2026 Common issues with Documentation, Coding and our Health Care system

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Introduction

The OSMA is committed to ongoing support and education of physicians and staff. This program today is presented to support this mission. If there are questions after the program, please contact the presenter at dezucker@sbcglobal.net or OSMA at info@osma.org.

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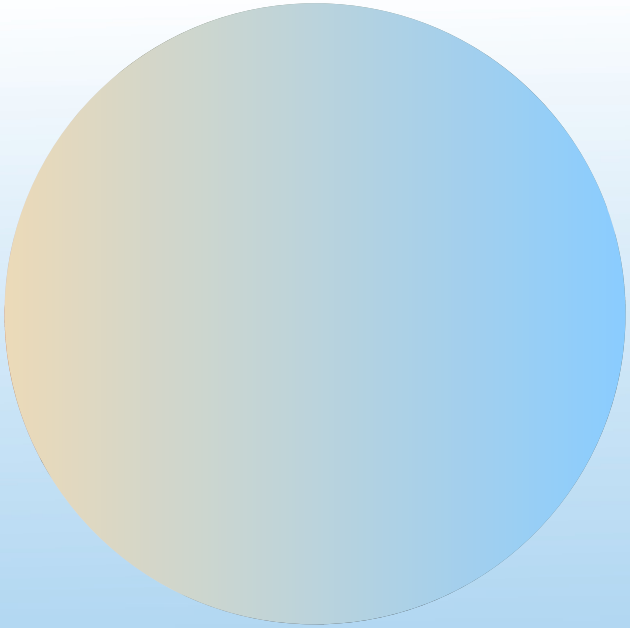
2026 Common issues with Documentation, Coding and our Health Care system

- A review of what is in the proposed 2027 rule released 7/14/2026.
- Review of telehealth rules and practical use.
- Discussion about claim denials and down coding.
- A quick discussion of Social Determinants of Health.
- Prevention and Annual Wellness for Medicare and commercial plans.
- Summary and send me your questions via email at dezucker@sbcglobal.net



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Where AI meets health care….

- The expansion of AI in health care impacts all providers from charting through CPT and ICD 10 coding of care; through prior authorization; claim processing and review and auditing.
- As AI Charting becomes more prevalent this raises issues for patient consent as well as clinical review of the final document and code recommendations prior to finalizing the document within the EMR.
- For practice management the AI chat bots impact how claims are processed, reviewed and possibly re-coded as well as prior authorization.
- And then there is the patient access to AI chat boxes, google searches with information and in some cases misinformation.
- Management of the AI within the practice is a new frontier that needs close review and creation of set policies and procedures for all involved in this process.

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2027 and the Proposed changes for the Fee schedule and related policies

Every July CMS identifies a proposed rule and payment rates, policy changes and other factors for the coming year with comments taken until 9/14 and the final rule published in November.

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The fee schedule…

- The rate setting for 2027 will have two conversion factors:
  - One for the qualifying alternative payment model – which relates to participation in a Quality program.
  - The second for providers who do not qualify for the alternative payment model.
- Another factor is that the raise in rates provided for 2025/2026 will be discontinued in 2027 leading to a potential decrease in payments with either conversion process for all providers of care.

Accounting for overlap of E/M and global periods

- The proposed rule would reduce payment for an E/M and procedure on the same date of care as a procedure by 50% of the second or lesser component of care.
- This change is for procedures with a 0, 10 or 90 day global time frame and would include injection procedures, biopsies as well as laceration repair, and major surgeries.
- The impact of this change would be for those services coded with modifier -25 (E/M and procedure on the same day) or modifier -57 (decision for surgery) and would be implemented across all specialties.
- Diagnostic services that do not have a global time frame attached (lab, EKG, spirometry) are not impacted with this change.

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Changes in complexity coding

- In 2025 Complexity coding is identified with specific diagnoses coding and the addition of the G2211 HCPCS code that has a specific price as part of the process.

- The proposal is to create a complexity modifier and have additional payment based on a 16% increase based on the specific E/M code identified.

- There is also a proposal to create a second modifier for providers involved with an ACO model with an increase in pay at 32% of the E/M services that are part of the Shared Shaving Program.

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Remote monitoring changes.

- The key change for remote monitoring it that this service can only be provided to established patients – not new patients. The patients can be established from a place of service other than an office (hospital, NH, ER, etc.)
- The rule also clarifies that this is for the practice use related to their own employees not contractors.
- There may be additional new codes for these services in 2027 (HCPCs codes) to provide better options for these services.
- Things that fall into this are remote BP monitoring, heart failure monitoring, diabetes care as well as some other cardiac monitoring.

Practice expense proposed changes.

- The initial RVU model that was imitated in 1992 is being reviewed with changes in how the practice expense will be calculated. The RVU model combines physician work, practice expense, and professional liability expenses.

- This process will review how practice expense is calculated along with adjustments related to facilities (hospitals, nursing homes, assisted living) as well as determining a better method to assess this.

A few other areas of focus for updates and changes

- The “Make America Healthy” program to redesign primary care payments around prevention as part of the payment model; the role of technology in this process and ACO with Shared Saving Model.
- Review global surgery payment model for services with 10 and 90 day time frames for pre and post operative time frames.
- Review policies and payments around patients with chronic illness and behavioral health issues. This also includes increasing payment for therapy services for BH and SUD care.
- Updating RHC and FQHC for diabetic self management services.
- Updating the clinical lab coding and billing requirements.
- Review and update drug pricing process for Medicare Part D.

A review of Advance Care Planning

- The ACP process is currently in place with two CPT codes based on total time in the activity by the provider or other qualified health care professional. CMS is looking to expand this process with HCPCs codes in 2027 for use by support/clinical staff in this role.
- CMS is proposing that the CPT codes 99497 and 99498 be used only by an MD, DO, APN, or PA not support staff under their direct supervision.
- There is also a clarification that this process can include symptom management and enhance the quality of life in palliative care and hospice care.

Updating the Medicare Eligibility Coverage Criteria

- CMS is looking to revise the eligibility criteria. This may impact naturalized citizens, aliens with identified work status in the US, aliens who have TIPs status for Haiti or Cuba or others who have legal residence in the US but may or may not have contributed to the Medicare trust fund.

- This process also looks at the eligibility of providers and organizations who provide care.

Telehealth

What is telehealth vs. telemedicine

- Telehealth is the delivery of health care and health-related services at a distance using digital communication technologies. It allows you to consult with a provider via video or phone, transmit health records, or use wearable monitors to track your health from home
  - This can include live (secure) two- way communication; remote monitoring; sending secure messaging (test results); and mobile health using smart phones, text messaging for non- verbal communication
- All of these methods needs to be secure and with the patient consent and authorization.

To telemedicine – where care is provided…

- The telehealth heath process can include
  - Office visits, psychotherapy, advance care planning, caregiver training, depression screens, diabetic education and support, medical nutrition, pulmonary and cardiac rehab services and speech therapy are some of the services provided via this method of care.
- CMS changed coverage to continue telehealth through 12/31/2027 for all providers of care.
- Some Medicare Advantage Coverage, Commercial Coverage and Medicaid plans may have different rules on coverage than traditional Medicare.

Things to consider with telehealth/telemedicine

- The decision about how and who to provide these services remains with the provider (MD, DO, APN, PA, counselor, etc.).
- The need to verify identify is critical for both management of PHI, confidentiality as well as coding, billing and reimbursement.
- Though CMS no longer requires a face to face with the patient (delayed until 12/31/2027) many practice require this for the care process, particularly if medications are part of the care plan.
- Documentation of this process is critical for care and compliance.

Documentation of telemedicine requires…

- Reflection of informed consent at each and every visit.
- Identification of the method (secure) of the telehealth/telemedicine encounter.
- Identification of where the patient is (and who is with them with access to PHI) and in 2026 the location of the provider.
- The patient must be in Ohio when you are providing care unless you are part of an interstate compact – and then this location may be subject to some insurance rules.
- Patients will be responsible for co-pays and co-insurance.
- For CMS and Medicaid phone calls can be coded with E/M CPT codes with modifier 93 but one should identify why the care was provided with this method and not audio/video.

Place of service for telemedicine varies..

- For commercial insurance and Medicare the POS for telehealth/ telemedicine is POS 02 or if the patient is at their home POS 11.
- Modifier -95 is used to identify telehealth/telemedicine care when POS 02 or 10 are used this is not required for traditional Medicare but may be for Medicare Advantage plans.
- For Medicaid this POS is the office (11) with modifier GT.
- When this is a telephone only type service the -93 modifier is appended for Medicare at this time – Medicaid allows only modifier GT.

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Phone calls for commercial plans…

- Depending on the commercial insurance plan they may continue to allow the traditional E/M CPT codes with modifier -93 or require the use of the audio only codes.
- The audio only CPT codes in the 98008-90815 may be required. These CPT codes require the same level of acuity as the traditional E/M CPT codes but are unique to telephone only care.
- Many commercial plans have limits on phone calls and may require face to face visits at least yearly, may only allow in certain circumstances and gatekeep this process. Know before you provide care what the coverage may be and inform the patient of their responsibility.

The Brief Synchronous Communication Technology Service (e.g., Virtual Check-In) still exists and can be used.

- 98016 Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

- The 98016 can be used for a phone only service when audio and video are not available (and documented)

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Denials and Down coding of care

What is a denial, miss paid claim or claim misadventure?

- A denial is a clearly rejected service with a specified reason – this may include non enrollment, service not supported by a diagnoses or a specifically non covered service.
  - This is usually related to patient enrollment, provider enrollment or diagnoses coding

- A miss paid claims are those that the payment does not meet the fee schedule or the payment process within the contract with the third party.

- A claim misadventure might be a claim that the insurance program is asking for documentation but never seems to respond or adjudicate the claim despite your efforts or information provided.

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When an insurance does not pay according to fee schedule

- Know your fee schedule and the timeframe it covers (year, month, etc.)
  - Know if there is a variation for multiple procedures including E/M with procedure pricing.
- Download the fee schedule and highlight your specific services and their fees – and if there are any payment variations based on policy
- Review the EOB's to make sure the approved amount matches – if there is a specific claim that does not, have copies of EOB's with the correct amount and provide this as an attachment (redacted of PHI).
  - The best way to argue incorrect payment is showing where correct payment has been made.
- If the third party follows CMS guidelines, then use the CMS fee schedule as proof that their denial is out of the overall agreement.
  - Make sure the fee schedule is supported for the correct year (many insurance programs are a year behind).

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Let's look at the key issues you deal with

- Enrollment issues – participation and in or out of network status and be clear with the patient of your status.
- Managed Care Plans have issues with their unique requirements for prior authorization, in network care or other specific rules within their policy manual. These are supposed to mirror Medicaid (and Medicare) requirements but some are allowed greater latitude than others.
- Denials based on the type of issues and coding and this time is shrinking to 30 days for many commercial plans.
- Down-coding based on an arbitrary algorithm of an insurance plan related to diagnoses coding.

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Take backs and down coding on level of care for MA and all insurance plans.

- This type of down coding and take back is across all insurance plans. The issue is the documentation. Remember the changes in 2023 require that the acuity of the case be clearly documented, as it is no longer about bullets for care but:
  - Status of the condition – review what supports high level complexity and any secondary issues are addressed and coded as appropriate.
  - The data reviewed documented in the A/P.
  - The risk of the condition and the plan
- For practices that need a review of this there are some resources available, and usually these situations are correct because the documentation is not specific and/or the diagnoses is not accurately reflected.

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Take backs have some limits in Ohio…

- In Ohio, insurance "take-backs" (retroactive claim adjustments and recoupments) are governed by **Ohio Revised Code (ORC) Section 3901.388 that changes 10/7/2026.**
- The updated law cuts the time limit and expands provider rights
- **One-Year Recoupment Window**: Health insurers now have **12 months** (reduced from the previous 24 months) from the original payment date to initiate the recovery of an overpayment.
- **Finality**: After that 1-year mark, a claim payment is considered legally final and can no longer be adjusted by the insurer, unless there is proven fraud by the provider.
- **60-Day Appeal Period**: Providers now have **60 days** (doubled from the previous 30 days) to appeal an overpayment notice, and insurers are prohibited from charging appeal fees
- The only exception to this rule relates to specific fraud. These changes take effect October 7.2026.

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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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) limited to BH/SUD care in 2025
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 99202-99205 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 Center	99202-99215 and related E/M codes -payment differential for facility location

Decision Tree for New or Established Office/Outpatient E/M
Coding critical for correct coding of patient status!

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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Medical decision making is not…

- Listing diagnoses from the EMR without reflection in the documentation for the current encounter.
- Documenting a complete PMH, SH, FH and a 10 review of systems without being pertinent to the care provided and documentation of the medical necessity of this information.
- Documenting a complete exam – even when required for a referral, or administrative purpose.
- Cutting and pasting every test a patient has had.
- Cutting and pasting the last 10 years of labs.
- Listing a medication with details for rationale, response, risk/benefit and potential side effects.
- Identifying a follow up with details.

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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. Trending of testing should be identified as such.
- 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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Your action plan when denials or down coding happens..

- Review the documentation to make sure that….
  - It was completed and signed prior to billing.
  - All diagnoses codes are specific and mirror the medical record.
  - Verify any modifiers used.
  - Perform a formal appeal with all documents (including specific data used in the care provided).
  - Follow up regularly on claim denials and down coding – at least every other week until resolved.
  - Keep copies of your response and information in case you need to elevate this to a higher level

G0136 – Social Determinants of Health Assessment – coding and care

Social determinants of health is a critical part of health care in today's world.

- The SDoH may be the rationale for telehealth/telemedicine; frequency of visits; length of visits and/or additional referrals and coordination of care.

- When pertinent to care this should be a clear and separate part of the providers assessment and plan with specific ICD 10 codes identified with the impact on care and action items clearly documented.

- These issues may change over time or be a constant – but when coded must be reflected within the note process.

SDOH G0136 – can be billed by all specialties

G0136 Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months." The risk assessment is in relation to the patient's social risk factors that influence the diagnosis and treatment of medical conditions. This is a service that can be performed in outpatient settings, with the exception of discharge visits.

They believe this is **not a screening** but an assessment, and it is to be used when the practitioner believes that the patient has unmet SDOH needs that are interfering with the diagnosis or treatment of an illness. CMS is also allowing G0316 to be furnished on the same day as 90791 (psychiatric diagnostic evaluation) and with Health Behavior Assessment and Intervention codes 96156, 96158, 96159,96164, 96165, 96167, and 96168.

G0136 may also be done in conjunction with the AWV for primary care.

G0136 SDOH assessment coding..

- G0136 may be billed with discharge visits from the hospital. However, it is CMS's expectation that for patients with unmet needs, there will be follow up visits either as outpatients or a transitional care management visit to try and meet those needs.
- G0136 will be subject to cost sharing, (co-pay and deductible) unless it is done at an Annual Wellness Visit (AWV).
- The SDoH needs that are identified during the assessment be documented in the medical record and actively encouraging Z-code reporting to improve data collection by CMS. If there are no findings then the Z13.89 would be used.
- The tool(s) used would document the assessment of finances, family and community support, education, physical activity, substance use, mental health concerns, and disabilities.
- **This service must now include physical activity and nutritional assessment.**

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Sample SDOH questionnaire links….

- **PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences):** One of the most common tools, especially in community health centers. It covers 12 core domains ranging from income and housing to incarceration and intimate partner safety
- **AHC-HRSN (Accountable Health Communities Health-Related Social Needs):** Developed by CMS, this tool features a core 10-item screening questionnaire that assesses five key domains: housing instability, food insecurity, utility needs, transportation difficulties, and interpersonal safety.
- **AAFP Social Needs Screening Tool:** Created by the American Academy of Family Physicians, this tool asks targeted questions about housing, food, utilities, and transportation to gauge immediate needs
- **WE CARE:** A pediatric-focused screening tool (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education) that identifies family social risks during well-child visits

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How do we document this assessment:

- The specific screening tool(s) should be within your EMR process with the identified screening process if there are no issues identified then the Z13.89 code would be appended for the tools used.

- If there are positive features identified within the screening each one addressed, referred for or coordinated with an entity would be coded with the appropriate Z code as part of the assessment and plan process.

The social determinants of health often define the care provided and may be part of the Quality Process

Neighborhood & Environment
- Z59.00 Homelessness
- Z58.81 Basic services unavailable

Social & Community
- Z60.2 Problems living alone
- Z60.0 Problems if adjustment to life cycle

Economic Stability
- Z59.6 Low Income
- Z59.41 Food insecurity
- Z59.86 Financial insecurity

Health Care
- Z55.6 Problems Related to Health Literacy

Education
- Z55.0 Illiteracy and low level literacy

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Putting This all Together in the note and claim form…

Primary ICD 10 Code(s)	Secondary Informational Codes	Social Determinants of Health/History
• Identify the code or codes for the treatment today and the status, risk for treatment and overall plan needs	• There may or may not be issues in this area but if they are be specific	• The identified psycho-socials issues that impact patient care

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Diagnoses coding in general

- Diagnoses coding is key to many of the changes, issues and concerns in 2025, with that in mind let's review some important facts…
  - Avoid unspecified ICD 10 codes when possible as this is why you are often down coded or services are denied.
  - If one is not sure of a diagnoses use the symptom code in section R.
  - Make sure you are following the rank order rules and process.
  - Never code an uncomplicated or unspecified ICD 10 when also coding a more specific code – know the inclusion and exclusion rules in ICD10.
  - Symptoms that are a manifestation of a condition are not routinely coded with that disease (asthma with exacerbation – not asthma and SOB)
- The link for ICD 10 data dot com: https://www.icd10data.com/
- The link for the CDC complete file: https:/cdc.gov/nchs/icd/icd-10/index.html/

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Annual Wellness and Prevention Services

A few words about prevention

- Coding is age specific (and new or established). For Medicare IPPE or AWE
- Must include PMH, SH and FH and risk factor review
- Must have age- appropriate exam
- 99459 Pelvic Exam (carrier specific)
- G0101 For Medicare
- Include pertinent screening based on age and issues
- Must include anticipatory guidance for chronic issues, risk facts and age specific issues
- If an E/M is coded in addition this must be supported with problem status and plan.

Prevention coding

- Z00.00 Encounter for general adult medical examination without abnormal findings
- Z00.01 Encounter for general adult medical exam with abnormal findings
- Screening codes (a few..)
- Z13.31 Screening for depression
- Z13.6 Screening for CV disorders – and new cardiac risk assessment in the abscess of a cardiac diagnoses.
- Z13.1 Screening for diabetes
- Z11.1 Screening for TB

9938 -- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient 5th digit based on age

9939 -- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 5th digit based on age

What is anticipatory guidance?

- Discussion of prevention measures by age and sex that would support a healthier lifestyle – diet, weight, exercise, taking medications, sleep hygiene, helmets, safe sex
- Inclusion of age- appropriate screening and follow up care needs
- Risk issues – fall, SUD, abuse, hearing or vision loss, cognitive status
- Discussion about DNR
- Emergency plans based on chronic issues (asthma plan)
- Refill and status of chronic conditions – this can only be coded as an additional 9921x if there are issues, changes in care plan and a significant status issue
- A template that covers all of these issues without specificity does not work!

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Screening Counseling codes that are critical for Quality Care coding

- The diagnoses for these prevention services would be the identified prevention Z codes or in some cases specific BMI and weight, pre- diabetes or other identified risk factors
- 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
  - 99409 – greater than 30 minutes

99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402 - 30 minutes
99403 - 45 minutes
99404 – 60 minutes
99411 - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412 – Group 60 minutes
Some of these things can be provided by specialists

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Example the coding process – patient 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) • 9938x/9939x by age	• ADHD, combined type (F90.2) • Exposed to smoke (Z77.22) • Screening and /or Counseling codes as pertinent to care.	• Housing instability with prior homelessness (Z59.812) • Exposure to lead (Z77.011) • Recurrent pregnancy loss N96

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Annual Wellness – CMS tool for decision tree

› https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html

› This tool identifies the specific services CMS and the Medicare Advantage plans cover (and many commercial plans follow this as well based on patient age); the timing of the service; specific ICD 10 codes for coverage as well as the specific CPT/HCPCS codes.

Specific codes to know and understand….

- G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment - Plus Global EKG coding with the G0403
- G0438 Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
- G0439 Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

- G0442 Annual Alcohol misuse screening 5-15 minutes
- G0443 Brief face to face BH counseling for ETOH misuse
- G0444 Annual depression screening 5-15 minutes
- G0445 Semiannual high intensity BH counseling to prevent STI
- G0446 Annual face to face intensive BH therapy for cardiovascular disease 15 minutes
- G0447 Face to face BH counseling for obesity, 15 minutes

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Our time has come to an end…

Key take aways from this program…

- Keeping informed about changes is critical for all settings.
- Identify key issues and educate all levels of staff on areas that impact their work, the care you provide and long term practice needs.
- Diagnoses coding is the key to many good things and bad things.
- Even with the new AI generated documentation and coding support it all comes down to what humans do with the information and their diligence with knowing the rules, the process and the patient.

This concludes the presentation

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