not separately reported)
99205 **99215**	Extensive



Review the radiograph.
Document your interpretation.

Vignette 7

- 16-year-old established patient presents with chest pain and palpitations off and on for 1 week.
- On exam, normal heart, lung, and musculoskeletal exam.
- ECG performed in the office.

What happens next might alter the service that you submit.

Electronically send ECG to cardiologist.

Await cardiologist's interpretation.

Then inform patient of result and plan.

Review the ECG.

Provide a formal report.

Inform patient of result and plan.

Electronically send ECG to cardiologist.

Meanwhile, provide independent interpretation.

Document interpretation.

Inform patient of result and plan.

Cardiologist will provide formal report on ECG.

Office Visits Level of Medical Decision-making (MDM) Table	
	Amount/Complexity of Data to Be Reviewed/Analyzed
99211	N/A
99202 **99212**	Minimal or none Ordered 1 test (ECG)
99203 **99213**	Limited
99204 **99214**	Moderate
99205 **99215**	Extensive

Electronically send ECG to cardiologist.

Await cardiologist's interpretation.

- Submit **93005** (ECG tracing only, without interpretation and report) in addition to the E/M service **99212–99215**.
- **Cardiologist** will submit **93010** (ECG, interpretation and report only).

Office Visits Level of Medical Decision-making (MDM) Table	
	Amount/Complexity of Data to Be Reviewed/Analyzed
99211	N/A
99202 **99212**	Minimal or none Ordered 1 test (ECG)
99203 **99213**	Limited
99204 **99214**	Moderate
99205 **99215**	Extensive

Review the ECG.

Provide a formal report.

- Submit **93000** (ECG, 12-lead, with interpretation and report) in addition to the E/M service **99212–99215**.

Office Visits Level of Medical Decision-making (MDM) Table	
	Amount/Complexity of Data to Be Reviewed/Analyzed
99211	N/A
99202 **99212**	Minimal or none
99203 **99213**	Limited
99204 **99214**	Moderate Category 2: Independent interpretation of test (not separately reported)
99205 **99215**	Extensive

Electronically send ECG to cardiologist.

Meanwhile, provide independent interpretation. **Document interpretation.**

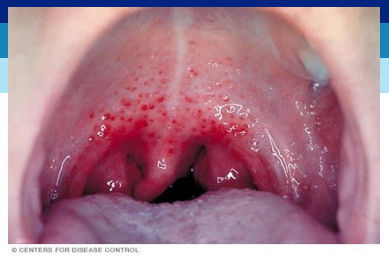
Cardiologist will provide formal report on ECG.

- Submit **93005** (ECG tracing only, without interpretation and report) in addition to the E/M service **99212–99215**.
- Cardiologist will submit **93010** (ECG, interpretation and report only).

It’s unfair!

While waiting for test results, I did not appreciate the higher level of risk.

Revisiting Vignette 5



- 11-year-old established patient presents with fever and sore throat for 2 days.
- On exam, throat erythematous, tonsils 2+ bilaterally, palatal petechiae, tender LAD.
- Rapid strep in the office is negative.
- Collect and send a COVID-19 PCR nasal swab and throat culture to the lab.
- Assessment: pharyngitis, viral vs strep.
- Plan on day of visit: Supportive care. Await labs.
- Culture is positive for GAS 2 days later.
- Call the patient with results and prescribe antibiotics.

Photo source: Center for Disease Control and Prevention

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low 1 acute, uncomplicated illness	Limited	Low risk	**Low**
99204 99214	Moderate	Moderate Category 1: Ordering of (3) unique tests Independent historian	Moderate risk Prescription drug management	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Tip

For some visits, it may be appropriate to hold off on submitting service until after labs/studies are available.

Would it just be easier to submit service based on time instead of consulting the MDM chart for every visit?

Vignette 8

- 2-month-old established patient presents with rash on face and extensor surfaces of arms and legs. Family history of eczema in 2 older siblings.
- Assessment: eczema.
- Plan: Topical corticosteroid twice daily as needed. Liberal application of moisturizer. Discussed skin care and bathing.
- Time spent: 10 minutes.

Photo source: Shutterstock. Used with permission.

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 **99212**	Minimal 1 self-limited problem	Minimal or none	Minimal risk	**Straightforward**
99203 **99213**	Low	Limited	Low risk Low risk from additional testing or treatment	**Low**
99204 **99214**	Moderate	Moderate	Moderate risk	**Moderate**
99205 **99215**	High	Extensive	High risk	**High**

Time Spent: 10 Minutes

New Patient	Total Time Range (min)	Established Patient	Total Time Range (min)
99202	15–29	**99212**	10–19
99203	30–44	**99213**	20–29
99204	45–59	**99214**	30–39
99205	60–74	**99215**	40–54

Vignette 9

- 2-month-old established patient presents with rash on extensor surfaces of arms and legs.
- First child for this family.
- Assessment: eczema.
- Plan: topical corticosteroid twice daily as needed and liberal application of moisturizer.
- Parent with multiple questions about hygiene, soaps and detergents, feeding and food allergies, and expected course of condition. All questions answered.
- Time spent: 25 minutes.

Photo source: Shutterstock. Used with permission.

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal 1 self-limited problem	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low	Limited	Low risk Low risk from additional testing or treatment	**Low**
99204 99214	Moderate	Moderate	Moderate risk	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Time Spent: 25 Minutes

New Patient	Total Time Range (min)	Established Patient	Total Time Range (mins)
99202	15–29	**99212**	10–19
99203	30–44	**99213**	20–29
99204	45–59	**99214**	30–39
99205	60–74	**99215**	40–54

Make sure to document the time spent and how you spent that time.

Vignette 10

- 9-year-old established patient presents for follow-up on ADHD and asthma.
- ADHD is well controlled, based on parent and teacher Vanderbilt assessments. No concerns for side effects from medication.
- Asthma is also reported to be well controlled with use of rescue albuterol only twice in preceding 3 months.
- Physical exam is normal.
- Assessment/plan
  1. ADHD, well controlled. Provided refills of medication.
  2. Asthma, well controlled. Reviewed medications and no refills needed at this time.
- Time spent: 20 minutes.

Time Spent: 20 Minutes

New Patient	Total Time Range (min)	Established Patient	Total Time Range (min)
99202	15–29	**99212**	10–19
99203	30–44	**99213**	20–29
99204	45–59	**99214**	30–39
99205	60–74	**99215**	40–54

Also submit **96127** x 2 for parent and teacher Vanderbilt assessments (brief behavior/emotional assessment with scoring and documentation, standardized instrument).

Office Visits Level of Medical Decision-making (MDM) Table

	Number/Complexity of Problems Addressed	Amount/Complexity of Data to Be Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low	Limited Independent historian	Low risk	**Low**
99204 99214	Moderate 2 chronic problems	Moderate	Moderate risk Prescription drug management	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Also submit **96127** x 2 for parent and teacher Vanderbilt assessments (brief behavior/emotional assessment with scoring and documentation, standardized instrument).

Vignette 11

- 10-year-old established patient with complex medical history presents for routine follow-up on multiple medical issues including chronic lung disease, trach and vent dependence, cerebral palsy, developmental delay, G-tube dependence, and VSD.
- You evaluate each condition, adjust medications as warranted, adjust tube feeding schedule, and place referrals to specialists as indicated. You also review and complete forms for school as requested.
- Time spent: 60 minutes on the same date of visit.

Time Spent: 60 Minutes

Established Patient	Total Time Range (min)
99212	10–19
99213	20–29
99214	30–39
99215	40–54

99215 does not capture the entire time for this 60-minute visit.

Therefore, you will add **99417** to report the full service.

Prolonged Services	
Established Patient	Total Time Range (min)
99215	40–54
99215 + **99417**	55–69
99215 + **99417** x2	70–84
99215 + **99417** x3	85–99

Tips Regarding Time

- Time must be **documented**.
- Use total time **on same day** of service, including pre- and post-service time.
- Do not "double dip."
  - Do not include time spent on a different service (eg, review of study that you separately reported).

More Tips Regarding Time

- Do not include time spent by medical students, residents, or clinical staff.
- Do not include time spent teaching medical students, residents, or other learners.
- *Combine* physician and advanced practitioner time on the same date, *but* do not count time twice when time overlaps.

More Tips Regarding Time

- Typically, use of MDM will contribute to a higher service than use of time.
- Use either time or MDM, **whichever is most advantageous to you.**

My patients are more complicated than typical patients.

My patients are more demanding than typical patients.

Vignette 12

- 14-year old established patient presents for follow-up of hypertension. His blood pressure has worsened. You learn that he lives in a neighborhood without convenient access to a grocery store and family purchases their food at local corner store. He eats a lot of processed and salty foods.
- Physical exam is normal with the exception of blood pressure and BMI at 94th percentile.
- Assessment: Essential hypertension
- Plan: Encourage lifestyle modifications with healthy diet & exercise. Referral to local food pantry to help with obtaining fresh foods.

Office Visits Level of Medical Decision Making (MDM) Table

	Number /Complexity of Problems Addressed	Amount/Complexity of Data to be reviewed/ analyzed	Risk of complication/ morbidity or mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low	Limited	Low risk	**Low**
99204 99214	Moderate 1 chronic illness with progression	Moderate	Moderate risk Diagnosis or treatment significantly limited by SDoH	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Vignette 13

- 12-year old established patient presents with history of headaches 3 times last week which all occurred after school in the afternoon. You take detailed relevant history regarding headaches as well as sleep, diet, activities, and medications. Parent is requesting CT scan, MRI, and blood work to look for anemia, and hormone problems.
- Physical exam is normal including thorough neurological exam.

- Assessment: Tension Headaches
- Plan: Reassurance.
  - Discuss with parent each of the requested labs/studies and why you do not recommend them at this juncture.

Office Visits Level of Medical Decision Making (MDM) Table

	Number /Complexity of Problems Addressed	Amount/Complexity of Data to be reviewed/ analyzed	Risk of complication/ morbidity or mortality of Patient Management	MDM Level (need 2 of 3)
99211	N/A	N/A	N/A	**N/A**
99202 99212	Minimal	Minimal or none	Minimal risk	**Straightforward**
99203 99213	Low	Limited	Low risk	**Low**
99204 99214	Moderate 1 undiagnosed new problem with uncertain prognosis	Moderate *Decision regarding* ordering of each unique test (4)	Moderate risk	**Moderate**
99205 99215	High	Extensive	High risk	**High**

Summary

- History and PE will *not* be used to select code level.
- Choose code level based on MDM or time.
- MDM requires 2 of the 3 elements to reach a level.
- Time is a specific range.
- Time includes *all* time spent on day of encounter, even non–face-to-face time.
- Use prolonged services code to capture all time.

Acknowledgments

Many thanks

Margie Andreae, MD, FAAP
Member, Committee on Coding and Nomenclature, and AAP RUC representative
Slides from her 2020 webinar have been used here.

Becky Dolan, MPH, CPC, CPEDC
AAP coding staff
For support, encouragement, and review of this presentation

AAP Resources

Coding Publications

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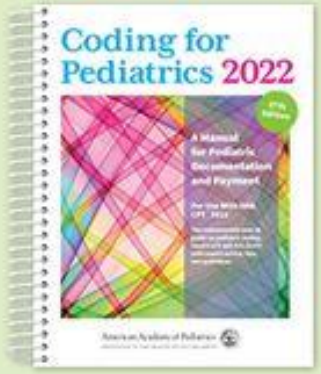

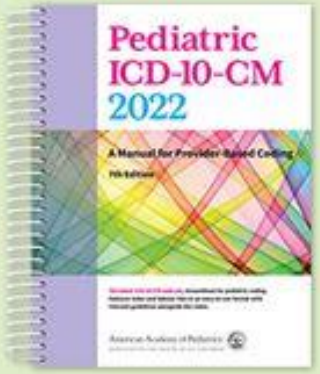

Coding Website

- Visit the Coding and Valuation site
  - www.aap.org/coding

Coding Hotline/Payer Hassle Factor Form

- For coding questions or issues with insurance payers, including Medicaid, reach out to AAP staff on the hotline.

- Please fill out 1 form per issue or payer concern:

https://form.jotform.com/Subspecialty/aapcodinghotline

Thank you!

For additional questions

https://form.jotform.com/Subspecialty/aapcodinghotline

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