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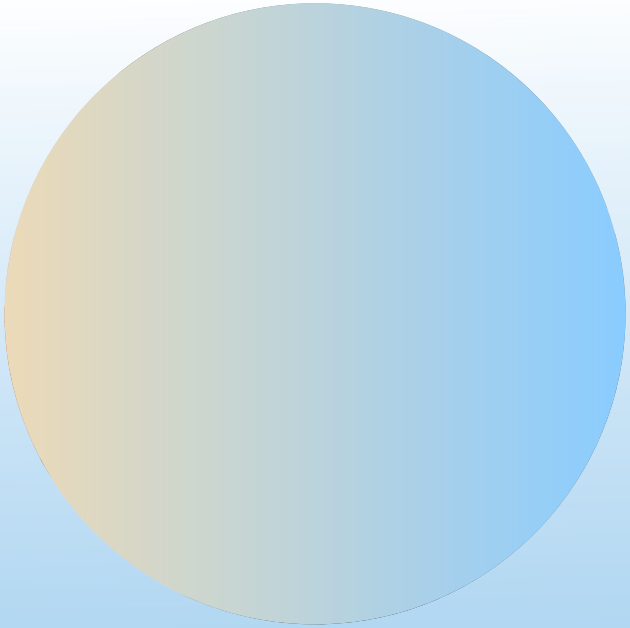
Topics Covered

- Discussion about down-coding by insurance of E/M services and a review of E/M criteria.
- A review of Medicaid overpayments and the actions practices need to follow for compliance.
- Review of MUE edits for injections and all services.
- A review of G2211 for complexity documentation and coding.
- A review of the Medicare updates for 2026
  - Status of telehealth – review of supervision requirements.
  - Continuation of chronic illness process.
- Q&A



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E/M Coding review and discussion of down-coding and take back actions by insurance/CMS

As we review the specific CPT E/M codes and their requirements for Documentation… and challenge down-coding and denial of care our documentation must be complete – let's review this process…

Pertinent History and/or Exam

+

Medical Decision Making

Or

Total Time of Day in Clinical Activities

POS	Description of location of care	Considerations in CPT coding
02/10	Telehealth – general or patient's home	Coded with office- based CPT codes (99202-99205) or the POS where the patient is (NH) – modifier GT or 95 may not be required
11	Office	CPT codes 99202-99205 paid at full PFS rate.
12	Patient's home	CPT codes 99341, 99342, 99344, 99345 and 99347-99350
13/14	Assisted Living/ Group Home	CPT codes 99341, 99342, 99344, 99345 and 99347-99350
19/22	Off Campus Hospital – Out Pt On Campus Hospital – Out Pt or Observation	CPT codes 9202-99205 with payment differential for facility location or Observation services coded with 99221-99233 Critical care 99291-99292 based on circumstance.
21	In patient Hospital	CPT codes 99221-99223, DC codes/Critical care 99291-99292 CPT for Admit and discharge same day 99234-99236
23	Hospital emergency	CPT for ER providers 99281 -99285, other providers may use out-patient/office E/M codes 99201-99205; critical care codes.
31/32	Skilled Nursing Facility/IMC	CPT codes 99304-99310
33	Custodial Care	CPT codes 99341, 99342, 99344, 99345 and 99347-99350
24	Ambulatory Surgical Care	99202-99215 and related E/M codes -payment differential for

Decision Tree for New or Established Office/Outpatient E/M Coding

Received any professional service from physician or other qualified health care professional in the same group or same specialty within the past 3 years ?

Yes, Same exact Specialty or subspecialty

No

Yes, established patient

No – New patient

New Patient

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The levels of Medical decision making across all coding no mater what the location:

- There are four types of medical decision making:

  1) **STRAIGHTFORWARD**; 2) **LOW**; 3) **MODERATE** AND 4) **HIGH**

- The 99211 and 99281 the level of MDM does not apply as these are services provided by support staff under the direct supervision of a physician or other qualified health care professional
- **Medical Decision Making is defined by 3 elements**:
  - The number and complexity of the problems addressed during the encounter
  - The amount and/or complexity of data to be reviewed and analyzed for the care of the patient
  - The risk of complications and/or morbidity or mortality of patient management

The visit – in any place of service requires…

- The components of the documentation should always clearly identify the issues pertinent to the care. This process reduces unnecessary documentation of "elements" just for documentation sake – such as review of systems not pertinent to care or exam elements that are not relevant to the treatment needs and plan.
- The place of service and nature of the service must be documented.
- The focus is on the problems addressed.
- Amount and/or complexity of the data to be reviewed and analyzed specific to the encounter/visit.
- Risk of complications and/or morbidity or mortality of patient management specifically stated within the note.

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E/M care starts with the “problem” and history and exam

- The document should identify the problem(s) you are assessment, treating and providing care for throughout the note and within the Assessment and plan process
- The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of a CPT code.

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The E/M problem levels that should be reflected with the Assessment and Plan Narrative:

- Minimal problem (nursing level of care) – nurse type visit
- Self limited or minor problem – something that will go away without your intervention
- Stable, chronic illness (something at least 12 months in duration) (asthma, DM, COPD, Depression)
- Acute, uncomplicated illness/injury (strep throat, sprained ankle)
- Acute uncomplicated illness or injury requiring hospital inpatient or observation level of care
- Stable, acute illness (resolving gastritis)
- Chronic illness w/exacerbation, progression, side effects (poorly controlled..)
- Undiagnosed new problem with uncertain diagnoses – that can cause major medical issues
- Acute illness with systemic symptoms (COVID, RSV)
- Acute complicated injury
- Chronic illness w/severe exacerbation, progression or side effects of treatment elevating care plan
- Acute or chronic illness or injury that poses threat to life or body function

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Importance of reflection of problem status – and the specific ICD 10 code(2) to support this!

- How the status of the condition is reflected within the note will support the level of acuity for care. testing, work up and intervention identified as needed and planned.
- Is the issue acute or chronic; mild, moderate or severe, life-threatening or incidental.
- What are the concerns for functional status, long term impact and treatment

- In the assessment the note should show:
  - Primary problem today – asthma, in poor control with exposure to 2nd hand smoke.
  - Secondary issues – obesity with BMI of 33 referred to dietician.
  - Social determinant of health – housing insecurity (Z codes).
  - Co-morbid issue impacting treatment and addressed in the plan.

The Grid for level of level of problems is … based on documentation.

Level of MDM	
Straight-forward	Minimal - 1 self limited or minor problem
Low	• 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute uncomplicated illness/injury requiring hospital inpatient or observation level of care
Moderate	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment or • 2 or more stable chronic illnesses or • 1 Undiagnosed new problem with uncertain prognoses or • 1 acute illness with systemic symptoms or • 1 acute complicated injury
High	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment with consideration of inpatient care or • 1 acute or chronic illness or injury that poses a threat to life or bodily function

Grid for Data Levels – based on documentation.

Level of MDM	Data Components
Straight-forward	Minimal or none
Low – Limited at least one of these 2 category	Category 1: Tests and documents Any combination of 2 from the following: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*
Moderate Moderate Must meet the requirement of at least 1 of the 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*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)

Data Level for high Level

Level of MDM	Data Components
High Extensive must meet requirements of at least 2 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*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) **or** Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); Or Category 3: Discussion of management or test interpretation Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

How is risk defined in these changes

- Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event/problem 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. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purpose of MDM, level of risk is based upon 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. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter. Risk defined for a condition may be similar to treatment risk but is part of this overall process.

How we document risk in the assessment: (no assumptions)

- New onset of…. and is considered a chronic condition in need of regular monitoring by lab, visits and (any other monitoring factors).
- Acute condition should resolve with treatment and what that treatment is with risks.
- Acute condition should resolve with treatment but complicating factors of….
- Chronic condition (in good control, marginal control) managed by…. With monitoring needs (time frame and frequency of visits or care plan).
- Poorly controlled condition requiring higher level of care and intervention (referral to specialist, hospital, etc.).
- Chronic conditions in an at- risk patient due to (SDOH, chronic issues, history, life or functional threats).
- What are the long and short -term functional issues and risks?

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Documentation of prescription medication management… within the assessment and plan process.

Medication	Status/How to use	Risk/Benefits	Monitoring Needs
Hydrochlorothiazide – used for HTN	Taken once a day, usually in the AM	Helps to lower blood pressure, side effects may include frequent urination, diarrhea, headaches	Monitoring home and office BP with lab work
Levothyroxine used for underactive thyroid	Taken once a day in the morning 30 minutes prior to eating	This medication reduces the symptoms of underactive thyroid. The side effect may include heat intolerance and rarely weight issues, headache	Lab monitoring for correct dosing
Eliquis – used to manage atrial fibrillation and blood clots. This is considered a high-risk medication.	Take daily at the same time with or without food. Monitor for signs of bleeding	This medication helps to manage blood clotting with some risk of bleeding, and side effects may include nausea, and fatigue. Close monitoring is required.	Lab monitoring of chronic issues related to renal, liver and bleeding, but frequency is based on clinical needs determined by your provider.

Risk by level of care –documented in the assessment.

Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straight-forward	N/A
Low	Minimal risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ■Prescription drug management ■Decision regarding minor surgery with identified patient or procedure risk factors ■Decision regarding elective major surgery without identified patient or procedure risk factors ■Diagnosis or treatment significantly limited by social determinants of health
High	High risk of morbidity from additional diagnostic testing or treatment Examples only: ■Drug therapy requiring intensive monitoring for toxicity ■Decision regarding elective major surgery with identified patient or procedure risk factors ■Decision regarding emergency major surgery ■Decision regarding hospitalization or escalation of hospital-level care ■Decision not to resuscitate or to de-escalate care because of poor prognosis

Components related to risk – documented in the A/P.

- 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.
- Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- Surgery (minor or major, elective, emergency, procedure or patient risk):
  - Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.
  - Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
  - Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.
- For medication is the medication high risk, black box warning, higher level of testing/monitoring.

When Time is the Driver of Care and the coding of prolonged care services

<u>This must be specifically documented in the medical record</u>

Time as the factor in coding of care

- When time is the driver of care for services this time will includes face to face and non face to face work:
  - Pre-visit preparing to see and care for the patient – review of records, calls, reports
  - Time face-to-face with the patient
  - Time throughout the day of the visit involved in direct patient care (orders, discussion, review, etc.)
  - Unique documentation (ISP, care plans, goals/objectives, etc.)
  - Specific time range for each level of care will be identified
  - Additional coding will be available for prolonged care that can only be added to the highest level of E/M codes – 99205 for new patients and 99215 for established patients in the office, 99223 or 99233 in the hospital, 99306 or 99310 in a SNF, IMC or the 99345 or 99350 for Home/AL or Custodial services.
- Remember if one uses an add on code that is time based (therapy 90833 example) one cannot base the E/M service on time per CPT coding rules).

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Determining the correct Prolonged care code to use…

None face to face on a non patient care day	99358 Prolonged evaluation and management service before and/or after direct patient care; first hour (at least 31 minutes) ✚ 99359 each additional 30 minutes (List separately in addition to code for prolonged service)	Not to be confused with telephone or telehealth services
Additional time on a date of care outpatient/office or patient home/residence setting	+99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service) **G2212 Prolonged care coding for Medicare/Medicare Advantage plans – time begins at 89 min for New Patients and 69 minutes for Established Patients**	Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483 (Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416) (Do not report 99417 for any time unit less than 15 minutes)
Additional time on a date of care for a facility-based service	+ 99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service) **G0316/G0317/G0318**	(Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310); (Do not report 99418 on the same date of service as 90833, 90836, 90838, 99358, 99359)(Do not report 99418 for any time unit less than 15 minutes)

Table for Medicare G codes for prolonged care codes based on place of service and CPT code family

Code	CPT Code family and time thresholds for CMS for first unit. Each additional unit is coded at the next 15- minute time frame.
G2212	For use with office/outpatient codes 99205/99215 and the first unit for 99205 begins at 89 minutes for 99215 at 69 minutes Cognitive impairment assessment CPT 99483 at 110 minutes
G0316	For use with hospital setting codes 99223/ 99233 or 99236 (admit/DC same day). Time for the first unit for 99223 begins at 90 minutes/ for 99233 at 65 minutes/ for 99236 at 110 minutes.
G0317	For use with nursing facility (SNF/IMC) codes 99306 or 99310. For 99306 first unit at 95 minutes/ for 99310 first unit at 85 minutes.
G0318	For use in a home or residential setting when billing 99345 or 99350. For 99345 first unit at 140 minute/ 99350 at 110

If a service is coded at a higher level…

- Always code the diagnoses at the most specific level and code all diagnoses that are pertinent to care.
- If the service is time based and the level of care does not really “make sense” for the diagnoses, then identify the specific time on line 19 of the claim form: Total time in clinical activities --- minutes.
- If the take back, denial or down coding is supported by your then appeal but make sure that your documentation clearly identifies the elements required for the MDM process or the time based process.
- Time must be specific to the care – not a time range!
- Verify your coding and POS is correct

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Identifying the Sequence of Coding critical to surviving an audit or down coding…

Primary ICD 10 Code(s)	Secondary Informational Codes	Social Determinants of Health or History
• The primary reason for care, symptom or condition(s) managed/ treated and planned for – there can be more than one primary.	• Issues be pertinent elements for care – a complicating diagnoses, history, specific element (BMI), or add on symptom	• The factors in economics, lifestyle, family history, genetic risk factors, education, support system that impact health and well-being

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Example 1 of this coding process – a 21 year old here for prevention…

Primary ICD 10 Code(s)	Secondary Informational Codes	Social Determinants of Health/History
• Prevention visit (Z00.01) • Immunizations (Z23) • Identified moderate persistent asthmatic with exacerbation (J45.31)	• ADHD, combined type (F90.2) • Exposed to smoke (Z77.22)	• Housing instability with prior homelessness (Z59.812) • Exposure to lead (Z77.011) • Recurrent pregnancy loss N96

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Example 2 of this coding process – Adult for follow up care with multiple issues

Primary ICD 10 Code(s)	Secondary Informational Codes	Social Determinants of Health/History
• HTN (I10) • Diabetes with vascular issues (E11.59) • HDL (E78.5) • GERD (K21.9) • Obesity due to diet (E66.09)	• BMI of 32 (Z68.32) • Personal history of self harm (suicidal 10 years ago) (Z91.51)	• Problems of living alone (Z60.2)

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When you are down- coded…

- Review your documentation and make sure that it meets the level coded.
- Review the diagnoses and make sure that ALL the diagnoses pertinent to care are in the Assessment and Plan and coded to the highest level of specificity.
- Challenge the down-coding of care as soon as possible and reflect in your challenge:
  - Acuity of the care
  - Complication, risk and relapse issues
  - Complexity of the plan

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Medical decision making is not…

- Listing diagnoses from the EMR.
- Documenting a complete PMH, SH, FH and a 10 review of systems.
- Documenting a complete exam.
- Cutting and pasting every test a patient has had.
- Cutting and pasting the last 10 years of labs.
- Listing a medication without details.
- Identifying a follow up without identifying A/P process.

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Medical Decision making is…

- Being specific on status of specific problems addressed
- Identifying pertinent history and exam that support the status and condition
- Identifying data that was reviewed specific to the care today or reflecting the orders for new tests/information
- Identifying the short and long term risks and prognosis of a condition with anticipated functional needs
- Identifying the treatment plan with specific risk and benefits of the testing, medication, and recovery considerations
- And having a return plan.

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Medicaid and Overpayments

When an overpayment is identified….

- Ohio Administrative Rule 5160-1-19 takes precedent
  - Submission of an electronic adjustment to ODM within 60 days of discovery – this must be through the web portal.
  - Medicaid will identify an offset on future payments or issue an invoice to the provider.
  - Ohio Medicaid does not accept any paper checks as of 2025
  - For office based providers (not institutions) the best method is through the Provider Portal
  - If all else fails 1-614-466-5080 is the last option.
  - Some practices have submitted some payments owed through the Ohio unpaid claims process – this is no longer recommended!

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The process through the Provider Portal

- You will need the claim number you are trying to adjust – and offset
- On the Screen – For Paid claims select the Adjustment option at the bottom – once this is selected a new claim is created and assigned an ICN #. When an adjustment shows Account Receivable amount this will be a deduction with this assigned ICN # on your next payment for claims.
- This process can also be used to obtain additional payment when the claim was underpaid from the fee schedule.
- If you are using the system to void a claim you must wait at least 7 days to re-submit a corrected claim or it will bounce out as a duplicate (I suggest waiting 9-10 days to make sure the system has cleared the incorrect claim)

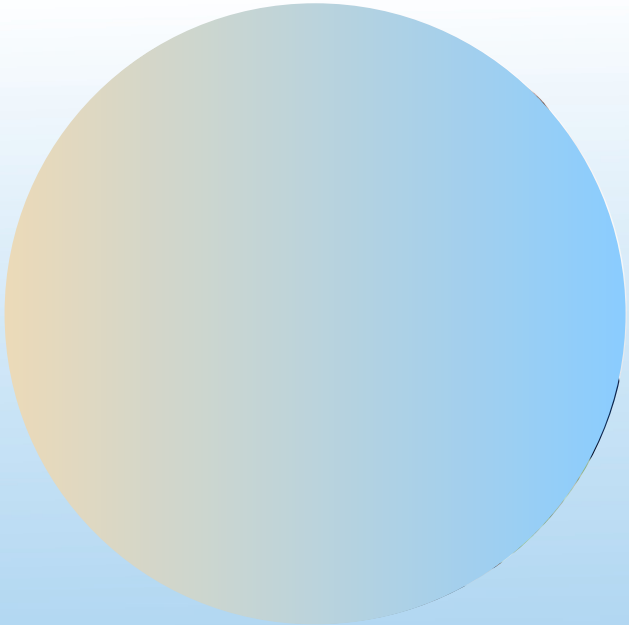
When the re-payment is over 3 years old…

- When the repayment to Ohio Medicaid is over 3 years old one needs to make the phone call and the Ohio Medicaid person will provide you with methods to refund this via a created credit process with an ICN # for the claim or claims involved.
- Refunds and repayments owed to Medicaid over 3 years will require a phone call.

Medically Unlikely Edits and Medicare

What is an MUE

- Medically Unlikely Edits (MUEs) are part of the National Correct Coding Initiative (NCCI) developed by CMS to reduce payment errors on Medicare claims. They are essentially billing limits, specifying the maximum number of times a specific procedure or service code can be reported for the same patient on the same day.
- Most common ones are multiple E/M per day; re-amputation or surgical removal of an already removed body part; drugs or biologics at the level that would cause harm; testing services that overlap other testing services; some therapeutic interventions.



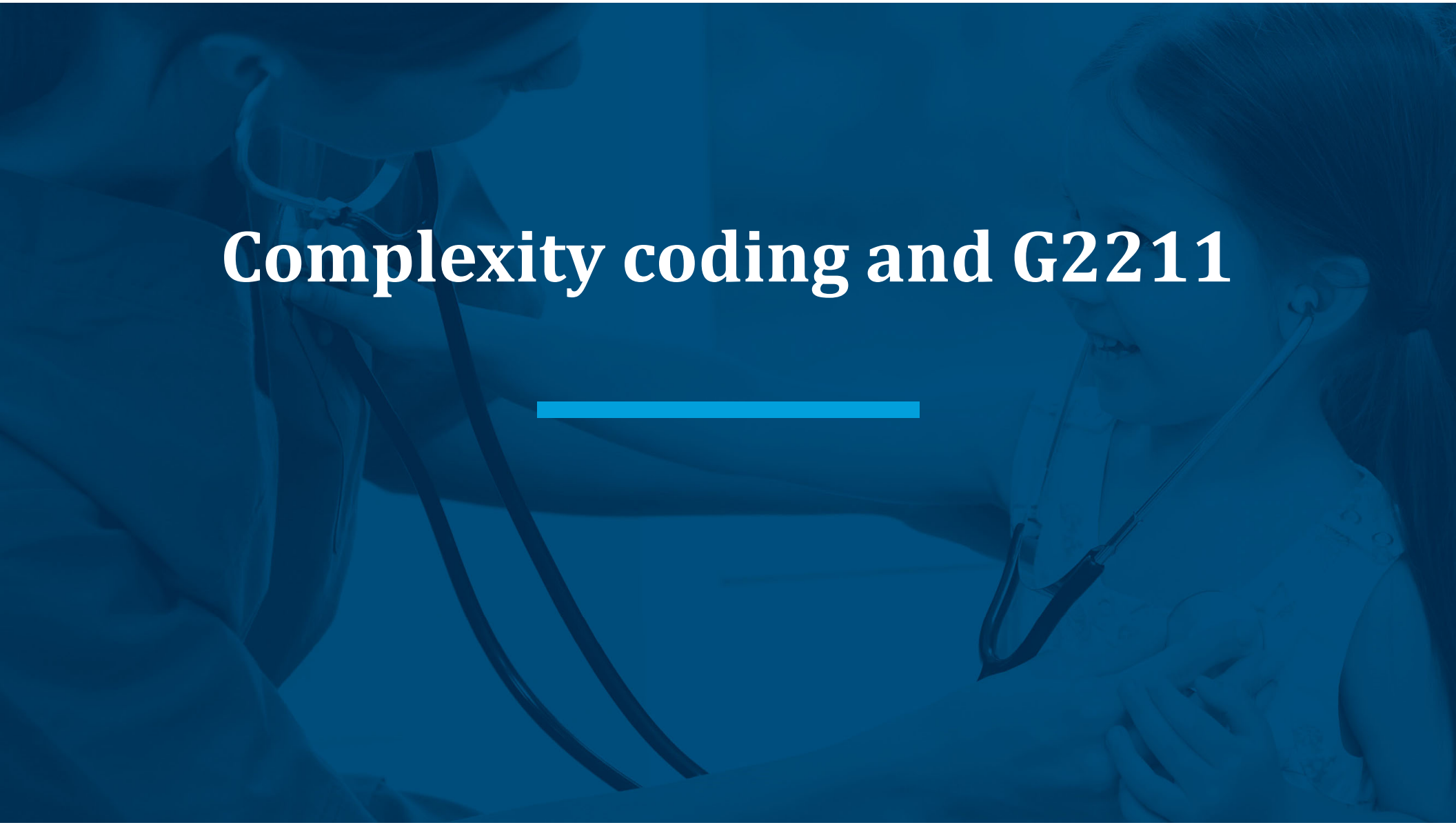
The process has been updated in 2025

- The CMS web site that holds all of this information is: https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits
- The information is updated quarterly.
- For drugs and biologics when a dose limit has been met for an injection (and not a joint but an IM) then the information for the rationale would be attached to the claim and identified in the comment section of the claim form.
  - If the biologic is for a joint injection – separating the amounts with the modifier RT and LT were injected.
  - If this is different lesions then the modifier -59 or XU is appended and a comment in the comment section.

Overlap with NCCI Policy

- In cases where the MUE and the NCCI policy overlap or are in conflict the NCCI policy normally takes precedence.
- The NCCI policy is updated yearly (January) unless there is a new code or new technology that requires refinement in the policy and then this are published for April, July and October implementation.
- These guidelines are used by CMS for traditional Medicare and the Medicare Advantage plans. Commercial insurance programs may or may not follow these same guidelines and the guidelines they follow would be part of their contract language and their online manuals. For commercial insurance plans January and July are common times for these shifts in policy.

Complexity coding and G2211



G2211 is an add on code to identify visit complexity ($15.17)

- 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)
- One cannot add this code when providing a procedure (example knee injection or biopsy) when using modifier -25.
- It can be used by all specialties that provide longitudinal services – not acute care or one-time services
- The nature of this service is continuity, consistency over time, longitudinal care.
- Expected use initially 38% of the patients, over time up to 54%

More on G2211

- E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. In response to comments, we also made further refinements to the HCPCS code descriptor to clarify that the code applies to a serious condition rather than any single condition.
- No specific documentation requirements identified but this would be supported within the assessment and plan process that reflects continuity, complexity and care needs in both the narrative and diagnoses (ICD 10 coding).

How this might be documented…

› Within the assessment and plan will reflect…

- The chronic or acute problem and how this complexity is impacting the management and care of the patient
- Requires that care is ongoing (not episodic) with this in mind there should be a follow up care plan
- Any secondary issues that are impacting this process should be identified and ICD 10 coded specific to the encounter and care – not just from the EMR problem list
- If others are involved in this complex process making sure they are referenced as part of the assessment and plan (home health, VNA, other providers, community agencies, etc.)

How we document this…

› Within your EMR identify within the assessment and plan:

› Patient care is ongoing for this problem and complex today because of the …

- Coordination of care beyond today with……
- Ordering, reviewing and follow up of issues (narrative) …..
- Secondary issues of….

› There needs to be a clear narrative within the A/P to support this – no assumptions by diagnoses!

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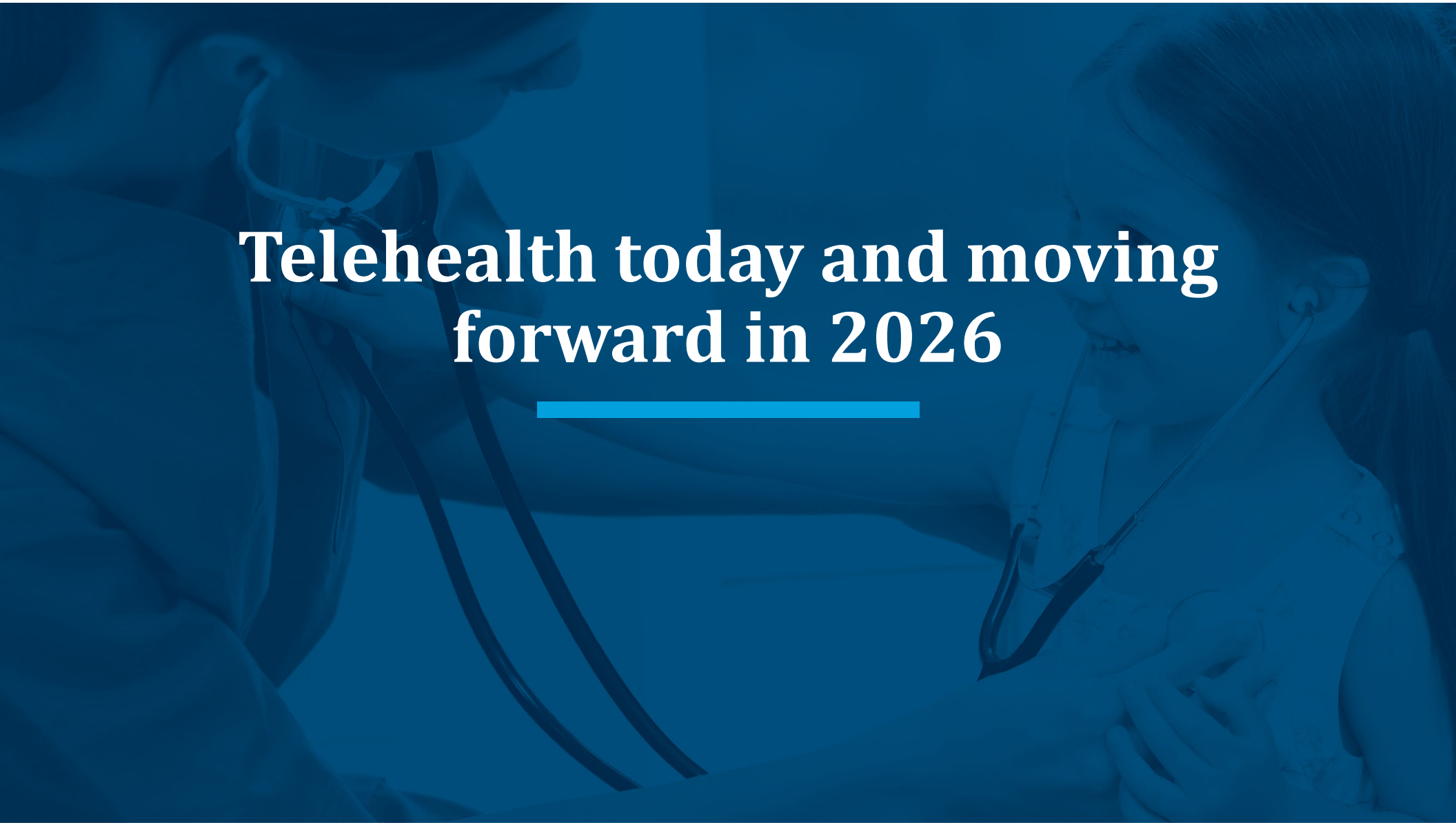

Telehealth today and moving forward in 2026

Status of telehealth as of today (8/6/2025)

- There is an extension through 9/30/2025 for telehealth to continue as during the PHE – with the E/M codes and POS 02/10 not the new CPT codes
- For BH/SUD this will continue through 12/31/2025.
- For medical care the telehealth rules may return to prior PHE on 9/30/2025 with:
  - Geographic limitations that will be permitted only for underserved areas, FQHC and RHC and practices that met the criteria prior to the pandemic.
- If you are a BH or SUD prescribing provider doing telehealth beyond 4/1/2025 you must see the patient face to face within 6 months of this time frame and at least yearly thereafter and more frequently based on medication
- These services can be self pay with the appropriate prior notification (signed) and coded with the new CPT codes to get the appropriate denial.

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In 2026..

- The proposed rule making has not been clear if telehealth will continue for the medical services as it is now through 9/30/2025.
- The process for supervision of incident to services will be permanently adopted to allow for this to be through real time audio video communication.
- BH and SUD services will continue to be paid on the PFS in 2026 and there are proposed additions for family therapy, group counseling for obesity to be added to the telehealth service list.
- Ongoing support in coding chronic disease management and coordination of care continues to be proposed.

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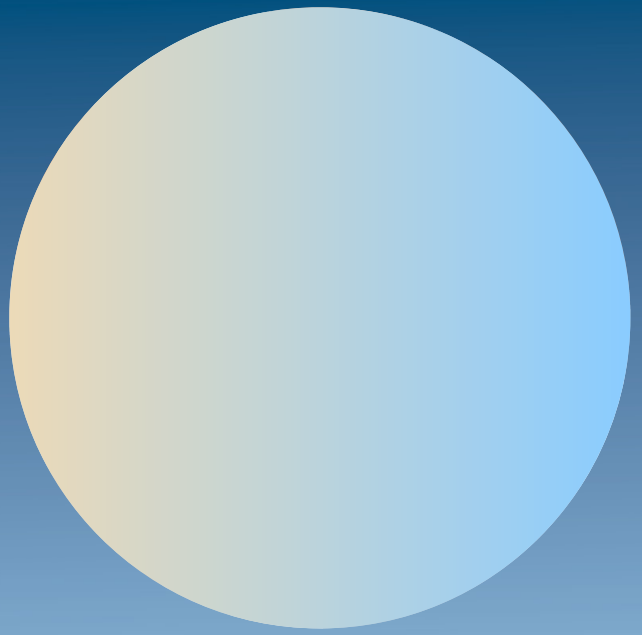
What are your questions…

- This concludes are formal part of the presentation and we now open the floor to your questions. As always feel free to email Diane Zucker at dezucker@sbcglobal.net for questions after the program. If you reach out to me make sure to identify you were a participant in today's OSMA program.



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