Q: What level is acute otitis media?

A: There is some gray areas here. A simple ear infection with fever that patient is otherwise acting well and symptoms improved with ibuprofen or acetaminophen is more likely a 3. A child with an ear infection that fever is hard to treat, not sleeping, not eating, and acting fussy can be argued as a 4 as this can be interpreted as an acute illness with systemic symptoms. Most important take away is documenting your support for MDM as the level 3 or 4.

Q: If each MDM element is different, which level should you choose?

A: If Problems is a 4, Data is a 2, and Risk is a 5 - the level will be a 4 because Risk can be drop to a 4 but Problems and Data cannot be brought up.

Q: Impact on Procedures and Splint in urgent care.

A: I have reached out to AAP for clarification. Current recommendations are that any procedure, labs, test, or splinting that carries its' own CPT code that is bill by the current provider cannot be used in MDM decisions.

Q: What is the Risk level of medications given in clinic, ie PO vs IM vs IV

A: There are no current examples. I have reached out to AAP for clarification.

Q: How can you calculate time for multiple siblings?

A: It would be very complicated, especially when complaints overlap. So unless you are specifically timing yourself for each patient in the same room, they would recommend focusing on MDM for those visits.

Tips and Clarifications:

In Data Reviewed/Analyzed. Point of care labs should not count as a data point because they carry their own CPT code that will be bill by the provider. You must submit and bill these CPT codes. Do not omit the billing to increase your level of MDM. This is fraud. No one looks good in orange. Now, if you order a rapid strep that is done in your office and it is negative and there is a send out throat culture that is done at an outside lab - the throat culture DOES could for MDM as a unique lab.

Category 3: Discussion of management or test interpretation with external physician/QHP does NOT include nurses. The only exception is if you are giving report to the nurse for the transfer of a patient to the emergency department.

Billing should be based on information in the provider note as a stand alone. If you are giving supportive care instructions and have an attached handout with recommendations that most

likely will not count. To be cautious you should include specific recommendations for supportive care - for example Tylenol/Ibuprofen, suction, pushing fluids.

Time: Though there is no specific template for time, you should document time spent in prework, direct patient care, and post visit work on date of service. You need to be able to defend your time spent if there is an audit. The more specific - the better.

Remember - no double dipping. If your colleague/partner in your practice ordered a CBC that you reviewed at a later visit that does not count because your practice received payment for that at the initial visit. If you order a unique lab (i.e send out CBC), you cannot count it as reviewed as well because your review is assumed in the initial ordering - even if you discuss it with the patient at a subsequent visit.

I know the 2021 CPT changes are very overwhelming and much is still uncertain and changing. I will update SPUC as new changes come out. Remember how you documented to support your level in the 1995/1997 codes you should think of the new key elements in the same manner. Document to support your MDM and Time spent.

Resources:

Free online coding calculator by Chip Hart: mdm2021.com

Thuylinh Pham: tnpham@cmh.edu

Maria Blanco: mblanco@cmh.edu