American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Dear Reader,

Updates have been made to *Pediatric Office-Based Evaluation and Management Coding: 2021 Revisions.*

1/19/2021

Page 57

The following sentence has been deleted:

> Remember, code **GPC1X** is a placeholder code.

The following paragraph *has been added* in its place:

> In the Consolidated Appropriations Act of 2021, the US Congress prohibited the CMS from making payment for **G2211** (or any successor or substantially similar code) prior to January 1, 2024.

Page 82

The second sentence of the final paragraph has been updated. It previously read as follows:

> Do not count ordering and review of results for the same test separately in determining the amount and/or complexity of data at a single encounter.

It *has been updated* to read as follows:

> Do not count ordering and review of results for the same test separately. Review of test results is part of the encounter at which the tests are ordered and not a subsequent encounter.

Page 83

The sentence immediately beneath the table title "Requirements for Amount and/or Complexity of Data" has been updated. It previously read as follows:

(Count each unique test, order, or document to meet requirements of category 1.)

It *has been updated* to read as follows:

(Count each unique test, order, or document to meet requirements of category 1. Do not count tests that are performed and reported by the physician or QHP during the encounter.)

Page 98

The first two bullets beneath the heading "Prolonged Service" have been revised. They previously read as follows:

- The AMA is reviewing the currently published guidance on the threshold time for reporting the new office E/M prolonged service code. More information will be forthcoming in AAP coding resources when available.
- At the time of publication, the Centers for Medicare & Medicaid Services had released a proposed rule stating that prolonged services will not begin until 15 minutes beyond the highest time in **99205** or **99215**. A final rule is not expected until December 2020. Please refer to www.aap.org/coding for more information.

They *have been updated* to read as follows:

- The AMA has published guidance on the threshold time for reporting the new office E/M prolonged service code. Code **99417** is reported when total time on the date of service exceeds the minimum time in the time range assigned to either **99205** or **99215**.
- The Centers for Medicare & Medicaid Services has adopted policy to not pay for code **99417** and instead pay for code **G2212** (prolonged office or other outpatient E/M service[s] beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or QHP, with or without direct patient contact). As with **99417**, **G2212** is reported only in addition to code **99205** or **99215**. Other payers may adopt Medicare policy. Please refer to www.aap.org/coding for more information.

Page 129

Footnote [a] beneath "Table 2. Time Requirements for Code **99417**" has been revised. It previously read as follows:

> [a] The times in this table are based on current *Current Procedural Terminology* (*CPT*®) recommendations. The Centers for Medicare & Medicaid Services (CMS) has proposed different thresholds for prolonged services. We will update this publication at www.aap.org/coding if *CPT* is revised or we learn payers are adopting CMS policy.

It *has been updated* to read as follows:

> [a] The times in this table are based on current *Current Procedural Terminology* (*CPT*®) recommendations. The Centers for Medicare & Medicaid Services (CMS) has adopted a different code, **G2212**, for prolonged office E/M service. Please see the "Prolonged Service" section of the article "Evaluation and Management Codes: A Work in Progress" earlier in this manual for details.

1/7/2021

Page 11

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.

Page 12

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 20

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

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

Page 21

The Teaching Point in the third example on page 21 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 22

The Teaching Point in the first example on page 22 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 25

The following has been added to footnote [b] of Table 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.

Pages 47 and 48

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 56

The first sentence in the box titled "Beyond *CPT:* CMS Add-on Code for Certain E/M Services in 2021" has been revised. The sentence previously read as follows:

> The Centers for Medicare & Medicaid Services (CMS) has expressed an intent to provide enhanced payment to physicians who predominantly provide evaluation

and management (E/M) services in provision of *primary care or ongoing management of single, serious, or complex chronic conditions* in 2021.

It *has been updated* to read as follows:

> The Centers for Medicare & Medicaid Services (CMS) has expressed an intent to provide enhanced payment to physicians who predominantly provide evaluation and management (E/M) services in provision of *primary care or ongoing management of a single, serious condition or complex conditions* in 2021.

Page 57

Throughout the shaded box, code **GPC1X** has been replaced with **G2211**. Additionally, code **99204** has been replaced with **99205** and code **99214** has been replaced with **99215**.

Additionally, the code language that appears next to **GPC1X**—now **G2211**—has been updated. It previously read as follows:

> Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

It *has been updated* to read as follows:

> Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

Finally, the last sentence in the box ("Remember, code **GPC1X**…") has been deleted.

Page 67

A new item has been added to the end of the section titled "Amount and/or Complexity of Data to Be Reviewed and Analyzed." It reads as follows:

- Tests performed and/or interpreted and reported by the physician or other QHP are not counted toward the amount and/or complexity of data reviewed and analyzed.

Page 68

A sentence has been added to the end of the bulleted item labeled "Independent interpretation." It reads as follows:

Both the order for and independent interpretation of a test may be counted toward the amount and/or complexity of data to be reviewed and analyzed.

Page 82

A sentence has been added to the end of the paragraph that begins "Ordering a test is included in the category of test result(s)." That sentence reads as follows:

Tests performed and/or interpreted during an encounter and separately reported by the physician or other QHP are not counted toward the amount and/or complexity of data to be reviewed and analyzed.

Page 85

A new paragraph has been ended at the end of the page. It reads as follows:

This example uses review of test results to support the amount and/or complexity of data. However, if the tests were performed and reported by the physician or the order for the tests occurred at a prior visit, the tests would not be counted in determining the amount and/or complexity of data for this visit.

Page 102

Footnote [a] beneath Table 2 has been updated. It previously read:

[a] Each unique test (as identified by 1 code), order, or document contributes to the combination of 2 or combination of 3 in Category 1. Do not count data review or communications reported with other codes (eg, test interpretation, interprofessional consultation).

It *has been updated* to read as follows:

[a] Each unique test (as identified by 1 code), order, or document contributes to the combination of 2 or combination of 3 in Category 1. Do not count data review or communications reported with other codes (eg, tests performed and/or interpreted during the encounter and separately reported by the physician or other QHP, interprofessional consultation).

Page 128

A new paragraph has been added immediately following the first sentence on the page. It reads as follows:

This example assumes laboratory testing by an external provider. If the pediatrician in this example performs and reports codes for the laboratory tests, these tests would not be counted toward the amount and/or complexity of data. The data to be reviewed and analyzed would then be moderate. However, the high number and complexity of problems addressed and high risk would still support a level 5 service.

November 2, 2020

An example has been updated on page 29 of *Pediatric Office-Based Evaluation and Management Coding: 2021 Revisions*. 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 29

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,

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