New
2023 Changes
2021
Revisions

Pediatric Evaluation and Management Coding Revisions

Facility and Office Services

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

Pediatric Evaluation and Management Coding Revisions

Facility and Office Services

American Academy of Pediatrics
Linda D. Parsi, MD, MBA, CPEDC, FAAP, Editor

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

American Academy of Pediatrics Publishing Staff

Mary Lou White, *Chief Product and Services Officer/SVP, Membership, Marketing, and Publishing*
Mark Grimes, *Vice President, Publishing*
Mary Kelly, *Senior Editor, Professional/Clinical Publishing*
Laura Underhile, *Editor, Professional/Clinical Publishing*
Jason Crase, *Senior Manager, Production and Editorial Services*
Leesa Levin-Doroba, *Production Manager, Practice Management*
Peg Mulcahy, *Manager, Art Direction and Production*
Mary Jo Reynolds, *Marketing Manager, Practice Publications*

Published by the American Academy of Pediatrics
345 Park Blvd
Itasca, IL 60143
Telephone: 630/626-6000
Facsimile: 847/434-8000
www.aap.org

Printed in the United States of America

11-135 1 2 3 4 5 6 7 8 9 10

MA1095
ISBN: 978-1-61002-670-3
eBook: 978-1-61002-671-0

Disclaimer

Every effort has been made to include the new and revised 2023 *Current Procedural Terminology* (*CPT*®) codes, their respective guidelines, and other revisions that might have been made. Because of our publishing deadlines and the publication date of the American Medical Association *CPT*, additional revisions and/or additional codes may have been published subsequent to the date of this printing. It is the responsibility of the reader to use this manual as a companion to the *CPT* publication. Vignettes are provided throughout this publication to illustrate correct coding applications. They are not intended to offer medical advice on the practice of medicine. Further, it is the reader's responsibility to routinely access the American Academy of Pediatrics website (www.aap.org/errata) for any errata in the published version. At the time of this publication, final changes for 2023 codes and Medicare payment policies were pending. See www.aap.org/coding for updates.

Copyright Acknowledgment

Current Procedural Terminology (*CPT*) is a listing of descriptive terms and 5-digit numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. This presentation includes only the *CPT* descriptive terms, numeric identifying codes, and modifiers for reporting medical services and procedures that were selected by the American Academy of Pediatrics (AAP) for inclusion in this publication. The inclusion of a *CPT* service or procedure description and its code number in this publication does not restrict its use to a particular specialty group. Any procedure or service in this publication may be used to report the services provided by any qualified physician or, when appropriate, other qualified health care professional.

The American Medical Association (AMA) and the AAP assume no responsibility for the consequences attributable to or related to any use or interpretation of any information or views contained in or not contained in this publication.

The most current *CPT* is available from the AMA.

No fee schedules, basic unit values, relative value guides, conversion factors or scales, or components thereof are included in *CPT*.

Equity, Diversity, and Inclusion Statement

The American Academy of Pediatrics is committed to principles of equity, diversity, and inclusion in its publishing program. Editorial boards, author selections, and author transitions (publication succession plans) are designed to include diverse voices that reflect society as a whole. Editor and author teams are encouraged to actively seek out diverse authors and reviewers at all stages of the editorial process. Publishing staff are committed to promoting equity, diversity, and inclusion in all aspects of publication writing, review, and production.

Contents

Chapter 3. Emergency Department Services

Chapter 4. Noncritical Hospital Evaluation and Management Services

Appendix

Certificate of Completion

An online quiz is available for you to further enhance your coding knowledge and demonstrate your understanding of the concepts in this book. Upon successful completion of the quiz, you will receive a Certificate of Completion from the American Academy of Pediatrics. To complete the quiz and obtain the certificate, please go to www.aap.org/EMcertificate.

Note: This quiz is not for official credit from any credentialing society.

Updates

Evaluation and management coding continues to evolve. As they become available, updates will be posted at www.aap.org/errata.

Introduction

Pediatric Evaluation and Management Coding Revisions: Facility and Office Services takes an in-depth look at the *Current Procedural Terminology®* office and facility-based evaluation and management code changes. It was developed to help you understand these changes and what their implications are for your practice documentation and code selection.

This publication contains contents curated from American Academy of Pediatrics (AAP) coding publications. The first half of the book contains excerpts from 4 chapters of *Coding for Pediatrics 2023.* These chapters, listed below, contain a detailed overview of the changes, key definitions, coding examples, and much more.

- Evaluation and Management Documentation Guidelines
- Non-preventive Evaluation and Management Services in Outpatient Settings
- Emergency Department Services
- Noncritical Hospital Evaluation and Management Services

The Appendix in the second half of the book contains articles from the *AAP Pediatric Coding Newsletter™*. In April 2022, the newsletter began publishing articles related to these coding revisions. Within these articles, you will find detailed information on the codes and examples to help guide implementation. We recommend reading them in the order in which they appear, as some articles build on the contents of previous articles.

An online quiz is available for you to further enhance your coding knowledge and demonstrate your understanding of the concepts in this book. On successful completion of the quiz, you will receive a Certificate of Completion from the AAP. To complete the quiz and obtain the certificate, please go to www.aap.org/EMcertificate.

The AAP coding experts are ready to assist you with any coding-related questions or concerns.

Linda D. Parsi, MD, MBA, CPEDC, FAAP
Editor in Chief, AAP Coding Publications Editorial Advisory Board

CHAPTER 1

Evaluation and Management Documentation Guidelines

Contents

Chapter Highlights

- Services to which general and specific evaluation and management (E/M) guidelines apply.
- Concepts of new versus established patient and initial versus subsequent encounter.
- *Current Procedural Terminology* (*CPT*®) terms and definitions used in determining a level of E/M service based on a physician's or other qualified health care professional's (QHP's) total time on the date of an encounter (regardless of the percentage spent in counseling and/or coordination of care) or on medical decision-making (MDM).
- Appropriate use of total time for reporting services provided as a teaching physician, when applicable.

This chapter outlines the *CPT* E/M guidelines used in selecting codes for encounters to evaluate and manage a patient's health problems. The content of this chapter provides the basis for learning category-specific instructions for code selection discussed in later chapters.

How Guidelines Have Changed Since 2022

In 2023, the division between guidelines for office and other outpatient evaluation and management (E/M) services and guidelines for other E/M services for which codes are selected on the basis of key components or typical time is unnecessary. The basic format of codes with levels of E/M services based on medical decision-making (MDM) or time is now the same. Revisions to codes throughout the E/M section have resulted in a single set of guidelines that apply to the following services:

- **Office or other outpatient services**
- **Hospital inpatient and observation care services**
- **Consultations**
- **Emergency department services**
- **Nursing facility services**
- **Home or residence services**
- **Prolonged service with or without direct contact on the date of an E/M service**

Additionally, definitions of initial and subsequent services are added to assist with selecting code categories for services to patients in facility settings. Certain other definitions are added or revised to guide in selecting a level of MDM.

The MDM table in *Current Procedural Terminology* previously used only for office and other outpatient E/M services is revised for use for all the services listed above.

General Guidelines

The E/M guidelines in *CPT* are used to guide code selection and are neither documentation guidelines nor standards of care. The E/M guidelines section of *CPT* mostly applies to codes selected on the basis of the physician's or the QHP's total time on the date of an encounter (total time) or on the basis of the level of MDM required for the problems addressed. However, the following portions of the E/M guidelines apply to many E/M services, including those not selected on the basis of total time or MDM:

- Definitions of new versus established patients and initial versus subsequent encounters
- Other services provided on the same date as an E/M service

Additional service-specific guidelines are found preceding categories of E/M service (eg, home and residence E/M services) and subcategories (eg, initial hospital inpatient or observation care services, **99221–99223**) and, in parenthetical instructions, following E/M codes.

Please refer to your *CPT* coding reference for more detailed guidelines for reporting services such as normal newborn care in the hospital, hourly or daily critical care services, intensive care services, care plan oversight, care management services, and preventive medicine E/M services.

About Documentation

Although *Current Procedural Terminology* guidelines are not documentation guidelines, the information documented in the medical record must support the reported procedure codes.

When selecting a code based on total time, *the total time* and a summary of activities during that time (eg, history and examination findings, counseling topics) must be documented.

When selecting a code based on the level of medical decision-making, the documentation should demonstrate the basis for the level selected. For instance, the record should include the signs, symptoms, and diagnoses that were addressed, including any conditions that were considered plausible but ruled out. It is also important to demonstrate review of external records or prior test results. The physician or other qualified health care professional might sign the external record or report of test results to indicate review or might document a brief notation of findings in the encounter note. Conversations with external physicians and other health care professionals or sources (eg, social workers) should also be summarized in the documentation (eg, "Spoke with Dr X regarding management options for this patient").

Another clinician or coding auditor should be able to readily determine your basis for the code reported.

New Versus Established Patients

New and established patients are defined in the *CPT* E/M guidelines. The categorization of patients influences coding for the following services:

- Office or other outpatient E/M services (new patient, **99202–99205**; established patient, **99211–99215**)
- Home or residence services (new patient, **99341** and **99342**, **99344** and **99345**; established patient, **99347–99350**)
- Preventive medicine services (new patient, **99381–99385**; established patient, **99391–99395**)

No distinction is made between new and established patients for emergency department (ED) services, for consultations, or for observation, inpatient, or nursing facility care. Evaluation and management services in these categories may be reported for any new or established patient. For E/M services provided to patients in observation or inpatient status or in a nursing facility, services are distinguished as initial or subsequent encounters during the same admission, as discussed in the Initial and Subsequent Services section later in this chapter.

Following are the criteria for distinguishing between new and established patients:

- *New patients* have not received a face-to-face professional service from the physician or other QHP, or any physician or QHP of the same group practice and same exact specialty and subspecialty (eg, primary care, allergist), in the prior 3 years.
- *Established patients* have received, and been charged for, a face-to-face professional service from a physician or QHP of the same group practice and same exact specialty and subspecialty within the past 3 years.
- Per *CPT,* a QHP working with a physician(s) and who may report E/M services is considered to be working in the exact same specialty and subspecialty as the physician(s). (Medicare assigns different specialty designations to QHPs and does not consider the specialty of the physician providing supervision when determining whether a patient is new. Medicaid and private plans may follow either *CPT* or Medicare practices.)
- When a physician is covering for another physician of the same specialty, the patient's encounter is reported as it would have been by the physician who is not available. However, a physician covering for another physician of a different specialty determines new or established on the basis of the rules listed earlier in this list for new and established patients (see the first 2 bulleted items).
- If the physician has moved to a different location or changed their tax identification number, patients would still be considered established if they were established patients before these changes took place.

– When a new physician joins a group practice, patients who follow the physician to the new practice are considered to be established patients to any physician of the same specialty in the new practice because the patients were seen by a physician of the same specialty in the group within the past 3 years.

Examples

➤ **A physician provides an office visit to an infant who received newborn hospital care from a physician of the same group and same exact specialty.** The patient is considered established at the office visit.

➤ **A physician provided an outpatient consultation to a patient within the past 3 years.** Another physician in the same group but *different specialty* is asked to provide an office or other outpatient E/M service to the patient. The patient is new for this encounter.

When a physician is covering for another physician of the same specialty, the patient's encounter is reported as it would have been by the physician who is unavailable. When QHPs are working with physicians, they are considered to be working in the exact same specialty and subspecialty as the physician.

Initial and Subsequent Services

The following services are described as initial or subsequent services as opposed to services provided to a new or established patient:

- Hospital inpatient and observation care services (initial, **99221–99223**; subsequent, **99231–99233**)
- Nursing facility services (initial, **99304–99306**; subsequent, **99307–99310**)

Intensive and Critical Care Services

Please see the prefatory guidelines for critical care (99291, 99292), inpatient neonatal and pediatric critical care (99468–99472; 99475, 99476), and neonatal intensive care services (99477–99480) for distinct instructions on reporting initial and continuing services.

As with new and established patients, differentiating between initial and subsequent encounters is based on the timing of the professional (face-to-face) services provided by a physician or other QHP to the patient during an admission/stay.

- Admission/stay: The duration of time from admission to discharge from a facility. For the purpose of determining initial versus subsequent encounters, an admission/stay that includes a transition in levels of care from observation to inpatient or between skilled nursing facility and nursing facility is one admission/stay.
- Initial service: During the inpatient or observation or nursing facility admission/stay, the patient has not received any professional services from the physician or QHP or another physician or QHP of the exact same specialty and subspecialty who belongs to the same group practice.
- Subsequent service: During the admission/stay, the patient has received professional service(s) from the physician or QHP or another physician or QHP of the exact same specialty and subspecialty who belongs to the same group practice.

For the purpose of selecting between initial and subsequent evaluation and management services provided in a facility setting, a single admission/stay includes any transfers from one level of care to another (eg, observation to inpatient). A transfer in the level of care is not a new admission/stay.

Examples

➤ **A physician provides hospital care to a patient who has received no prior care from the physician or any physician or QHP of the same group practice and same specialty during this admission/stay.** Initial hospital care is reported.

➤ **A physician provides hospital care to a patient who received observation care from a physician of the same group and same exact specialty on a prior date during this admission/stay.** The encounter is reported as subsequent hospital care.

➤ **A physician who is covering for a patient's attending physician who is unavailable sees the patient for the first time during an inpatient stay.** The encounter is subsequent hospital care.

Separately Reported Services

Procedures and services described by *CPT* codes distinct from those of an E/M service provided on the same date may be separately reported except where specifically noted as included/bundled in *CPT*. For example, critical care E/M services include services such as electrocardiographic collection and interpretation and vascular access procedures that are reported in addition to most other E/M services.

When an evaluation and management service is caused or prompted by the symptoms or condition for which another diagnostic or therapeutic service (eg, electrocardiography, injection of medication, surgery) is provided on the same date, different diagnoses are not required for reporting the 2 services on the same date.

Example

➤ **A physician provides an office E/M service to a patient who describes limited hearing and fullness in their right ear.** Examination of the right ear reveals impacted cerumen that requires removal with instrumentation (performed by the physician on the same date). The physician reports *International Classification of Diseases, 10th Revision, Clinical Modification* code **H61.21** (impacted cerumen, right ear) linked to a code for the E/M service (eg, **99213 25**) and to **69210** (removal of impacted cerumen requiring instrumentation, unilateral).

Modifier **25** (significant, separately identifiable E/M service) is appended to an E/M code when an E/M service provided on the same date as a procedural service is significantly beyond the preservice work of the procedural service.

E/M Guidelines for Use of Total Time or MDM

Applicability of E/M Guidelines for Use of Total Time or MDM

Evaluation and management guidelines used for selecting codes from the following categories are further discussed in this chapter:

- Office or other outpatient services (new patient, **99202–99205**; established patient, **99211–99215**)
- Hospital inpatient or observation care services (initial, **99221–99223**; subsequent, **99231–99233**; same date admission and discharge, **99234–99236**; discharge day management, **99238–99239**)
- Outpatient and inpatient consultations (outpatient, **99242–99245**; inpatient, **99252–99255**)
- Emergency department services (**99281–99285**)
- Nursing facility services (initial, **99304–99306**; subsequent, **99307–99310**; discharge day management, **99315** and **99316**)
- Home or residence services (new patient, **99341** and **99342**, **99344** and **99345**; established patient, **99347–99350**)
- Prolonged service with or without direct contact on the date of an evaluation and management service (**99417**, **99418**)

Each of the listed code categories involves selecting a code based on the location where a face-to-face service is provided and a physician's or a QHP's total time on the date of the encounter or the level of MDM associated with the encounter. All other E/M services are reported on the basis of guidelines specific to the code category.

Telemedicine evaluation and management services (delivered via real-time audiovisual technology) are face-to-face services even though the physician is present only by audiovisual technology.

Each of the categories and subcategories of E/M service to which these general guidelines apply may also have additional guidelines presented before the list of codes and/or as parenthetical instructions after the codes in *CPT 2023.* For instance, unique prefatory guidelines for hospital inpatient and observation care provide important guidance for reporting the correct subcategory of service: initial care, subsequent care, discharge day management, or same date admission and discharge.

History and Examination

History and examination are included components of all evaluation and management (E/M) services addressed by the E/M guidelines. However, the extent of history and examination, while lending support for the amount of time spent or the level of MDM, are not directly used in code selection. A medically appropriate history and examination, as determined by the reporting physician or qualified health care professional (QHP), should be documented for each E/M service.

History and examination are important elements of documentation to support that medical services provided were clinically indicated and to support quality initiatives (eg, verification of timely immunization and review of current medications and supplements). History documented by a patient, caregiver, or clinical staff member should be reviewed, expanded (when indicated), and authenticated by the reporting physician or QHP.

Code Selection Options

Once you have determined the correct code category (eg, outpatient consultation) or subcategory (eg, initial hospital inpatient or observation care), there are 2 options for selecting the appropriate codes based on these guidelines. An exception is services provided in the ED (**99281–99285**) that are selected on MDM alone, with no option for selection based on time.

- Select the code based on the reporting physician's or QHP's *documented total time* directed to care of the individual patient *on the date of the encounter.*
- Select a code based on meeting 2 of 3 elements of MDM.

Time and Emergency Department Services

Per *Current Procedural Terminology,* time is not a descriptive component for the emergency department (ED) levels of evaluation and management services because ED services are typically provided on a variable-intensity basis, often involving multiple encounters with several patients over an extended period.

Box 1-1 provides an overview of code selection based on total time or MDM. For each method of code selection, the documentation should support the clinical indication for the level of service reported.

Box 1-1. Evaluation and Management Code Selection Based on Total Time or Medical Decision-making

Select a code based on the pediatrician's or the QHP's total time on the date of the encounter or the level of MDM.

Time: May be used to select a code level whether or not counseling and/or coordination of care dominates the service.

- Time includes the total time on the date of the encounter (face-to-face and non–face-to-face) personally spent by the physician and/or QHP focused on the care of 1 patient.
  - Do not include time in activities performed or normally performed by clinical staff (eg, rooming the patient).
  - Time does not need to be continuous. Total all time on 1 date.
- Include the time of the following activities when performed by the reporting pediatrician/QHP:
  - Preparing to see the patient (eg, reviewing previous test results)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient, family, or caregiver
  - Ordering medications, tests, or procedures
  - Referring/communicating with other QHPs (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (when not separately reported) and communicating results to the patient, family, or caregiver
  - Coordinating care (when not separately reported)

Box 1-1 (*continued*)

MDM: Four types of MDM are recognized: straightforward, low, moderate, and high. Determine the level of MDM based on the highest 2 of 3 elements of MDM.

1. Number and complexity of problems addressed. Include problems addressed or managed by the reporting pediatrician/QHP as part of the encounter.
2. Amount and/or complexity of data reviewed and analyzed. Data include
   - Tests, documents, orders, or independent historian(s)
   - Independent interpretation of tests (not separately reported)
   - Discussion of management/test interpretation with an external physician, QHP, or appropriate source (not separately reported)
3. Risk of complications, morbidity, and/or mortality of patient management decisions made during the encounter, including decisions against a considered management option.

Abbreviations: MDM, medical decision-making; QHP, qualified health care professional.

Time Guidelines and Application

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

- Time is the physician's and/or QHP's total time on the date of service, not their time in a 24-hour period.

The total time should be documented in the medical record when used as the basis for code selection. No specific verbiage is required by *Current Procedural Terminology*. Remember, when not documented, time is not an option for code selection.

- Only time spent in activities directed to care of the individual patient is counted in the total time on the date of an encounter.
- Both face-to-face and non–face-to-face time or time on or off the unit/floor spent on the date of service are included in the time of the encounter. **Figure 1-1** illustrates the time included in the physician's or QHP's total time.

Figure 1-1. Time on Date of Service

Code Descriptors and Total Time

It is important to identify the time required in each code's descriptor to accurately assign codes based on total time. There are differences in how time is described across various categories of service.

Office and other outpatient evaluation and management services are described by ranges of time spent on the date of the encounter (eg, code 99202 includes 15–29 minutes).

For most other codes that may be selected on the basis of a physician's or qualified health care professional's total time on the date of the encounter, a specific time must be met or exceeded.

Other codes, such as hourly critical care codes 99291 and 99292, have different guidelines and code descriptors that include only the time spent providing critical care services (ie, not the total time spent on the date of the encounter).

Examples

➤ **A physician spends 10 minutes reviewing laboratory results and consultation reports before an E/M encounter with an established patient on the same date.** Later that day, a face-to-face visit with the patient and caregivers lasts 20 minutes. After the visit but on the same date, the physician spends 10 minutes in discussion with a consulting subspecialist and another 10 minutes in follow-up with the caregivers and in documentation. The physician's total time on the date of service is 50 minutes.

Teaching Point: The physician reports code **99215** (40–54 minutes). All the physician's time spent in activities directed to the care of the single patient is counted.

***Current Procedural Terminology* does not require documentation of each segment of time spent on the date of service or documentation in any specific format. The physician must, however, document the total amount of time spent on the date of the encounter and be able to account for the time spent.**

➤ **A physician spends 10 minutes reviewing laboratory results and medical records before an outpatient consultation on the same date.** Later that day, a face-to-face visit with the patient and caregivers lasts 20 minutes, and another 10 minutes is spent documenting the encounter and preparing a report to the QHP who requested the consultation. The physician's total time on the date of the face-to-face E/M service is 40 minutes. On the next day, the physician spends 10 minutes in