

Impact and Application of 2021 CPT Coding Changes for the Outpatient Pediatrician

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- ▶ I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

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- ▶ Information presented is gathered from available resources from AAP, AMA, CPT Workbooks, and other available resources prior to date of presentation
- ▶ Refer to official AMA and CPT resources when submitting billing claims to insurance providers

Learning Objectives

- ▶ Understand the current CPT guidelines for outpatient coding based on the element of TIME
- ▶ Understand the current CPT guidelines for outpatient coding based on the element of MDM
- ▶ Effectively utilize prolonged service codes for complex patients
- ▶ Apply coding changes to common patient encounter examples
- ▶ Approach billing and coding with more efficiency and confidence in the office setting

Overview

- ▶ Previous coding elements
 - ▶ ROS components
 - ▶ PE components
 - ▶ MDM
 - ▶ Face time with patient
- ▶ 2021
 - ▶ Time
OR
 - ▶ MDM

Overview, cont'd.

If coding by MDM, same level of coding is utilized for new vs established patients

- ▶ Previously, different criteria required for meeting MDM for new vs established
- ▶ RVU remains higher for new patients
- ▶ RVU changes have been established and some are pending which may offset a shift in the percentage of each level of coding

Comparison of Work RVU Changes

CPT Code	Current Work RVU	2021 Work RVU	Percent Increase
99202	0.93	0.93	
99203	1.42	1.60	13%
99204	2.43	2.60	7%
99205	3.17	3.50	10%
99211	0.18	0.18	
99212	0.48	0.70	46%
99213	0.97	1.30	35%
99214	1.50	1.92	28%
99215	2.11	2.80	33%
99417	NA	0.61	

2021 RVUs for Outpatient E/M

- ▶ Medicare has agreed on the 0.61 work RVU's for the prolonged service codes, and other payors have been encouraged to follow suit.
- ▶ Practice expense RVU's have decreased for these visits, so practice will not fully feel full work RVU increase.

TIME

- ▶ Total time spent by rendering provider on care of the patient on that date of service
 - ▶ Chart review
 - ▶ Referral note review
 - ▶ Exam and discussion in the room
 - ▶ Ordering tests
 - ▶ Discussion of test results and treatment plan with family
 - ▶ Note documentation
 - ▶ Updating problem list
 - ▶ Care coordination if calling other specialists/therapists/social workers

Time: Parameters

New Patient	2021 Total Time Range		Established Patient	2021 Total Time Range
99202	15-29 mins		99212	10-19 mins
99203	30-44 mins		99213	20-29 mins
99204	45-59 mins		99214	30-39 mins
99205	60-74 mins		99215	40-54 mins

- ▶ 99201 has been deleted
- ▶ 99211 should not be used if a provider sees the patient

Time: Pearls

- ▶ Time spent by nurses/MA does not count towards total time
- ▶ Time spent performing a task with a billable CPT such as wart removal or wound dressing does not count toward total time = no double dipping
- ▶ Reviewing discharge summary or newborn summary or any chart data on the day prior to date of service does not count
 - ▶ Recommend allowing additional prep time in the morning for chart review if applicable for expected work flow and type of billing
- ▶ Notes can be finalized on a later date, but only the time spent on the date of service can be counted.
 - ▶ If you think you will be able to bill higher based on time for a complicated patient such as anxiety/depression, take the time to finish documenting on that date of service as you might easily reach a 99215 based on time alone (40 total minutes!)
- ▶ We will re-visit prolonged service codes for time
- ▶ Some EMR providers may update their systems to help with code auditing support

Time: Solutions

- ▶ EMR system may help track provider time in the chart and encounter note on date of service to help suggest a level for coding by time
 - ▶ Unsure how accurate this will be
- ▶ Recommended for provider to keep track of time spent on patient and document in note
- ▶ Create template to layer into plan section if planning to bill on time
 - ▶ Time spent performing chart and data review: *** minutes
 - ▶ Time spent evaluating patient: *** minutes
 - ▶ Time spent documenting in EHR and coordination of care: *** minutes
- ▶ **TIME BREAKDOWN NOT REQUIRED**, but helpful

Prolonged Service Codes

- ▶ Can only be applied if billing a 99215 based on TIME
 - ▶ Cannot add this code to a 99215 if billing based on MDM
- ▶ Uncommon, but for prolonged mental health visits, there may be days that we can reach this level of billing
- ▶ Payor coverage of these codes may be inconsistent

Prolonged Service Code Chart

Time spent (minute)	Codes reported
New Patient	
60-74	99205
75-89	99205 + 99417 x 1
90-104	99205 + 99417 x 2
≥105	99205 + 99417 x 3
Established Patient	
40-54	99215
55-69	99215 + 99417 x 1
70-84	99215 + 99417 x 2
≥85	99215 + 99417 x 3

MDM

- ▶ Three elements:
 - ▶ Problems
 - ▶ Data
 - ▶ Risk
- ▶ Billed based on highest level reached in **2 out of 3 categories**
- ▶ Recommend purchasing laminated reference sheet from AAP or printing “cheat sheet” from AMA
- ▶ Will require more individualized documentation
 - ▶ Other broad diagnoses considered
 - ▶ Why tests were ordered or deferred in each case
 - ▶ If you think it, type it
 - ▶ If using templates, add more descriptive wording in the plan with regard to differential and risk
- ▶ Problems are not additive = this is important later

MDM Overview

	Problem	Data	Risk
Level 2	Minimal	Minimal	Minimal
Level 3	Low	Limited	Low
Level 4	Moderate	Moderate	Moderate
Level 5	High	Extensive	High

Helpful Descriptors

- ▶ Acquired, congenital, familial, hereditary
- ▶ Acute; acute on chronic; chronic, recurrent
- ▶ Focal, generalized, localized
- ▶ Improving, intractable, stable, worsening
- ▶ Infectious, bacterial, viral, allergic
- ▶ Intermittent, persistent
- ▶ Mild, moderate, severe
- ▶ Not at goal
- ▶ Primary, secondary
- ▶ Uncertain, undetermined

Adapted from AAP Coding Newsletter, July 2022

Problems (Element 1)

- ▶ Minimal (Level 2) = straightforward = self limited = minor
 - ▶ Runs a definite course, transient, won't affect long term health
 - ▶ bug bites, diaper rash, f/u AOM (resolved), simple URI, school clearance after illness
- ▶ Low (Level 3) = low complexity = meets one of the following:
 - ▶ 2 or more self limited or monitor problems (see above)
 - ▶ 1 stable, chronic illness (well controlled asthma)
 - ▶ Illness expected to last at least 1 year (does not have to be present for one year prior)
 - ▶ NOTE! = Stable = at specific treatment goal
 - ▶ Even if condition is unchanged from prior, is considered UNstable if not meeting the set goal
 - ▶ Risk of morbidity without treatment is high
 - ▶ 1 acute, uncomplicated illness/injury (sprain, URI, AR, Uncomplicated AOM)
 - ▶ Recent or new short term problem with low risk of morbidity
 - ▶ Can be a problem that was considered minor (level 2) but is not resolving as expected

Problems (Element 1), cont'd

- ▶ Moderate (level 4) = one of the following
 - ▶ 1 or more chronic illness(es) with exacerbation, progression, or side effect
 - ▶ Poorly controlled Asthma
 - ▶ May be improving, but is considered unstable if not at treatment goal = be descriptive
 - ▶ Worsening HA/migraine
 - ▶ Decreased appetite on stimulant
 - ▶ 2 or more stable, chronic illnesses (see level 3 examples)
 - ▶ Chronic allergic rhinitis and chronic eczema
 - ▶ Undiagnosed new problem with uncertain prognosis
 - ▶ No definitive diagnosis on date of service, but the DDx contains a diagnosis that could result in high risk of morbidity without treatment
 - ▶ Rashes might be a possible example, chronic diarrhea, recurrent AOM, abdominal pain
 - ▶ Acute illness with systemic symptoms *** = subject of debate
 - ▶ AOM with perforation and fever, GI with relative dehydration, febrile UTI
 - ▶ Acute, complicated injury
 - ▶ Concussion with LOC
 - ▶ MVA with multiple injuries

Problems (Element 1), cont'd

- ▶ High (Level 5)
 - ▶ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
 - ▶ May require hospital level care
 - ▶ Depression with SI
 - ▶ Mild persistent asthma with status asthmaticus
 - ▶ Intractable migraine
 - ▶ 1 acute OR chronic illness or injury that poses a threat to life or bodily function
 - ▶ SI, Respiratory distress, new onset seizure, GE with dehydration

Data (Element 2)

- ▶ Minimal (Level 2) = adult patient who requires no testing and is able to provide all history
 - ▶ OR the parent does not provide any additional pertinent history that changes MDM
- ▶ Limited (Level 3) = meet the requirement of Category 1 OR Category 2
 - ▶ Category 1: Combination of 2 out of 3
 - ▶ Review of prior EXTERNAL note from each unique source (GI and Rheum = 2 separate)
 - ▶ Ordering a unique test **which does not have a billable CPT code *****
 - ▶ Reviewing a unique test
 - ▶ Cannot get a point for ordering plus a point for reviewing the same test
 - ▶ Category 2: Requires Independent Historian for Historical Data = ANY PARENT OR GUARDIAN who gives relevant!
 - ▶ We get to a level 3 on data for essentially every visit!
 - ▶ Support this in the HPI if the patient would reasonably be expected to report all pertinent information, i.e. teenager with sore throat
 - ▶ It is recommended to be as specific as possible, i. e. mom provides pertinent family history

Data (Element 2), cont'd.

- ▶ Moderate Complexity (Level 4) = meet 1 out of 3 following categories
 - ▶ Category 1: Any combo of 3 out of the following 4
 - ▶ Review of prior EXTERNAL note from each unique source (GI and Rheum = 2 separate)
 - ▶ Ordering a unique test without billable CPT code: rapid strep, rapid flu, TSH, fT4, CBC, Vanderbilt form; note that a lab panel counts as 1
 - ▶ Reviewing a unique test without billable CPT code
 - ▶ Cannot count point for ordering plus reviewing same test
 - ▶ Independent historian
 - ▶ Category 2: Independent interpretation of test performed by another physician
 - ▶ Interpret and review **and document impression** of labs or actual image tracing ordered by a specialist or obtained in ED and document your own interpretation
 - ▶ Category 3: Discussion of management or test interpretation
 - ▶ Call and discuss with specialist, social worker, therapist, teacher, etc.

Data (Element 2), cont'd.

- ▶ Extensive Data Review (Level 5) = meet 2 out of 3 categories
 - ▶ Category 1: Any combo of 3 out of the following 4
 - ▶ Review of prior EXTERNAL note from each unique source (GI and Rheum = 2 separate)
 - ▶ Ordering a unique test without billable CPT code
 - ▶ Reviewing a unique test without billable CPT code
 - ▶ Independent historian
 - ▶ Category 2: Independent interpretation of test performed by another physician
 - ▶ Interpret and review labs or actual image tracing ordered by a specialist or obtained in ED and document your own interpretation
 - ▶ Category 3: Discussion of management or test interpretation
 - ▶ Call and discuss with specialist, social worker, therapist, teacher, etc.

Data (Element 2), cont'd

► Moderate Data Examples

- 15 yo with fatigue and ordered CBC, fT4, TSH (Meets Category 1)
- 2 yo with history of cyclic neutropenia and discussed labs or treatment plan with Hem/onc (Meets Category 3)
- 6 yo with pneumonia f/u from ER and personally reviewed the CXR from the ED and include your interpretation in your encounter note (Meets Category 2)

► Extensive Data Examples

- 8 yo with history of syncope with history provided by dad; ordered CBC, iron studies, and RFP and reviewed EKG tracing obtained in ED and commented interpretation in note (Category 1 and 2)
- 11 yo with behavioral issues with history provided by parents; ordered TSH and fT4 due to family history; discussed with school counselor (Category 1 and 3)

Risk (Element 3)

- ▶ Risk = Risk based on your management of the patient and not from the disease process
 - ▶ The probability or consequences of an event which is based on the usual behavior and thought process of a physician in the same specialty
- ▶ Morbidity = state of illness or functional impairment that is expected to be of “substantial duration” with limited function, impaired quality of life, or lasting organ damage
- ▶ Social determinant of health
 - ▶ Low socioeconomic conditions that affect health
 - ▶ Access to food
 - ▶ Housing insecurity
 - ▶ Inability to obtain or give medication as prescribed
- ▶ Drug therapy requiring monitoring for toxicity
 - ▶ Measured by a lab or test

Risk (Element 3), cont'd.

- ▶ Level 2 = minimal risk from testing or treatment
 - ▶ Supportive care with humidifier, topical diaper rash cream
 - ▶ Obtain a nasal swab for a test
- ▶ Level 3 = low risk from testing or treatment
 - ▶ Blood draw or XR
 - ▶ OTC med recommended (even if prescribed because insurance will cover it!)
- ▶ Level 4 = moderate risk from testing or treatment OR treatment limited by SDH
 - ▶ Amoxil for AOM
 - ▶ Zoloft or Vyvanse management
 - ▶ Family unable to give treatment as prescribed bc cannot afford the most appropriate med or cannot give as frequently as recommended
 - ▶ Low income so cannot obtain humidifier for baby with bronchiolitis

Risk (Element 3), cont'd.

- ▶ Level 5 = high risk of morbidity from additional labs or treatment
 - ▶ Drug therapy requiring extensive monitoring
 - ▶ Unusual in gen peds
 - ▶ Autistic pt on Risperdal needing intermittent CBC/CMP
 - ▶ Decision to perform elective surgery with risk factors (N/A)
 - ▶ Decision to perform emergent major surgery (N/A)
 - ▶ DNR orders or de-escalation of care (extremely uncommon)
 - ▶ **Decision regarding hospitalization**
 - ▶ SI, bronchiolitis, status asthmaticus

Risk (Element 3): Possible EMR Solutions

- ▶ Update plan portion in common templates to include risks of dehydration, lack of scheduled albuterol, non-adherence to SSRI, etc.
 - ▶ Must discuss fully with family before leaving the documentation in the note if relying on a template
- ▶ Update plan portion to include more extensive DDX for common templates
 - ▶ If you think it might be a possibility, document it
- ▶ AAP recommends avoiding bullet points in plans

MDM Pearls

- ▶ More individualized documentation
 - ▶ Most webinars suggest this type of billing means moving away from only templates
 - ▶ It is ok to use these in order to work smarter, just be sure to follow the rule “if you think it, then type it”
 - ▶ Add why you ordered or deferred a test or treatment in a specific case
- ▶ “Consult” to colleague within the practice doesn’t count
 - ▶ Conferring with a LCSW in the same building does increase MDM in Data portion
- ▶ Add tailored documentation regarding risk
 - ▶ Patient travels between two parent houses and often forgets to bring daily asthma controller

Example Vignette #1

- ▶ 14 with recent swimming with 4 days of ear pain which has not improved despite OTC treatment. Mom reports trying OTC swimmer's ear drops and motrin with no improvement. Noted to have Diffuse OE left ear. Prescribed ofloxacin.

Example Vignette #1

- ▶ 14 with recent swimming with 4 days of ear pain which has not improved despite OTC treatment. Mom reports trying OTC swimmer's ear drops and motrin with no improvement. Noted to have Diffuse OE left ear. Prescribed ofloxacin.
 - ▶ Low complexity problem (level 3)
 - ▶ Limited data review (level 3) = AAP suggests this may be level 2 if relevant historical information is not added by the parent
 - ▶ Moderate risk (level 4)
- ▶ 99213 (MDM)

Example Vignette #2

- ▶ 4 year old with splinter in foot x2 days that has not improved with parent attempting removal. Spent 2 minutes obtaining history from family, 3 minutes performing brief physical exam, 5 minutes removing splinter, and 5 minutes charting. Recommended topical antibiotic and wound care after removal.

Example Vignette #2

- ▶ 4 year old with splinter in foot x2 days that has not improved with parent attempting removal. Spent 2 minutes obtaining history from family, 3 minutes performing brief physical exam, 5 minutes removing splinter, and 5 minutes charting. Recommended topical antibiotic and wound care after removal.
 - ▶ Time = 15 minutes = 99212
 - ▶ If you bill for foreign body removal with appropriate CPT, total time = 10 minutes
 - ▶ Minor problem (level 2)
 - ▶ Limited data review (level 3)
 - ▶ Low risk (level 3)
- ▶ MDM = 99213

Example Vignette #3A

- ▶ 14 year old with 2 days of sore throat. Mom reports no fever and she gave pt Zyrtec and motrin x2 days with no improvement. History of AR but had not been routinely using preventative medication. On exam, allergic shiners, boggy turbinates, and normal OP. Mom requests RSS due to history and pt in school and found to be negative. Throat culture send out pending. Discussed addition of OTC flonase to Zyrtec and allergen avoidance.

Example Vignette #3A

- ▶ 14 year old with 2 days of sore throat. Mom reports no fever and she gave pt Zyrtec and motrin x2 days with no improvement. History of AR but had not been routinely using preventative medication. On exam, allergic shiners, boggy turbinates, and normal OP. Mom requests RSS due to history and pt in school and found to be negative. Throat culture send out pending. Discussed addition of OTC flonase to Zyrtec and allergen avoidance.
 - ▶ Moderate complexity (level 4)
 - ▶ Moderate Data review (level 4)
 - ▶ Low risk (level 3)
- ▶ 99214

Example Vignette #3B

- ▶ 14 year old with 2 days of sore throat and occasional cough. Mom reports no fever and she gave pt Zyrtec and motrin x2 days with no improvement. On exam, allergic shiners, boggy turbinates, and normal OP. Mom requests RSS due to history and pt in school and found to be negative. Lungs clear on exam and discussed that cough likely 2/2 PND. Discussed addition of singulair to Zyrtec along with allergen avoidance because you note that pt also has mild intermittent asthma after reviewing prior note from Family Allergy and Asthma. Per patient and mother, he has not required albuterol in several months for asthma flare. Advised to continue albuterol 4 puffs with spacer q4h if needed for exacerbation. Provided pt with spacer bc his was lost at soccer practice.

Example Vignette #3B

- ▶ 14 year old with 2 days of sore throat and occasional cough. Mom reports no fever and she gave pt Zyrtec and motrin x2 days with no improvement. On exam, allergic shiners, boggy turbinates, and normal OP. Mom requests RSS due to history and pt in school and found to be negative. Lungs clear on exam and discussed that cough likely 2/2 PND. Discussed addition of singulair to Zyrtec along with allergen avoidance because you note that pt also has mild intermittent asthma after reviewing prior note from Family Allergy and Asthma. Per patient, he has not required albuterol in several months for asthma flare. Advised to continue albuterol 4 puffs with spacer q4h if needed for exacerbation. Provided pt with spacer bc his was lost at soccer practice.
 - ▶ Moderate complexity (level 4)
 - ▶ One chronic stable problem and one chronic problem with worsening
 - ▶ Moderate Data review (level 4)
 - ▶ Historian, RSS, throat culture, Reviewed specialist note
 - ▶ Moderate risk (level 4)
 - ▶ Singulair prescribed and reviewed albuterol management and documented asthma recs/risk
- ▶ 99214

Example Vignette #4

- ▶ 9 yo presents for 6 month routine f/u of asthma. She feels she is doing well on daily Qvar but reports needing to use albuterol about once per week due to SOB and coughing episodes per mom. Normal pertinent PE. Spirometry obtained and reviewed. Refilled Qvar, added singulair, and refilled Albuterol. Filled out school form for Med admin. Spent 3 minutes reviewing last well visit and last sick visit. Spent 10 minutes in room discussing history and PE. Spent 7 minutes discussing changes to current and goals for patient. Spent 2 minutes filling out school form. Spent 3 minutes back in room because mom had question about if patient should be on daily allergy pill. Spent 8 minutes documenting in chart and updating problem list.
 - ▶ Moderate complexity (level 4)
 - ▶ Minimal Data (level 3)
 - ▶ Mom as historian and spirometry
 - ▶ Moderate Risk (level 4)
- ▶ 99214 (MDM)
- ▶ 99214 (Time) = 31

Example Vignette #5

- ▶ 4 month old with 3 day history of worsening congestion and cough and mom noted breathing faster overnight with last wet diaper 8 hours ago and not taking bottle. Pulse ox 90% on RA on arrival. Exam consistent with bronchiolitis. RSV found to be positive. COVID negative. Decision made to suction and re-evaluate. Pulse ox still 91% on RA and RR 61 with subcostal and intercostal retractions. Decision made to admit for increased WOB and bronchiolitis protocol. Spent 8 minutes obtaining history and PE. Spent 1 minute ordering suctioning and ordering labs. Spent 8 minutes re-evaluating patient and explaining lab results to mom as well as need for admission for further monitoring. Spent 8 minutes documenting encounter. Spent 6 minutes calling report to direct admit team.

Example Vignette #5

- ▶ 4 month old with 3 day history of worsening congestion and cough and mom noted breathing faster overnight with last wet diaper 8 hours ago and not taking bottle. Pulse ox 90% on RA on arrival. Exam consistent with bronchiolitis. RSV found to be positive. COVID negative. Decision made to suction and re-evaluate. Pulse ox still 91% on RA and RR 61 with subcostal and intercostal retractions. Decision made to admit for increased WOB and bronchiolitis protocol. Spent 8 minutes obtaining history and PE. Spent 1 minute ordering suctioning and ordering labs. Spent 8 minutes re-evaluating patient and explaining lab results to mom as well as need for admission for further monitoring. Spent 8 minutes documenting encounter. Spent 6 minutes calling report to direct admit team.
- ▶ Time 99214 = 31 minutes
- ▶ MDM:
 - ▶ High complexity (level 5)
 - ▶ Extensive Data (level 5)
 - ▶ Historian, COVID, RSV (Category 1) and Called to ER (Category 2)
 - ▶ High Risk (level 5)
- ▶ **99215**

Example vignette #6

- ▶ 18 month old with history of 3 ear infections in the last 7 months presents with fever, fussiness when lying down, and pulling at ears. R eye was also crusted shut this morning. ROM on exam with conjunctivitis. You treat with polytrim and Augmentin and refer to ENT for evaluation with plan to f/u in office prn.
 - ▶ Moderate complexity (level 4)
 - ▶ Acute, complicated problem (recurrent AOM)
 - ▶ Minimal Data (level 3)
 - ▶ Mom as historian
 - ▶ Moderate Risk (level 4)
- ▶ 99214
- ▶ Referrals do not count as data and do not elevate risk

Example Vignette #7A

- ▶ 13 year old with fever, fatigue, cough, red eyes, body aches presents with mom who reports most history as patient does not remember when he first complained of symptoms and does not know which OTC meds mom has tried. Has used Mucinex DM and motrin with no significant improvement. Friends at school sick with unknown illness. Flu A/B negative. COVID positive. Reviewed supportive care and isolation guidelines. Follow prn.
 - ▶ Low complexity (level 3)
 - ▶ Moderate Data (level 4)
 - ▶ Mom as historian, flu, COVID
 - ▶ Low Risk (level 3)
- ▶ 99213

Example Vignette #7B

- ▶ 13 year old with fever, fatigue, cough, red eyes, body aches presents with mom who reports most history as patient does not remember when he first complained of symptoms and does not know which OTC meds mom has tried. Has used Mucinex DM and motrin with no significant improvement. Friends at school sick with unknown illness. Flu A/B negative. COVID positive. Reviewed supportive care and isolation guidelines. Mom requested trial of bromfed at bedtime to help sleep with cough. Reviewed use. Follow prn.
- ▶ Low complexity (level 3)
- ▶ Moderate Data (level 4)
 - ▶ Mom as historian, flu, COVID
- ▶ Moderate Risk (level 4)
- ▶ 99214

Example Vignette #8A

- ▶ 15 year old with history of anxiety presenting for follow-up. She reports she has been improving on her Lexapro 10mg but having some days of breakthrough anxiety related to school functions. She has just started working with a therapist. Discussed treatment plan and mom and patient desired to continue current dose of medication and see if anxiety improves with addition of therapy.
- ▶ Moderate Problem (Level 4)
- ▶ Limited Data (Level 3)
- ▶ Moderate Risk (Level 4)
- ▶ 99214

Example Vignette #8B

- ▶ 13 year old presents for follow-up of ADHD. School performance and behavior at home are excellent per parents with no side effects reported by patient. He also has history of insomnia but this has been improved with use of melatonin or magnesium nightly for sleep. Refills of stimulant provided.
- ▶ Moderate Data (Level 4) = 2 stable problems
- ▶ Limited Data (Level 3)
- ▶ Moderate Risk (Level 4)
- ▶ 99214

Next Steps

- ▶ Practice!
- ▶ Internal audit
 - ▶ Peer review redacted charts
 - ▶ Recommendations for added documentation that would support higher MDM level
- ▶ External audit with certified coding specialist
- ▶ Examine progress at scheduled provider meetings to ensure all providers are practicing guidelines cohesively

Questions?



Helpful Resources

- ▶ AAP Coding newsletters
- ▶ PedialinkAAP Coding Webinars
- ▶ AAP MDM Coding Chart:
https://downloads.aap.org/AAP/PDF/Coding_MDM_Grid_BD.pdf
- ▶ AMA CPT Changes: <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>