American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Dear Reader,

Updates have been made to *Coding for Pediatrics 2021.*

1/6/2021

Page 117

The following bulleted text has been added beneath the heading "*Current Procedural Terminology* Guidelines":

- *CPT* revised E/M guidelines in 2021 and included a new instruction that prohibits the counting of tests performed and/or interpreted during an encounter and separately reported by the physician or other QHP toward the level of MDM for the encounter. See more about MDM later in this chapter.

Page 140

The final item listed beneath the heading "Amount and/or Complexity of Data to Be Reviewed" has been revised. The item previously read as follows:

> •*DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

It *has been updated* to read as follows:

> •*DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.* CPT 2021 *specifies that 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.*

Page 156

The following has been added to the end of the paragraph that begins, "Independent interpretation":

> Both the order for and the independent interpretation of the test may be counted toward the level of data reviewed and analyzed.

The following has been added to the end of the paragraph that begins, "Test":

> The performance and/or interpretation of diagnostic tests or studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Additionally, it is inappropriate to not report a code for a test to increase the level of MDM of a visit.

Page 161

The following has been added to footnote [a] of Table 7-4:

> However, only tests not performed and/or interpreted during the encounter and separately reported by the physician or other qualified health care professional are counted in determining the level of data to be reviewed and analyzed.

The Teaching Point in the final example on page 161 has been updated. The item previously read as follows:

> **Teaching Point:** This is based on orders for 2 unique tests, assessment requiring an independent historian, and discussion of management with an external physician.

It *has been updated* to read as follows:

> **Teaching Point:** This is based on orders for 2 unique tests, assessment requiring an independent historian, and discussion of management with an external physician. If the 2 tests ordered are performed and/or interpreted by the pediatrician and separately reported, these would not be counted toward the level of data reviewed, reducing the level from extensive to moderate.

Page 162

The Teaching Point in the first example on page 162 has been updated. The item previously read as follows:

> **Teaching Point:** This is based on 2 unique tests ordered, assessment requiring an independent historian, and independent interpretation of a test by a physician not reporting a code for the interpretation and report of the findings.

It *has been updated* to read as follows:

> **Teaching Point:** This is based on 2 unique tests ordered, assessment requiring an independent historian, and independent interpretation of a test by a physician not reporting a code for the test. If the code for the influenza test is reported by the physician, this would not count toward the level of data reviewed and analyzed, reducing the level from extensive to moderate.

Page 164

The following has been added to footnote [b] of Table 7-6:

However, tests performed and/or interpreted during the encounter by the physician or QHP are not counted toward the amount and/or complexity of data to be reviewed and analyzed.

Page 176

Two cells have been updated in the table titled "Continuum Model for Otitis Media," in the column titled "Amount and/or Complexity of Data Reviewed and Analyzed."

The first cell in the column previously read as follows:

> **Limited:** Tympanometry, audiometry, and/or assessment requiring an independent historian

It *has been updated* to read as follows:

> **Limited:** Assessment requiring an independent historian

The fourth cell in the column previously read as follows:

> **Moderate:** Orders and/or review of laboratory tests, chest radiograph, and possible lumbar puncture. Assessment requiring an independent historian.

It *has been updated* to read as follows:

> **Limited:** Assessment requiring an independent historian.
>
> or
>
> **Moderate:** If 2 or more tests are ordered from an external source and assessment requiring an independent historian

Page 181

A new paragraph has been added to the section titled "Selecting the Appropriate Evaluation and Management Codes." The new paragraph directly precedes the second shaded box on the page ("See also Chapter 6…") and reads as follows:

> In 2021, *CPT* prohibits physicians and other QHPs from counting tests performed and/or interpreted during the encounter and separately reported in the determination of the level of medical decision-making (MDM). This applies to tests such as point-of-care laboratory tests.

Page 185

An update has been made to the chart that follows the first paragraph beginning with "Assessment/plan."

The first cell in the chart previously read as follows:

> *MDM:* High complexity (new problem with additional workup; old record reviewed/summarized, laboratory tests reviewed, and medical test ordered)

It *has been updated* to read as follows:

> *MDM:* High complexity (new problem with additional workup; old record reviewed/summarized, laboratory tests reviewed, and medical test ordered but not performed during the encounter)

Additional information has been added to the last sentence of the first Teaching Point on the page.

It previously read as follows:

> However, if a payer requires reporting an office or other outpatient E/M service in lieu of an outpatient consultation, code **99204** is supported based on a moderate level of MDM because an undiagnosed new problem with uncertain prognosis was addressed and a moderate amount and complexity of data was analyzed (ie, review of external notes and laboratory tests and order of a sweat test).

It *has been updated* to read as follows:

> However, if a payer requires reporting an office or other outpatient E/M service in lieu of an outpatient consultation, code **99204** is supported based on a moderate level of MDM because an undiagnosed new problem with uncertain prognosis was addressed and a moderate amount and complexity of data was analyzed (ie, review of external notes and laboratory tests and order of a sweat test not performed during the encounter).

Page 398

The following 2 new sentences have been added to the end of the Teaching Point:

> The level of office or other outpatient E/M service may be affected if the cardiologist will perform and/or interpret the electrocardiogram and/or echocardiogram and will separately report the services. When a physician performs and/or interprets a test during an encounter and reports the service, the test is not counted toward the level of MDM for the encounter.

Page 413

The following new sentence has been added to the end of the second bullet that begins, "Performance and documentation…":

> In determining the level of MDM for an ED encounter, any tests or studies performed and/or interpreted during the encounter and separately reported by the ED physician are not counted toward the amount and/or complexity of data reviewed.

Pages 427 and 428

A footnote has been added to the table titled "Continuum Model for Asthma." The footnote, [a], has been added to the cell labeled "Medical Decision-making (1. diagnoses; 2. data; 3. risk)." The footnote reads as follows:

> [a] Any tests performed and/or interpreted during the encounter and reported by the ED physician will not be counted toward the amount and/or complexity of data reviewed.

Page 429

A footnote has been added to the table titled "Continuum Model for Head Injury." The footnote, [a], has been added to the cell labeled "Medical Decision-making (1. diagnoses; 2. data; 3. risk)." The footnote reads as follows:

> [a] Any tests performed and/or interpreted during the encounter and separately reported by the emergency department physician are not counted toward the amount and/or complexity of data reviewed.

Pages 430 and 431

A footnote has been added to the table titled "Continuum Model for Laceration." The footnote, [a], has been added to the cell labeled "Medical Decision-making (1. diagnoses; 2. data; 3. risk)." The footnote reads as follows:

> [a] Any tests performed and/or interpreted during the encounter and separately reported by the emergency department physician are not counted toward the amount and/or complexity of data reviewed.

11/2/2020

An example has been updated on page 166 of the first printing of *Coding for Pediatrics 2021.* The original example designates streptococcal pharyngitis in the category of acute uncomplicated illness with a low number and/or complexity of problems, but streptococcal pharyngitis is more appropriately considered as having a moderate number and/or complexity of problems due to a higher complexity of diagnosis (eg, laboratory test with relatively high false-negative rate) and risks of preventable and nonpreventable sequelae. A more correct example of a condition with a low number and complexity of problems is acute otitis media without complication.

The updated text is as follows:

Page 166

> **Original Example**
>
> ➤ **A 6-year-old new patient presents for complaint of sore throat for 2 days**. Parents report complaints of headache and abdominal pain today. Strep test result is positive. An antibiotic is prescribed.

ICD-10-CM: **J02.0** (streptococcal pharyngitis)

CPT: **99203**. Low MDM is supported by the acute uncomplicated illness, data (order/review of strep test and need for independent historian), and moderate risk (prescription drug management).

Prescription drug management alone supports moderate risk but not moderate MDM.

Updated Example

➤ **A 6-year-old new patient presents for complaint of right ear pain for 2 days.** Acute suppurative otitis media is diagnosed. An antibiotic is prescribed with recommendation for watchful waiting prior to filling the prescription.

ICD-10-CM: **H66.001** (acute suppurative otitis media without spontaneous rupture of eardrum, right ear)

CPT: **99203**. Low MDM is supported by the acute uncomplicated illness, data (need for independent historian), and moderate risk (prescription drug management).

Prescription drug management alone supports moderate risk but not moderate MDM.

Please contact AAP Member and Customer Care at mcc@aap.org if you have any questions.

Thank you,

AAP Publishing

Evaluation and Management (E/M) Documentation and Coding Guidelines

This chapter outlines the evaluation and management (E/M) guidelines for all E/M services *except* office and other outpatient E/M services (office E/M, **99202–99205**, **99211–99215**). *Current Procedural Terminology* (*CPT*®) introduces a distinct set of guidelines in 2021 that apply only to codes **99202–99205** and **99211–99215**. Please see **Chapter 7** for guidelines for code selection and documentation of office E/M services.

For all E/M services other than office E/M services, 3 versions of E/M documentation guidelines exist, including *CPT* and the 1995 and 1997 guidelines published by the Centers for Medicare & Medicaid Services (CMS). Most Medicaid and private payers allow use of either the 1995 or 1997 CMS guidelines in E/M code selection but include elements of the *CPT* guidelines for E/M services (eg, guidelines for distinguishing between new and established patients).

Separate Guidelines for Office Visits

Please see Chapter 7 for distinct documentation guidelines applicable only to office and other outpatient evaluation and management services (99202–99205, 99211–99215). Codes for these services are selected based on the level of medical decision-making alone or the physician's or other qualified health care professional's total time on the date of service with no rule regarding the amount of time spent in counseling and/or coordination of care.

Current Procedural Terminology Guidelines

- The vaguest of all guidelines; defines the components of E/M services and provides general guidance on selecting levels of history, examination, and medical decision-making (MDM) or code selection based on time.
- Includes specialty-specific clinical examples in Appendix C of the American Medical Association *CPT 2021*.
- Provides expanded guidelines for topics such as distinguishing new patients from established patients, use of time in E/M code selection, and distinguishing between physicians and other qualified health care professionals (QHPs) and clinical staff.

CPT revised E/M guidelines in 2021 and included a new instruction that prohibits the counting of tests performed and/or interpreted during an encounter and separately reported by the physician or other QHP toward the level of MDM for the encounter. See more about MDM later in this chapter.

American Medical Association clinical examples are only examples and should not be used as a basis for coding patient encounters with the same diagnosis because the selection of a code must be based on the medically necessary services performed and documented and may include clinical variations.

Centers for Medicare & Medicaid Services *Documentation Guidelines for Evaluation and Management Services*

- Two sets of guidelines, 1995 and 1997 (see in this chapter or online at www.aap.org/cfp, access code AAPCFP26).
- Followed by the Medicare program, most private payers, and state Medicaid programs.
- Go beyond the *CPT* definitions and guidance for selecting levels of service providing specific documentation guidance. For example
  - The chief complaint (CC), review of systems (ROS), and past, family, and social history (PFSH) may be listed as separate elements of history, or they may be included in the description of history of present illness (HPI).
  - Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.
- The CMS documentation guidelines were based on the adult population because few children are covered under the Medicare program. However, the 1995 and 1997 guidelines state that a history and/or examination performed on a pediatric patient may vary from the adult standard and yet be appropriate when considering the selection of an E/M code. As noted in the 1997 guidelines, under Section III, Documentation of E/M Services, paragraph 5:

  "These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents, and pregnant women may have additional or modified information recorded in each history and examination area.

  "As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy, and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate."

Each of the elements of medical decision-making is described below.

Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Generally, decision-making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- ***DG:*** *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*
  - For a presenting problem with an established diagnosis the record should reflect whether the problem is: (a) improved, well controlled, resolving, or resolved; or (b) inadequately controlled, worsening, or failing to change as expected.
  - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.
- ***DG:*** *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*
- ***DG:*** *If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

Amount and/or Complexity of Data to Be Reviewed

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- ***DG:*** *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (eg, lab or x-ray) should be documented.*
- ***DG:*** *The review of lab, radiology, and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*
- ***DG:*** *A decision to obtain old records or to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.*
- ***DG:*** *Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed" or "-additional history obtained from family" without elaboration is insufficient.*
- ***DG:*** *The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.*
- ***DG:*** *The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

CPT 2021 ***specifies that 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.***

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- ***DG:*** *Co-morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*
- ***DG:*** *If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (eg, laparoscopy) should be documented.*

Independent historian(s): An individual (eg, parent, guardian, surrogate, witness) who provides a history in addition to a history provided by a patient who is unable to provide a complete or reliable history (eg, due to developmental stage, loss of consciousness) 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 1 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. This does not apply when the same physician or QHP is reporting or has previously reported interpretation and report for the service. Both the order for and the independent interpretation of the test may be counted toward the level of data reviewed and analyzed.

An interpretation should be documented but need not conform to the usual standards of a complete report for the test (ie, notation of pertinent findings from review of an image or tracing is sufficient rather than the typical documentation completed by the radiologist or cardiologist providing an interpretation and report).

Medical decision-making: Work of establishing diagnoses, assessing the status of a condition, and/or selecting a management option. Medical decision-making in the office and other outpatient services code set is defined by the following 3 elements:

1. The number and complexity of problem(s) that are addressed during the encounter
2. The amount and/or complexity of data to be reviewed and analyzed
3. The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), and treatment(s)

Four types of MDM are recognized: straightforward, low, moderate, and high.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Problem: A disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Risk: The probability and/or consequences of an event. For the purposes of MDM, level of 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.

- Definitions of risk are based on the usual behavior and thought processes of a physician or QHP in the same specialty.
- Trained clinicians apply common meanings to terms such as *high, medium, low,* or *minimal* risk and do not require quantification for these definitions (quantification may be provided when evidence-based medicine has established probabilities).
- The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
- 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 about hospitalization includes consideration of alternative levels of care.

Shared MDM: Eliciting patient and/or family preferences and patient and/or family education and explaining risks and benefits of management options.

Shared or split visit: A visit in which a physician and QHP jointly provide the face-to-face and non–face-to-face work related to the visit.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Test: Imaging, laboratory, psychometric, or physiological data. A clinical laboratory is a single test panel (eg, basic metabolic panel [**80047**]). The differentiation between single or multiple unique tests is defined in accordance with the *CPT* code assignment. The performance and/or interpretation of diagnostic tests or studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Additionally, it is inappropriate to not report a code for a test to increase the level of MDM of a visit.

Time Guidelines and Application

Time may be used to select a code level in office E/M services *whether or not* counseling and/or coordination of care dominates the service.

- **The total time should be documented in the medical record when it is used as the basis for code selection. No specific verbiage is required by *CPT.***
- Time is the physician's and/or QHP's total time on the date of service.

Table 7-4. Defining Data Required by Level of Medical Decision-making

Limited *(Must meet the requirements of 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[a] • Review of the result(s) of each unique test[a] • Ordering of each unique test[a]
	Category 2: Assessment requiring an independent historian(s)
Moderate *(Must meet the requirements of 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[a] • Review of the result(s) of each unique test[a] • Ordering of each unique test[a] • Assessment requiring an independent historian(s)
	Category 2: Independent interpretation of tests performed by another physician/other qualified health care professional (not separately reported)
	Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
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[a] • Review of the result(s) of each unique test[a] • Ordering of each unique testa • Assessment requiring an independent historian(s)
	Category 2: Independent interpretation of tests performed by another physician/other qualified health care professional (not separately reported)
	Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

[a] Each unique test, order, or document is counted. However, only tests not performed and/or interpreted during the encounter and separately reported by the physician or other qualified health care professional are counted in determining the level of data to be reviewed and analyzed.

➤ **A 6-year-old patient presents for follow-up after treatment of otitis media that has occurred 3 times after removal of ear tubes 9 months ago.** Although the patient can provide some history, due to her developmental status, her parents provide details such as frequency, timing, and modifying factors related to the patient's history of otitis media, allergies, and a new complaint of frequent chest pain after meals. No external notes are reviewed, and no tests are ordered or reviewed.

Level of data reviewed and analyzed ➡ Low

Teaching Point: Data are low based on assessment requiring an independent historian.

➤ **A 6-year-old new patient presents with fever, cough, and vomiting for 2 days.** Parents provide past history of preterm birth, congenital heart defect (repaired), and failure to thrive in addition to history of the present illness. A chest radiograph and influenza test are ordered. The pediatrician contacts the child's former pediatrician and discusses the child's history before determining a diagnosis and plan of care.

Level of data reviewed and analyzed ➡ Extensive

Teaching Point: This is based on orders for 2 unique tests, assessment requiring an independent historian, and discussion of management with an external physician. If the 2 tests ordered are performed and/or interpreted by the pediatrician and separately reported, these would not be counted toward the level of data reviewed, reducing the level from extensive to moderate.

➤ **A 6-year-old new patient presents with fever, cough, and vomiting for 2 days.** Parents provide past history of preterm birth, congenital heart defect (repaired), and failure to thrive in addition to history of the present illness. A chest radiograph and influenza test are ordered. The physician accesses, views, and documents an impression of the chest radiographic image(s), but a radiologist has or will interpret and produce a formal report of findings from the image(s).

Level of data reviewed and analyzed ➡ Extensive

Teaching Point: This is based on 2 unique tests ordered, assessment requiring an independent historian, and independent interpretation of a test by a physician not reporting a code for the test. If the code for the influenza test is reported by the physician, this would not count toward the level of data reviewed and analyzed, reducing the level from extensive to moderate.

Risk of Complications and/or Morbidity or Mortality of Patient Management

For the purposes of MDM, the level of 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. Risk levels are minimal, low, moderate, and high. **Table 7-5** provides examples of each level of risk.

Table 7-5. Examples of Levels of Risk[a]

Minimal	Rest and drink plenty of fluids. Diaper ointment. Superficial wound dressing.
Low	Over-the-counter medication(s) Removal of sutures Physical, language, or occupational therapy
Moderate	Prescription drug management Decision about minor surgery with identified patient or procedure risk factors Decision about elective major surgery without identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health
High	Drug therapy requiring intensive monitoring for toxicity Decision about hospitalization Decision about emergency major surgery Decision not to resuscitate or to de-escalate care because of poor prognosis

[a] Examples are subject to clinical judgment for each individual patient and encounter.

Examples

➤ **A patient presents for follow-up after treatment of otitis media.** The patient appears well, and parents have no complaints. Tympanic membrane is white with evidence of mild effusion. The physician explains that effusion is expected to resolve without further treatment. The patient is to return as needed or at next scheduled preventive visit.

Risk ➡ Minimal to none

➤ **A 16-year-old boy presents with a fishhook in his finger.** After examination, a pediatrician clips the barb and removes the hook, cleans and bandages the wound, and orders a diphtheria and tetanus immunization. The patient is instructed to keep the wound clean and apply over-the-counter antibiotic ointment until healed.

Risk ➡ Low

➤ **A pediatric otolaryngologist sees a 6-year-old patient who presents for follow-up after treatment of otitis media that has occurred 3 times after removal of ear tubes 9 months ago.** Repeat bilateral myringotomy with tube insertion under general anesthesia is recommended, and parents agree to proceed with the procedure.

Risk ➡ Moderate

Teaching Point: Decision for major surgery equals moderate risk level.

Table 7-6. Code Selection Requirements for Office Evaluation and Management Service Levels 2 Through 5

Level/Codes/ Total Time (min)[a]	Medical Decision-making (2 of 3 required: data,[b] problems, risk)		
	Problems Addressed	**Data Reviewed and Analyzed[c]**	**Risk**
Straightforward *New patient* **99202** (15–29) *Established patient* **99212** (10–19)	1 self-limited or minor	Minimal or none	Minimal *Examples* • Rest and drink plenty of fluids. • Diaper ointment. • Superficial wound care.
Low *New patient* **99203** (30–44) *Established patient* **99213** (20–29)	Low—*Any 1 of* ≥2 self-limited or minor 1 stable chronic illness 1 acute, uncomplicated illness or injury	Limited (*Meet 1 of 2 categories*) Category 1: Tests and documents (*Any 2*) • Review of prior external note(s)—each unique source • Review of the result(s) of each unique test • Ordering of each unique test Category 2: Assessment requiring an independent historian(s)	Low *Examples* • Over-the-counter medication(s) • Removal of sutures • Physical, language, or occupational therapy
Moderate *New patient* **99204** (45–59) *Established patient* **99214** (30–39)	*Moderate—Any 1 of* ≥1 chronic illnesses with exacerbation, progression, or side effects of treatment ≥2 stable chronic illnesses 1 undiagnosed new problem with uncertain prognosis 1 acute illness with systemic symptoms 1 acute complicated injury	Moderate (*Meet 1 out of 3 categories*) Category 1 (*Meet any 3*) • Review of prior external note(s)—each unique source • Review of the result(s) of each unique test • Ordering each unique test • Assessment requiring an independent historian(s) Category 2: Independent interpretation of a test performed by another physician/ other QHP[c] Category 3: Discussion of management or test interpretation with external physician/ other QHP/appropriate source	Moderate *Examples* • Prescription drug management • Decision about minor surgery with identified patient or procedure risk factors • Decision about elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High *New patient* **99205** (**60–74**) *Established patient* **99215** (40–54)	High—*1 of* ≥1 chronic illnesses with severe exacerbation, progression, or side effects of treatment 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (*Meet 2 out of 3 categories*) Category 1: (*Meet any 3*) • 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) Category 2: Independent interpretation of a test performed by another physician/ other QHP Category 3: Discussion of management or test interpretation with external physician/ other QHP/appropriate source[c]	High • Drug therapy requiring intensive monitoring for toxicity • Decision about elective major surgery with identified patient or procedure risk factors • Decision about emergency major surgery • Decision about hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Abbreviation: QHP, qualified health care professional.

[a] Does not include time of clinical staff. Include only time spent by the physician or QHP directed to the individual patient's care on the date of the encounter.

[b] Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1. However, tests performed and/or interpreted during the encounter by the physician or QHP are not counted toward the amount and/or complexity of data to be reviewed and analyzed.

[c] Do not count data review or communications reported with other codes (eg, test interpretation, interprofessional consultation).

Continuum Model for Attention-Deficit/Hyperactivity Disorder (*continued*)

CPT Code With Total Physician Time and Vignette	MDM (2 of 3 elements required)		
	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99215 (Time: 40–54 min) Initial evaluation of patient with ADHD and new onset of suicidal ideation. Patient and mother refuse hospitalization due to cost. *Tip:* Add **99417** if time on the date of service is ≥55 minutes. Add **99058** if service(s) are provided on an emergency basis in the office, which disrupts other scheduled office services.	**High:** 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Moderate:** Assessment requiring an independent historian; discussion with behavioral health specialist; psychiatric testing	**High:** Decision regarding hospitalization

Abbreviations: ADHD, attention-deficit hyperactivity disorder; CC, chief complaint; *CPT*, *Current Procedural Terminology*; MDM, medical decision-making.

Continuum Model for Otitis Media

*Code selection at any level above **99211** may be based on the complexity of MDM or the total time spent by the physician or other qualified health care professional on the date of the encounter. (Code **99211** is not included due to lack of indication for follow-up by clinical staff.)*

CPT Code With Total Physician Time and Vignette	MDM (2 of 3 elements required)		
	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99212 (Time: 10–19 min) Follow-up otitis media, uncomplicated	**Minimal:** Follow-up otitis media, evaluation of effusion and hearing	**Limited:** Assessment requiring an independent historian	**Minimal:** Risk associated with diagnostic testing and treatment
99213 (Time: 20–29 min) 2-year-old presents with tugging at her right ear. Afebrile. Mild otitis media.	**Low:** 1 acute, uncomplicated illness or injury	**Limited:** Assessment requiring an independent historian	**Moderate:** Prescription drug management, delayed prescribing
99214 (Time: 30–39 min) Infant presents with fever and cough and suspected third episode of otitis media within 3 months.	**Moderate:** 1 acute illness with systemic symptoms	**Limited:** Assessment requiring an independent historian	**Moderate:** Prescription drug management
99215 (Time: 40–54 min) 6-month-old presents with high fever, vomiting, and irritability. After tests, antipyretics, and fluid, infant is stable.	**High:** 1 acute illness that poses a threat to life or bodily function	**Limited:** Assessment requiring an independent historian or **Moderate:** If 2 or more tests are ordered from an external source and assessment requiring an independent historian	**High:** Decision about hospitalization (Hospitalization discussed with parents and decision made for care at home with strict instructions and close follow-up.)

Abbreviations: *CPT*, *Current Procedural Terminology*; MDM, medical decision-making.

Selecting the Appropriate Evaluation and Management Codes

This chapter includes information on coding for evaluation and management (E/M) services provided in nonhospital settings (other than office E/M services [**99202–99205**, **99211–99215**]). Included here are codes for reporting

- Office and outpatient consultations (**99241–99245**)
- Home care services (**99341–99350**)
- Domiciliary, rest home, or custodial care services (**99324–99337**)
- Nursing facility care (**99304–99310**, **99315**, **99316**, **99318**)
- Out-of-office service add-on codes (**99056–99060**)
- Telephone services (**99441–99443**, **98966–98968**)
- Prolonged services (**99354–99359**)
- Critical care (**99291**, **99292**)

See Chapter 7 for information on office and other outpatient evaluation and management services (99202–99205, 99211–99215).

Note: All E/M code descriptors and their specific instructions reflect the exclusion of references to provider/professional type, when nonessential, throughout the code set. When the word "physician" is included in a code descriptor, a qualified health care professional (QHP) working within his or her scope of practice may also provide the service.

When codes are provided for new and established patient E/M services, a new patient is one who has not received any *face-to-face* professional services within the past 3 years from the physician or another physician of the same specialty who belongs to the same group practice.

Time may be used as the key controlling factor in the selection of the code, in lieu of key components, when appropriate. To report based on time for E/M services provided in the sites of service discussed in this chapter, counseling and/or coordination of care must account for more than 50% of the face-to-face time with the patient.

- Billing based on time requires documentation of the total face-to-face time (may be approximate) and the percentage or number of minutes spent in counseling and/or coordination of care.
- *Current Procedural Terminology* (*CPT*®) instructs that time is met when the midpoint is passed unless code descriptors or prefatory instructions indicate otherwise. Other payers may require that the typical time specified for a service be met or exceeded.

In 2021, *CPT* prohibits physicians and other QHPs from counting tests performed and/or interpreted during the encounter and separately reported in the determination of the level of medical decision-making (MDM). This applies to tests such as point-of-care laboratory tests.

See also Chapter 6 for a detailed description of evaluation and management guidelines, documentation requirements, and tips. See Chapter 12 for guidelines for reporting chronic care management and other non–face-to-face services provided to manage complex and/or chronic conditions.

Table 8-1 provides the key components and specific details on required elements within each level of history and physical examination (eg, problem focused, expanded) and MDM (eg, straightforward, moderate) for most E/M codes. Refer to this table for more information on key components when using some of the other tables in this chapter to assign codes to examples. These tables can be downloaded at www.aap.org/cfp (access code AAPCFP26).

The examples included throughout this chapter are based on the 1995 E/M documentation guidelines. Each section includes a table illustrating key components of each type of service. Medical decision-making is listed before history and physical examination because some payers place greater emphasis on MDM than history and examination. Some payers require that the level of MDM be 1 of the 2 key components met to support the level of service for an established patient encounter.

Medical necessity for the extent of history, examination, and MDM should be evident in the documentation for each encounter. Consider only clinically indicated services when selecting the level of E/M service.

Assessment/plan: Abnormal newborn screening; possible cystic fibrosis. A report is transmitted to the primary care pediatrician outlining the plan for sweat testing and, if indicated, follow-up appointments to assume management of cystic fibrosis.

MDM: High complexity (new problem with additional workup; old record reviewed/summarized, laboratory tests reviewed, and medical test ordered but not performed during the encounter) *History:* Comprehensive *Physical examination:* Detailed	***International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*)** **P09** (abnormal findings on neonatal screening) ***CPT*** **99243** or, if payer does not recognize consultations, **New Patient Office E/M** **99204** (moderate MDM—moderate number and complexity of problems and moderate amount and complexity of data reviewed and analyzed)

Teaching Point: The detailed examination limits the consultation code to **99243** because a comprehensive examination is required for **99244**. However, if a payer requires reporting an office or other outpatient E/M service in lieu of an outpatient consultation, code **99204** is supported based on a moderate level of MDM because an undiagnosed new problem with uncertain prognosis was addressed and a moderate amount and complexity of data was analyzed (ie, review of external notes and laboratory tests and order of a sweat test not performed during the encounter).

Because the code selection guidelines for office E/M services differ from those for consultations, the level of MDM supported for the consultation is high, but the level of MDM for the office visit is moderate. Medical decision-making alone is used in support of **99204**.

➤ **A 13-year-old boy who has obesity and Down syndrome (new patient) is referred to a cardiologist for evaluation of a murmur.** Past medical records and laboratory test results are reviewed and summarized by the cardiologist prior to the visit. A comprehensive history and physical examination are performed. Electrocardiogram (ECG) and echocardiogram are performed and interpreted.

Assessment/plan: Down syndrome. Patient with mitral valve prolapse with minimal regurgitation—will evaluate again in 6 months and start medication, if indicated. Obesity—dietary changes and increased exercise were recommended. A written report is sent back to the referring physician. Total face-to-face time of the consultation service was 30 minutes. Total physician time on the date of service was 60 minutes, not including time spent in interpretation and report of tests.

MDM: Moderate complexity (1 new problem with no additional workup and 1 stable chronic condition; review of laboratory test results and review and summarization of medical records) *History:* Comprehensive *Physical examination:* Comprehensive	***ICD-10-CM*** **I34.1** (nonrheumatic mitral [valve] prolapse) **E66.9** (obesity, unspecified) **Q90.9** (Down syndrome) ***CPT*** **99244** or, if payer does not recognize consultations, **New Patient** **99205** (60–74 minutes total time)

Teaching Point: The cardiologist evaluated the patient's murmur and addressed obesity. A cardiologist billing for interpretation and report of an ECG and/or echocardiogram will not count the test toward the data analyzed in determining the level of MDM. Where a payer requires an office E/M code in lieu of a consultation code, code **99205** is supported by the cardiologist's total time (60 minutes) on the date of the encounter. If time were used in selection of a consultation code, code **99242** would be reported for 30 minutes of face-to-face time.

➤ **A pediatrician is consulted for a 14-year-old boy who lives in a group home.** The boy has become withdrawn and disinterested in activities that he previously enjoyed. The social worker for the group home is concerned that he may need medical management of depression.

ICD-10-CM	CPT
R55 (syncope and collapse) **Z82.41** (family history of sudden cardiac death)	**99244** *MDM:* Moderate *History:* Comprehensive *Physical examination:* Comprehensive Or, if payer does not recognize consultations, office or other outpatient E/M service with moderate-complexity MDM **99204** (new patient) **99214** (established patient)

Teaching Point: If the payer does not allow payment for consultation codes, the appropriate office or other outpatient E/M code is reported. Level 4 (**99204**, **99214**) codes are supported based on the moderate complexity of MDM (supported by evaluation of an undiagnosed new problem with uncertain prognosis and a moderate amount and complexity of data to review and analyze). See **Chapter 7** for more information on office and other outpatient E/M code selection. The level of office or other outpatient E/M service may be affected if the cardiologist will perform and/or interpret the electrocardiogram and/or echocardiogram and will separately report the services. When a physician performs and/or interprets a test during an encounter and reports the service, the test is not counted toward the level of MDM for the encounter.

Inpatient Consultations

99251–99255 Inpatient consultation for a new or established patient

- Codes **99251–99255** are to be used only once by the reporting physician for an individual hospital patient for a particular admission. There are no specific guidelines for the length of stay.
- Follow-up visits provided in the hospital by the same physician must be reported using subsequent care codes (**99231–99233**). Examples of a follow-up visit might be to complete the initial consultation when test results become available or in response to a change in the patient's status.
- If a second consultation by a physician or physicians of the same specialty and same group practice is requested by the attending physician to address a completely different problem during the same hospital stay, subsequent hospital care codes (**99231–99233**) must be reported. The subsequent role of a consultant in the ongoing care of the patient must be clearly stated in the medical record by the attending physician. If the attending physician turns over the care of the patient to the consultant, the consultant, now the new attending physician, should use subsequent hospital care codes (**99231–99233**) to indicate the level of service provided.
- The attending physician and consultant may continue to provide care to the patient. Each would code for subsequent hospital care as long as the problems they manage are different. (The attending and consulting physicians should use different *diagnosis* codes to indicate they are managing different problems.) When 2 physicians provide care for the same diagnosis on 1 date, the medical necessity for each service must be clearly documented.
- If a patient is readmitted for the same or a different problem (ie, a new hospital stay), an initial inpatient consultation code may be reported if it meets the definition and requirements for reporting a consultation.
- When an inpatient consultation is performed on a date a patient is admitted to the hospital, all E/M services provided by the consultant (including any outpatient encounters) related to the admission are reported with the inpatient consultation service code. If a patient is admitted after an outpatient consultation (eg, office, ED) and the patient is not seen on the unit on the date of admission, only the outpatient consultation code is reported.

Use **Table 16-7** to help you in the selection of the appropriate codes in the following examples:

Examples

➤ **A 3-month-old patient is seen by the pediatrician in the ED and is subsequently admitted for bilious vomiting, dehydration, and possible bowel obstruction.** A pediatric surgeon is consulted and, following workup, diagnoses volvulus due to malrotation of the intestine. He documents his written report in the medical record, speaks to the parents, and arranges for immediate surgery. The surgeon reports his consultation service with

ICD-10-CM	CPT
K56.2 (volvulus) Or, if diagnosed as congenital volvulus, **Q43.3** (congenital malformations of intestinal fixation)	**99255 57** Or, if payer does not recognize consultations, **99223 57** (initial hospital visit) *MDM:* High complexity *History:* Comprehensive *Physical examination:* Comprehensive

- Selection of the appropriate E/M code is primarily driven by the risk involved in the presenting problem, evaluation measures, and/or treatment options.
- Performance and documentation of all 3 key components (ie, history, physical examination, and MDM) are used to select the level of an ED E/M code. In determining the level of MDM for an ED encounter, any tests or studies performed and/or interpreted during the encounter and separately reported by the ED physician are not counted toward the amount and/or complexity of data reviewed.

Emergency Department Caveat: Code 99285

The emergency department evaluation and management code 99285 allows an exception to the "3 key components" rule (Level 5 caveat) for patients whose clinical condition, mental status, or lack of available history may not permit obtaining a comprehensive history and/or physical examination. Therefore, code 99285 may be reported for patients presenting with a high-severity condition that requires a high level of medical decision-making when circumstances prevent the physician from obtaining a comprehensive history and/or completing a comprehensive physical examination. When such urgency exists, the physician must document the condition or reason why a comprehensive history and/or comprehensive physical examination could not be obtained.

- Time spent in counseling and/or coordination of care *cannot* be used as a key or controlling factor in the selection of the E/M code; nor can prolonged services be reported with ED codes. Because of the unpredictability and inconsistency in the intensity of these services, there are presently no time values assigned to this family of codes.
- There is no differentiation between new or established patients for ED encounters. All problems for encounters in the ED are considered new to the attending physician for purposes of determining MDM.
- The ED codes are not reported if the treating ED physician admits the patient to his or her service for observation or inpatient status on the same date of service as the ED encounter. Only the appropriate initial observation (**99218–99220**), initial hospital care (**99221–99223**), or initial observation or inpatient hospital admission and discharge, same day (**99234–99236**), codes are reported instead of ED codes. All the E/M work performed in the ED should be combined with any additional work performed for admission (and, when appropriate, discharge) when selecting the correct code and level of care.

Table 17-2 summarizes the key components required for each ED E/M code based on the 1995 and 1997 Centers for Medicare & Medicaid Services *Documentation Guidelines for Evaluation and Management Services.* Also refer to **Chapter 6**, Evaluation and Management Documentation Guidelines, for more details on E/M coding guidelines. Medical necessity is an overarching criterion for selecting the level of E/M service. Physicians should always consider whether the nature of the presenting problem supports the medical necessity of services rendered when selecting the level of E/M service.

Use **Table 17-2** to help you in the selection of the appropriate level of ED E/M service in the examples for each level of service that follow.

For more information on coding evaluation and management services in the emergency department, see "Evaluation and Management Coding in the Emergency Department" in the May 2018 *AAP Pediatric Coding Newsletter*™ (https://coding.solutions.aap.org/article.aspx?articleid=2679117; subscription required).

Examples

➤ **A 9-month-old presents with a rash.** History of present illness (HPI): Rash noted by mother this evening after arriving home from a trip to visit relatives. All systems are reviewed and results are normal other than rash. Immunizations are up to date. Current temperature is 36.4°C (97.5°F). The infant appears well with vesicles characteristic of heat rash on neck, back, and inner thighs. Examination of head, eyes, ears, nose, oropharynx, cardiovascular, and respiratory systems are normal. The diagnosis of miliaria rubra is discussed with parents, who are instructed to follow up with the primary care pediatrician if they have any concerns.

These codes are intended to describe services that are provided outside the normal time frame and location.

Code **99053** would be reported when services are provided between the designated time limits in an ED.

CPT does not restrict reporting of any procedure or service to any specific specialty. However, it would be inappropriate for an ED physician to report code **99056** or **99060** for services provided in the ED.

If appropriate, a non-ED physician could report *CPT* code **99056** or **99060** when he or she provides services in the ED in addition to an outpatient office or clinic visit, ED visit, or consultation E/M code.

Continuum Models for Asthma, Head Injury, and Laceration

The continuum model is a teaching tool that gives examples of how common conditions in the ED might be reported based on the severity and/or complexity of the presenting problem(s).

Following are 3 common conditions—asthma, head injury, and laceration—described across the continuum of codes **99281–99285** plus critical care. Although the actual assignment of a code for an individual patient may vary from the examples, members of the American Academy of Pediatrics Committee on Coding and Nomenclature generally agree that these examples provide an accurate representation of how 1 condition typically flows across the family of codes.

It is important to remember that all 3 key components (ie, history, examination, and MDM) must be met to support the code selected. Past, family, and social history elements are required only for codes **99284** (1 of 3) and **99285** (2 of 3).

Continuum Model for Asthma

CPT Code Vignette	History	Physical Examination (systems)	Medical Decision-making (1. diagnoses; 2. data; 3. risk)[a]
99281 Stable asthma, out of medication	***Problem focused*** CC: asthma medication concern HPI: duration of medication use, no side effects ROS: constitutional, respiratory	***Problem focused*** Constitutional (vitals, general appearance) and respiratory systems (effort and auscultation)	***Straightforward*** 1. Established problem, stable 2. Asthma control test reviewed 3. Anticipatory guidance with routine follow-up
99282 Stable asthma, out of medication and noncustodial parent concerned about continuous use of control medication	***Expanded problem focused*** CC: out of asthma medication HPI: stable but out of medication, no use of rescue inhaler ROS: normal ENMT, infrequent nighttime cough, all others reviewed and normal PFSH: current medications reviewed, no hospitalizations	***Expanded problem focused*** Constitutional (height, weight, temperature), respiratory system (effort and auscultation), eyes, and ENMT (nasal and oral mucosa)	***Low complexity*** 1. Established problem, stable 2. Review and evaluation of asthma control test 3. Alteration in medication regimen and/or refills
99283 Known asthma with URI symptoms	***Expanded problem focused*** CC: asthma with stuffy nose and sinus pressure HPI: stuffy nose for 2 days, sinus pressure today, dry cough this afternoon relieved by inhalation treatment ROS: no fever; denies postnasal drip, shortness of breath, and wheezing; no body aches PFSH: current medications and allergies updated, asthma diagnosed in 2016, to ED twice last year for asthma symptoms	***Expanded problem focused*** Constitutional (temperature, weight, height, pulse oxygen), eyes, ENMT, respiratory (effort and auscultation), and other pertinent organ systems	***Moderate complexity*** 1. Self-limited problem and 1 established problem with mild exacerbation or new problem with no additional workup 2. Asthma control test, pulse oxygen 3. ≥1 chronic illnesses with mild exacerbation, progression *or* side effects of treatment and/or prescription drug management

Continuum Model for Asthma (*continued*)			
***CPT* Code Vignette**	**History**	**Physical Examination (systems)**	**Medical Decision-making (1. diagnoses; 2. data; 3. risk)[a]**
99284 Known asthma with moderate exacerbation	***Detailed*** CC: shortness of breath, wheezing HPI: timing of symptom onset, context (exposure to flowers), modifying factors (used rescue inhaler and inhalation treatment at home), severity (worse than prior episodes) ROS: feels tired and scared, no fever, denies dizziness or fainting, no ear or throat pain, chest feels tight, no GI or GU complaints PFSH: medications and allergies updated	***Detailed*** Constitutional (temperature, blood pressure, pulse oxygen, general appearance), ENMT, neck, respiratory, cardiovascular, and skin	***Moderate complexity*** 1. New problem to examiner with or without additional workup planned 2. Pulmonary function testing, chest radiograph 3. Continuous or back-to-back inhalation treatments until improved
99285 Known asthma with moderate to severe exacerbation and hypoxia	***Comprehensive*** CC: unable to catch breath HPI: duration and severity of symptoms, medications used, other signs and symptoms ROS: constitutional, eyes, ENMT, respiratory, cardiovascular, and at least 5 more (all others reviewed and negative) PFSH: medications and allergies updated, no tobacco use or exposure	***Comprehensive*** Constitutional, eyes, ENMT, respiratory, cardiovascular, GI, neurologic, skin	***High complexity*** 1. New problem, additional workup planned (Transfer to hospitalist for observation care.) 2. Blood gases, pulse oxygen, pulmonary function testing, chest radiograph 3. Severe exacerbation of chronic condition
99291, **99292** **Critical Care** Known asthma unstable with marked distress and (impending) respiratory failure			***High complexity*** 1. Severe exacerbation with high probability of imminent or life-threatening deterioration requires >30 min of directed patient care. 2. Assess, manipulate, and support vital system function(s) to treat respiratory failure and/or to prevent further life-threatening deterioration of the patient's condition. (Usually requires use of additional therapies such as ketamine, magnesium sulfate, parenteral adrenergic agents, and/or heliox; ET intubation; or BiPAP.)

Abbreviations: BiPAP, bi-level positive airway pressure; CC, chief complaint; *CPT, Current Procedural Terminology;* ED, emergency department; ENMT, ear, nose, mouth, throat; ET, endotracheal; GI, gastrointestinal; GU, genitourinary; HPI, history of present illness; PFSH, past, family, and social history; ROS, review of systems; URI, upper respiratory infection.

[a] Any tests performed and/or interpreted during the encounter and reported by the ED physician will not be counted toward the amount and/or complexity of data reviewed.

Continuum Model for Head Injury

CPT Code Vignette	History	Physical Examination (systems)	Medical Decision-making (1. diagnoses; 2. data; 3. risk)[a]
99281 Repaired scalp laceration, well healed, presents for suture removal	***Problem focused*** CC: suture removal HPI: wound repair 10 days ago, no complaints	***Problem focused*** Limited skin	***Straightforward*** 1. Established problem, improved 2. No tests ordered/reviewed 3. Suture removal
99282 Minor head trauma without local bruising, swelling, or laceration, no neurologic changes	***Expanded problem focused*** CC: bumped head HPI: context (injury mechanism), timing	***Expanded problem focused*** Examination of skin and neurologic system	***Low complexity*** 1. New problem, no additional workup 2. No tests ordered/reviewed 3. Acute uncomplicated injury
99283 Minor head trauma with local bruising, swelling, or laceration, no neurologic changes; GCS 15	***Expanded problem focused*** CC: hit in head HPI: injury mechanism, timing, associated signs and symptoms ROS: neurologic, musculoskeletal	***Expanded problem focused*** Eyes, ENMT, skin, and neurologic system	***Moderate complexity*** 1. New problem, no additional workup 2. No tests ordered/reviewed 3. Acute complicated injury
99284 Head trauma with signs of concussion	***Detailed*** CC: head injury with LOC HPI: mechanism of injury, associated signs and symptoms (pain, loss of recall), duration of LOC (<5 min), severity (no focal neurologic changes; GCS ≥13) PFSH: medications, allergies, past illnesses/injuries	***Detailed*** Eyes, ENMT, neck, respiratory, cardiovascular, skin, neurologic, and other pertinent systems	***Moderate complexity*** 1. New problem, no additional workup planned. 2. Radiology and laboratory tests may be obtained. Neurology or neurosurgical consultation may be obtained. 3. Acute complicated injury.
99285 Head trauma with signs of concussion including LOC (<5 min), brief seizure, and/or persistent emesis; closed skull fracture and/or focal neurologic changes may be present; GCS 9–12	***Comprehensive*** CC: head trauma with LOC HPI: mechanism of injury, associated signs and symptoms (pain, emesis), duration of LOC (<5 min), severity (GCS 9–12) ROS: ≥10 systems PFSH: medications, allergies, past illnesses/injuries, family or social history (eg, bleeding disorders, use of drugs or alcohol)	***Comprehensive*** Constitutional, eyes, ENMT, respiratory, cardiovascular, gastrointestinal, neurologic, skin	***High complexity*** 1. New problem, no additional workup planned. 2. History obtained from someone other than patient. Radiology and laboratory tests may be obtained/reviewed. Neurology or neurosurgical consultation may be obtained. 3. Acute injuries that may pose a threat to life or bodily function.
99291, 99292 **Critical Care** Head trauma with persistent LOC and/or seizures; open or closed skull fracture and/or focal neurologic changes may be present; GCS ≤8			***High complexity*** 1. Critically ill, unstable patient; requires >30 min of directed patient care. 2. Physician assesses, manipulates, and supports vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Abbreviations: CC, chief complaint; *CPT, Current Procedural Terminology;* ENMT, ear, nose, mouth, throat; GCS, Glasgow Coma Scale; HPI, history of present illness; LOC, loss of consciousness; PFSH, past, family, and social history; ROS, review of systems.

[a] Any tests performed and/or interpreted during the encounter and separately reported by the emergency department physician are not counted toward the amount and/or complexity of data reviewed.

Continuum Model for Laceration

These codes reflect E/M services only and not any procedure the same physician may provide. The physician needs to be aware that the pre-procedural and intra-procedural global periods may include some of the medical decision-making indicated with each code, thus reducing the level of E/M service provided, and that any E/M service reported with a procedure must meet the requirement for a significant, separately identifiable service.

CPT Code Vignette	History	Physical Examination (systems)	Medical Decision-making (1. diagnoses; 2. data; 3. risk)[a]
99281 Repaired scalp laceration, well healed, presents for suture removal	***Problem focused*** CC: suture removal HPI: wound repair 10 days ago, no complaints	***Problem focused*** Limited skin	***Straightforward*** 1. Established problem, stable 2. No tests ordered/reviewed 3. Minimal risk—suture removal
99282 Uncomplicated laceration of single body area or organ system	***Expanded problem focused*** CC: laceration HPI: location, context (mechanism of injury), timing ROS: skin or musculoskeletal	***Expanded problem focused*** Skin and/or musculoskeletal, neurologic systems	***Low complexity*** 1. New problem, laceration 2. No tests ordered/reviewed 3. Acute uncomplicated injury
99283 Uncomplicated laceration of single body area or organ system with minor associated injury (eg, minor head injury) *or* Uncomplicated lacerations of >1 body area or organ system *or* Minimally complicated laceration (eg, small foreign body, delay in seeking care) of single body area or organ system	***Expanded problem focused*** CC: laceration(s) HPI: location, context (mechanism of injury), timing ROS: skin or musculoskeletal	***Expanded problem focused*** Constitutional, skin and/or musculoskeletal, neurologic systems	***Moderate complexity*** 1. New problem(s). 2. Radiograph of affected area may be ordered/viewed. 3. Acute complicated injury.
99284 Uncomplicated laceration of single body area or organ system with other associated injury (eg, mild concussion) *or* Minimally complicated lacerations (eg, small foreign body) of >1 body area or organ system *or* Complicated laceration (eg, infection, GSW, deep knife wound) of single body area or organ system without immediate threat to life or limb	***Detailed*** CC: injuries HPI: location, context (mechanism of injury), timing, associated signs and symptoms ROS: constitutional, skin, musculoskeletal, neurologic PFSH: medications and allergies	***Detailed*** Eyes, neck, respiratory, cardiovascular, skin, musculoskeletal, neurologic	***Moderate complexity*** 1. New problem. 2. Radiograph of affected area may be ordered/viewed. 3. Acute complicated injury.
99285 Uncomplicated laceration of ≥1 body area or organ system with significant associated injury (eg, multiple trauma) *or* Complicated laceration (eg, GSW, deep knife wound) of >1 body area or organ system without immediate threat to life or limb	***Comprehensive*** CC: injuries HPI: location, context (mechanism of injury), timing, associated signs and symptoms ROS: ≥10 systems PFSH: medications, allergies, and pertinent family history of tobacco, alcohol, or substance use	***Comprehensive*** Constitutional, eyes, ENMT, respiratory, cardiovascular, musculoskeletal, neurologic, skin	***High complexity*** 1. New problem 2. Tests ordered/reviewed (radiology and/or laboratory) 3. Acute injury that may pose a threat to life or bodily function or emergency major surgery

Continuum Model for Laceration (*continued*)			
***CPT* Code Vignette**	**History**	**Physical Examination (systems)**	**Medical Decision-making (1. diagnoses; 2. data; 3. risk)[a]**
99291, 99292 **Critical Care** Uncomplicated or complicated laceration of ≥1 body area or organ system with significant associated injury (eg, multiple trauma) with immediate threat to life or limb			**High complexity** 1. Critically ill, unstable patient; requires >30 min of directed patient care. 2. Physician assesses, manipulates, and supports vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Abbreviations: CC, chief complaint; *CPT, Current Procedural Terminology;* E/M, evaluation and management; ENMT, ear, nose, mouth, throat; GSW, gunshot wound; HPI, history of present illness; PFSH, past, family, and social history; ROS, review of systems.

[a] Any tests performed and/or interpreted during the encounter and separately reported by the emergency department physician are not counted toward the amount and/or complexity of data reviewed.

Resources

Evaluation and Management

"Evaluation and Management Coding in the Emergency Department," May 2018 *AAP Pediatric Coding Newsletter* (https://coding.solutions.aap.org/article.aspx?articleid=2679117; subscription required)

Repair of Integumentary Lacerations

"You Code It! Integumentary Repair," April 2020 *AAP Pediatric Coding Newsletter* (https://coding.solutions.aap.org/article.aspx?articleid=2763375; subscription required)