EVALUATION AND MANAGEMENT (E/M) 2025

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WHAT HAS CHANGED FOR 2025

Congress extended pandemic-era flexibilities for telehealth services through 03/31/2025

AMA provided new Telemedicine Service codes (CPT 98000-98015)

We will NOT be implementing them at this time

CMS issued a FAQ on usage of G2211 Visit Complexity

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WHAT HAS NOT CHANGED

- The need to document the Medical Necessity of the service
  - "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted". *CMS Internet Only Manual 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1*
- Attending Statement (when working with a resident/fellow)-the medical record must demonstrate:
  - The teaching physician performed or was physically present during the key or critical portions of the service when performed by a resident/fellow; and
  - The participation of the teaching physician in the management of the patient
- When working with an APP each must document their involvement and time
- We are not billing Consultation Codes (99241-99245, 99251-99255)

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NOTES SHOULD CONTAIN:

- Date of service
- Chief Complaint: a concise statement describing the reason for the encounter
- History of Present Illness, Any updates from last time patient was seen*
- Physical Exam*
- Medical Decision Making
- Time statement—if billing based on time spent

*No longer key elements in choosing the E/M level, but are still included in the descriptors for codes 99202-99205, 99212-99215, 99221-99223, 99231-99233 and 99234-99236

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G2211 – OFFICE AND OUTPATIENT E/M VISIT COMPLEXITY ADD-ON CODE

- Add-on code to an E/M levels 99202-99205 or 99211-99215
- Can be used regardless of specialty
- The **MOST** important information used to determine billing of the add-on code is the relationship between the practitioner and the patient
- Captures the inherent complexity of the visit that's derived from the longitudinal nature of the practitioner and patient relationship
- An additional payment to better account for the additional resources of visits associated with:
  - Serving as the continuing focal point for all of the patients' health care service needs *(like a primary care practitioner)*
  - Ongoing medical care related to a patient's single, serious condition, or complex condition *(like sickle cell disease or HIV)*
- Should NOT bill when relationship with patient is discrete, routine, or time-limited in nature
- Cannot bill when the modifier -25 is added to the E/M level,
  - i.e. when a procedure is billed by the same provider on the same date as an E/M visit
  - *New exceptions for 2025: AWV, vaccine administration or Medicare Part B preventative service furnished in the office or outpatient setting

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G2211 – CONTINUED

- While no specific documentation is required, notes should support a medically reasonable and necessary visit
- CMS medical reviewers could use these items to serve as supporting documentation for billing G2211:
  - Information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnosis
  - The practitioner's assessment and plan for the visit
  - Other service codes billed
- Suggestions your documentation should include to support billing G2211 (not all items needed):
  - Intent for on-going, continued care/care management beyond routine acute care
  - Coordinating care
  - Recommendations/Follow-up plan (when, where, who with)
  - Importance of following instructions/plan of care
  - Patient education provided
  - Shared decision making/commitment towards goals
- In Epic, can be added under the Level of Service screen under "Additional E/M Codes"
  - See "Add LOS Speed Button" job aide in PowerDMS

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SPLIT/SHARED VISITS

- "Physician(s) and other qualified health care professional(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service." *
- The billing provider can be either the physician or the APP, depending on who performed the *substantive portion* of the visit.
- The substantive portion of a visit is defined as:
  - More than half of the *total* time spent performing the visit
    - Distinct time personally spent by the physician and the APP on the date of the encounter is summed to define total time
    - When two or more providers jointly meet with or discuss a patient, only the time of one individual is counted (a minute can only be counted once)
  - The substantive part of the medical decision making (MDM)
    - Performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes the responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management.*
- *Exception*: Critical Care visits (99291-99292) can only be more than half of the total time
- Add the FS modifier to the level of service billed
- Does NOT apply to the non-facility/office setting (i.e. Highlands Ranch clinic)

*2025 AMA CPT book, pg 5

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SPLIT/SHARED VISIT DOCUMENTATION

- Documentation must identify both the physician and the APP who performed the visit.
- The substantive portion determines the billing provider
  - Both providers need to individually document their participation in the visit.
  - **Must clearly state who did what** portions of the visit or how much time each provider spent.
  - *"Although we continue to believe there can be instances where MDM is not easily attributed to a single physician or NPP when the work is shared, we expect that whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support billing of the visit." **
  - The billing provider must sign and date the documentation.
- Off Site Hospital Locations-(not on Epic)
  - Only submit **one charge per patient**—the same patient should not be on the MD's charge sheet and the APP's charge sheet
  - Include the **initials of both providers** **and** **circle the billing provider** (the provider who performed the substantive portion of the visit)

* 2024 CMS Final Rule, page 475

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SPLIT/SHARED VISIT TIME

- Distinct time personally spent by the physician and the APP on the date of the encounter is summed to define total time
- When two or more providers jointly meet with or discuss a patient, only the time of one individual is counted (a minute can only be counted once)
- *Examples:*
  - *20 min (APP time) +5 min (MD/APP overlap time) + 10 min (MD time)= 35 total minutes, billing under the APP*
  - *10 min (APP time) + 5 min (MD/APP overlap time) + 10 min (MD time) = 25 total minutes, billing under the MD*
- *Both providers should document their distinct time and involvement*
  - *APP: On this date, I personally spent a total of 20 minutes, excluding separately billable procedures, preparing to see the patient, examining the patient …. I spent an additional 5 minutes with Dr. X discussing the plan with the patient.*
  - *MD: On this date, I personally spent 10 minutes, excluding separately billable procedures, examining the patient, discussing the assessment and plan, and documenting the encounter.*

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00081589

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SPLIT/SHARED VISIT EXAMPLES

- MD statement billed based on time:
  - "I saw and examined the patient with Jane Smith, NP and agree with her note and plan. The QHP spent 10 minutes with the patient first. Then I personally spent an additional 20 minutes (excluding time spent on separately billable procedures) preparing to see the patient, examining the patient, ….."
- MD statement billed based on MDM:
  - Recommend using the attending note section so an auditor can tell who did what
  - Make or approve the management plan and take responsibility for the plan---i.e. documents the assessment and plan

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SAMPLE STATEMENT SPLIT / SHARED

Both providers need to document their patient's, and the billing goes to the provider who documents the substantive portion.

Billing goes to the MD:

APP:

On this date, I saw the patient jointly with Dr. X. I evaluated the patient, discussed with Dr. X, documented the history and exam.

MD:

On this date, I saw and evaluated the patient with APP Y. I agree with the history and exam as documented by APP Y. I developed the substantial portion of the assessment and plan and answered the patient's questions.

Billing goes to the APP (because who did the substantive portion of MDM is unknown):

APP:

On this date, I saw the patient jointly with Dr. X. I evaluated the patient, discussed with Dr. X., documented the history, exam, assessment and plan.

MD:

On this date, I saw and evaluated the patient with APP Y. I agree with the history and exam. I discussed the assessment and plan with the patient, answering their questions fully.

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SPLIT / SHARED TIME STATEMENT EXAMPLES

Both providers need to document their involvement and their distinct time (if using time).

When using time, the substantive portion is greater than 50% of the total time.

10 (APP time) +5 (MD/ APP overlap time) + 10 (APP time)= 25 total minutes, billing under the APP, 99214

APP: *On this date, I spent a total of 20 minutes, excluding procedures, preparing to see the patient, examining the patient and documenting the encounter.*

MD: *On this date, I spent a total of 5 minutes meeting with the patient and discussing the assessment and plan with APP Y.*

10 (APP time) + 5 (MD/APP overlap time) + 10 (MD time) = 25 total minutes, billing under the MD, 99214

APP: *On this date, I spent a total of 10 minutes, excluding procedures, preparing to see the patient, examining the patient and documenting the encounter.*

MD: *On this date, I spent a total of 15 minutes meeting with the patient and discussing the assessment and plan with APP Y.*

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SELECTING THE LEVEL BASED ON TIME

- Time included MUST be on the date of the face-to-face encounter
- Includes face-to-face and non face-to-face time
- Time spent by an attending physician and/or APP
  - Not time spent by clinical staff or fellows
- Not solely based on counseling and/or coordinating care
- Documentation of Start and Stop times are not required
- Documenting must include stating explicitly what was done during time

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WHAT COUNTS AS TOTAL TIME DONE ON THE DAY OF THE ENCOUNTER

- Total time includes the following activities, when performed:
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate exam and/or evaluation
  - Ordering medications, tests or procedures
  - Counseling and educating the patient/family/caregiver
  - Referring and communicating with other healthcare professionals (when not separately reported)
  - Documenting clinical information in the health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

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PROLONGED SERVICE W/WO DIRECT PATIENT CONTACT ON THE DATE OF AN E/M SERVICE

- **99417 outpatient:** "Prolonged outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or QHCP, with or without direct patient contact" Use in conjunction with 99205 or 99215
- **99418 inpatient or observation:** "Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or QHCP, with or without direct patient contact" Use in conjunction with 99223, 99233 or 99236

  - Only used when the service has been selected using time
  - Only used after the maximum time required to report the highest level service has been exceeded by 15 minutes
  - Has to be in 15 minute increments—rounding rules do not apply
  - Start and stop times are not required

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OUTPATIENT TOTAL TIME ON DAY OF ENCOUNTER

NEW	MINUTES Met or exceeded		ESTABLISHED	MINUTES Met or exceeded
NO BILL	Less than 15		99211	Less than 10
99202	15		99212	10
99203	30		99213	20
99204	45		99214	30
99205	60		99215	40
99205, 99417	89		99215, 99417	69
99205, 99417 X 2	104		99215, 99417 X 2	84
99205, 99417 X 3	119		99215, 99417 X 3	99

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INPATIENT / OBS TOTAL TIME ON DAY OF ENCOUNTER

Initial	Minutes (met or exceeded)		Subsequent	Minutes (met or exceeded)
99221	40		99231	25
99222	55		99232	35
99223	75		99233	50
99223, 99418	90		99233, 99418	65
99223, 99418 x 2	105		99233, 99418 x 2	80
99223, 99418 x 3	120		99233, 99418 x 3	95

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OTHER TIME BASED INPATIENT/OBSERVATION BILLING

Discharge Day Management	Minutes
99238	<=30
99239	>30

Inpt/OBS Admit & D/C on Same Date	Minutes met or exceed
99234	45
99235	70
99236	85+

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CRITICAL CARE TIMES

CMS (Medicare, Medicare Advantage Plans, Medicaid)

Critical Care	Minutes
Use E/M Code	<30
99291	30-74
99291, 99292	104-133
99291, 99292 x 2	134-163
99291, 99292 x 3	164-193

Non-Governmental Payers

Critical Care	Minutes
Use E/M Code	<30
99291	30-74
99291, 99292	75-104
99291, 99292 x 2	105-134
99291, 99292 x 3	135-164

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SAMPLE TIME STATEMENT

Your time statement should include:

- the time spent was only on the date of the encounter
- the activities you performed during that time
- the total minutes you *personally spent*, excluding any time spent on separately billable procedures

On this date, I personally spent __ minutes (excluding procedures) preparing to see the patient, evaluating the patient and documenting the encounter.

Can also add anything else done to show increased time such as counseling and educating care givers, referring and communicating with other healthcare providers

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VISITS INVOLVING RESIDENTS/FELLOWS

- Current CMS policy: For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Resident's/Fellow's time does NOT count.
  - Teaching that is general and not patient specific should not be counted toward total time
- Document an attending note in addition to your time
- Examples of attending notes with residents/fellows:
  - *"I saw the patient with the fellow and agree with their findings and plan. I personally spent 20 minutes with the patient discussing……"*
  - *"I saw and evaluated the patient. I reviewed the fellow's note and agree except (specify) I personally spent 25 minutes with the patient and resident performing….."*

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SELECTING THE LEVEL BASED ON MEDICAL DECISION MAKING (MDM)

- Documentation of a medically appropriate history and exam are still expected
  - The extent of history and exam is not an element in selecting the level of service
- MDM is defined by the following elements:
  - Number and Complexity of Problems Addressed at the encounter
  - Amount and/or Complexity of Data to be Reviewed and Analyzed
  - Risk of Complications and/or Morbidity or Mortality of Patient Management
- Two of the three elements for a particular level of MDM must be met or exceeded to select that level
- Definitions for the elements of MDM can be found at:
  - https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
    - Pages 14-19

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MEDICAL DECISION MAKING			
Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed (*Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below)	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from add'l diagnostic testing or treatment
Low	Low 2 or more self-limited or minor problems 1 stable, chronic illness 1 acute, uncomplicated illness or injury 1 stable, acute illness 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of 2 categories) Category 1: Tests and documents--any combo of 2 from the following: 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* Category 2: Assessment requiring independent historian	Low risk of morbidity from additional diagnostic testing or treatment *OTC drugs, minor surgery w/o risk factors, PT/OT, IV fluids w/o additives*
Moderate	Moderate 1 or more chronic illnesses with exacerbation, progression or side effects of treatment 2 or more stable, chronic illnesses 1 undiagnosed new problem with uncertain prognosis 1 acute illness with systemic symptoms 1 acute, complicated injury	Moderate (Must meet the requirements of at least 1 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) Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician/ other QHCP (not separately reported) Category 3: Discussion of management or test interpretation Discussion of management or test interpretatopm with external physician/ other QHCP/appropriate source (not separately reported)	Moderate risk of morbidity from addl diagnostic testing or tx -Prescription drug management -Decision regarding minor surgery with identified patinet or procedure risk factors -Decision regarding elective major surgery without identified patient procedure risk factors -Diagnosis or treatment significantly limited by social determinats of health
High	High 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the 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) Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician/ other QHCP (not separately reported) Category 3: Discussion of management or test interpretation	High risk or morbidity from.... -Drug therapy requiring intensive monitoring for toxicity -Decision re elective major surg w/ identified pt or proc risk factors -Decision RE: emergeny major surgery -Decision re hospitalization or escalation of hospital-level care -Decision not to resuscitate or to de-escalate care d/t poor prognosis -Parenteral controlled substances

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NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED AT THE ENCOUNTER

- Multiple new or established conditions may be addressed at an encounter and may affect MDM
  - Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition
- Comorbidities/underlying diseases are not counted unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed/analyzed or the risk of complications/morbidity/mortality of patient management
- Beware of copied and pasted elements—conditions need to be addressed that day

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AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED

- Divided into three categories:
  - Tests, documents, orders or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
    - e.g., two radiology orders = 2 points, two lab orders = 2 pts, panels = 1 pt
  - Independent interpretation of tests-performed by another physician/other QHCP
    - not a test ordered or performed by the provider
    - independent interpretation of spirometry or PFT's do not count
  - Discussion of management or test interpretation with external physician, APP, or appropriate source
    - can include non-healthcare professionals involved in the management of the patient (e.g., lawyer, case manager)
    - does not include discussion with family or informal caregivers
- Data copied/placed in the documentation does not count as reviewed unless the data is commented on

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AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED-CON'T

- Tests ordered are presumed to be analyzed when the results are reported. When tests are ordered during an encounter, they are counted as ordered and reviewed in that encounter.
  - Each new result of a recurring order, may be counted in the encounter in which it is analyzed.
- Only tests that are ordered outside of the encounter can be counted as reviewed at the next encounter. You cannot count the same test as ordered in the first encounter and then the same test reviewed in the next encounter.
- Tests that do not require separate interpretation (where they are results only) do not count toward independent interpretation, but can be counted as ordered / reviewed for selecting MDM level.

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RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT

- Based on the consequences of the problem(s) addressed at the encounter when appropriately treated
- Four levels:
  - Minimal
  - Low
  - Moderate
    - e.g., prescription drug management or diagnosis or treatment significantly limited by social determinants of health
  - High
    - e.g., drug therapy requiring intensive monitoring for toxicity

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RISK OF COMPLICATION AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT- PRESCRIPTION DRUG MANAGEMENT

- Is not just writing a prescription or documenting "continue current meds"
  - e.g., use a Z-pak, continue Rituxan
- Is documentation of a new prescription, a change to an existing prescription or a refill of a current medication
  - e.g., increase Prednisone to 10 mg per day for 5 days

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RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT-DRUG THERAPY REQUIRING INTENSIVE MONITORING FOR TOXICITY

- A therapeutic agent that has the potential to cause serious morbidity or death
- Monitoring is performed for assessment of these adverse effects and not primarily to assess therapeutic efficacy
- The monitoring should be that which is generally accepted practice for the agent, but may be patient specific
- May be long or short term, but not less than quarterly done by lab test, physiologic test or imaging
  - Monitoring done by history or examination does not qualify
- Example of monitoring that qualifies:
  - Monitoring for cytopenia in the use of an antineoplastic agent between dose cycles
- Example of monitoring that does not qualify:
  - Monitoring glucose levels during insulin therapy for therapeutic effect, UNLESS severe hypoglycemia is a current, significant concern

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RISK OF COMPLICATION AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT- PARENTERAL CONTROLLED SUBSTANCES

- Drugs that are not given orally, but are injected (either subq, IM or with infusions) that are controlled
  - Examples of (not a complete list): Amphetamine, Anabolic steroids, Barbital, Clonazepam, Codeine, Diazepam, Fentanyl, Hydrocodone, Lorazepam, Marijuana, Methamphetamine, Morphine, Oxycodone, Pentobarbital, Peyote, Testosterone, Tramadol

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RISK OF COMPLICATION AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT- SOCIAL DETERMINANTS OF HEALTH

- Newly added example of moderate risk
- Defined as economic and social conditions that influence the health of people and communities

Examples include:

Food or housing insecurity

Social connection and Isolation

Economic stability

Education

Transportation

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Code	Level of MDM (Based on 2 out of 3 elements of MDM)	# & Complexity of Problems Addressed at the encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Pt Mngmt
99211	N/A	N/A	N/A	N/A
99202 99212	**Straightforward**	**Minimal** ·**1** self limited or minor problem	**Minimal or None**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	**Low**	**Low** ·**2** or more self limited or minor problems OR ·**1** stable chronic or stable acute illness OR ·**1** acute uncomplicated illness or injury OR - 1 acute, uncomplicated illness or injury requiring hospital inpatient or obs level of care	**Limited** *(Must meet the requirements of at least 1 of 2 categories)* **Category 1: Test and documents** ·**Any combo of 2 from the following:** ·Review of prior external notes* ·Review result of each unique test* ·Ordering of each unique test* **OR** **Category 2: Assessment requiring an independent historian(s)**	**Low risk of morbidity from additional diagnostic testing or treatment**

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Code	Level of MDM (Based on 2 out of 3 elements of MDM)	# & Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Pt Mngmt
99204 99214	**Moderate**	**Moderate** ·**1** or more chronic illnesses w/ exacerbation, progression or side effects of treatment OR ·**2** or more stable, chronic illnesses OR ·**1** undiagnosed new problem with uncertain prognosis OR ·**1** acute illness with systemic symptoms OR ·**1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** **·Any combo of 3 from the following:** ·Review of prior external notes* ·Review results of each unique test* ·Ordering of each unique test* ·Assessment requiring independent historian **OR** **Category 2: Independent interpretation of tests** ·Independent interp of test performed by another physician or other QHP **OR** **Category 3: Discussion of mngmt or test interpretation** ·Discussion of mngmt or test interp w/ external physician or other QHP	**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 pt or procedure risk factors ·Diagnosis or treatment significantly limited by social determinants of health

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Code	Level of MDM (Based on 2 out of 3 elements of MDM)	# & Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Pt Mngmt
99205 99215	**High**	**High** ·**1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment OR ·**1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** **·Any combo of 3 from the following:** ·Review of prior external notes* ·Review result of each unique test* ·Ordering of each unique test* ·Assessment requiring independent historian **OR** **Category 2: Independent interpretation of tests** ·Independent interp of test performed by another physician or other QHP **OR** **Category 3: Discussion of mngmt or test interpretation** ·Discussion of mngmt or test interp w/ external physician or other QHP	**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 pt or procedure risk factors ·Decision regarding emergency major surgery ·Decision regarding hospitalization or escalation of hospital level of care ·Decision not to resuscitate or de-escalate care due to poor prognosis -Parenteral controlled substances

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Code	Level of MDM (Based on 2 out of 3 elements of MDM)	# & Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Pt Mngmt
99221 99231	**Straightforward** **Or** **Low**	**Minimal Or Low** ·**1** self limited or minor problem ·**2** or more self limited or minor problems OR ·**1** stable chronic or stable acute illness OR ·**1** acute, uncomplicated illness or injury OR - **1** acute, uncomplicated illness or injury requiring hospital inpatient or obs level of care	**Minimal, None Or Limited** *(Must meet the requirements of at least 1 of 2 categories)* **Category 1: Test and documents** ·**Any combo of 2 from the following:** ·Review of prior external notes* ·Review result of each unique test* ·Ordering of each unique test* **OR** **Category 2: Assessment requiring an independent historian(s)**	**Minimal or Low risk of morbidity from additional diagnostic testing or treatment**

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Code	Level of MDM (Based on 2 out of 3 elements of MDM)	# & Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Pt Mngmt
99222 99232	**Moderate**	**Moderate** ·**1** or more chronic illnesses w/ exacerbation, progression or side effects of treatment OR ·**2** or more stable chronic illnesses OR ·**1** undiagnosed new problem with uncertain prognosis OR ·**1** acute illness with systemic symptoms OR ·**1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ·**Any combo of 3 from the following:** ·Review of prior external notes* ·Review results of each unique test* ·Ordering of each unique test* ·Assessment requiring independent historian **OR** **Category 2: Independent interpretation of tests** ·Independent interp of test performed by another physician or other QHP **OR** **Category 3: Discussion of mngmt or test interpretation** ·Discussion of mngmt or test interp w/ external physician or other QHP	**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 pt or procedure risk factors ·Diagnosis or treatment significantly limited by social determinants of health

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Code	Level of MDM (Based on 2 out of 3 elements of MDM)	# & Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Pt Mngmt
99223 99233	**High**	**High** ·**1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment OR ·**1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ·**Any combo of 3 from the following:** ·Review of prior external notes* ·Review result of each unique test* ·Ordering of each unique test* ·Assessment requiring independent historian **OR** **Category 2: Independent interpretation of tests** ·Independent interp of test performed by another physician or other QHP **OR** **Category 3: Discussion of mngmt or test interpretation** ·Discussion of mngmt or test interp w/ external physician or other QHP	**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 pt or procedure risk factors ·Decision regarding emergency major surgery ·Decision regarding hospitalization or escalation of hospital level of care ·Decision not to resuscitate or de-escalate care due to poor prognosis -Parenteral controlled substances

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RESOURCES:

- CY 2024 Medicare Physician Fee Schedule Final Rule
- CY 2025 Medicare Physician Fee Schedule Final Rule
- CPT® Evaluation and Management (E/M) Code and Guideline Changes
  - https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
- AMA CPT® Evaluation and Management webpage
  - https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- AMA CPT Changes 2024: An Insider's View
- CMS 100-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners Section 30.6, 100.1.1, 100.1.4
- Novitas FAQs: E/M
  - https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004994
- Novitas split shared 2024:
  - https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00081589
- MLN matters MM 13473 for G2211:
  - https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

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QUESTIONS?

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