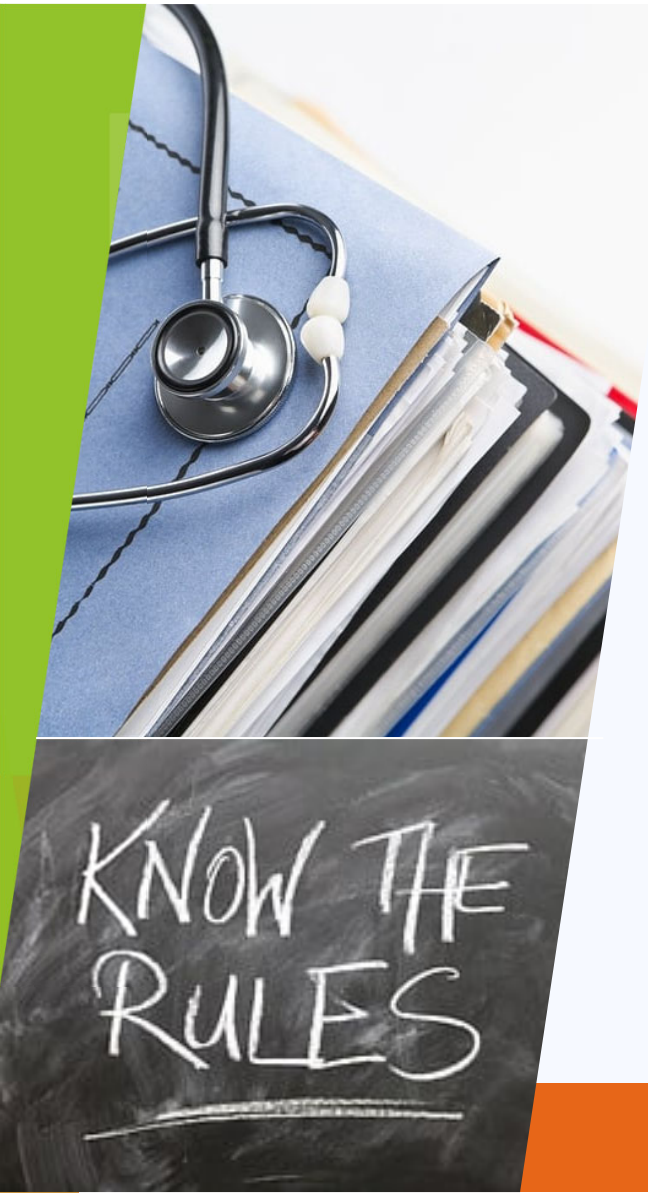

What to expect in 2025

Presented by:

- **Medical Practice Consultants, Inc.**
- **Renee M. Brown, ACS-EM, CHA, President**

Contact Information:

- **Renee@mpcinc.biz**
- **405/848-8558 (Work Number)**
- **405/990-3005 (Cell phone)**

WHAT WE NEED TO KNOW

AGENDA

PLICO MAY 2025

Federal & Commercial Insurance Plans follow the rules in this presentation.

1. Telemedicine/Telehealth Updates
2. Things that could possibly put you on the ‘radar’
3. Things to know in 2025
4. Refresher on Evaluation & Management Documentation

CHANGES IN THE CPT CODE BOOK FOR 2025

TELEMEDICINE!!

Big changes New telemedicine codes

TELEMEDICINE

1. “Telemedicine services are synchronous, real-time, interactive encounters between a physician or other QHP and a patient utilizing either combined audio-video or audio-only telecommunication.”

2. “Telemedicine services are used in lieu of an in-person service when medically appropriate to address the care of the patient and when the patient and/or family/caregiver agree to this format.”

*From the AMA 2025 CPT Code Book

TELEMEDICINE

1. "Code distribution selection for telemedicine services is based on either the level of medical decision making (MDM) or the total time for E/M services performed on the date of the encounter, as defined for each service." Just like your normal E/M office codes.

2. "Telemedicine services are not used to report telecommunications related to a previous encounter. They may be used for follow-up of a previous encounter when a follow-up E/M services is required in, the same manner as in-person E/M services are used."

*From the AMA 2025 CPT Code Book

TELEMEDICINE CODES

Katy Young, CHA
MPC, Inc.
kyoung@mpcinc.biz

NEW CODES FOR TELEMEDICINE

1. Synchronous Audio/Visual Codes (98000-98007)
2. Synchronous Audio Only (98008-98015)
3. Online Digital E/M Services (99421-99423)
4. Codes 98000-98015, the level of services is selected based on **MDM** or total **time** on the date of the encounter.

SYNCHRONOUS AUDIO/VISUAL

1. New and Established patient codes.
2. Choose MDM or time for level.

Code	New or Established	MDM	Time in Min, must meet or exceed
98000	New	Straightforward	15
98001	New	Low	30
98002	New	Moderate	45
98003	New	High	60
98004	Established	Straightforward	10
98005	Established	Low	20
98006	Established	Moderate	30
98007	Established	High	40

SYNCHRONOUS AUDIO-ONLY

1. New and Established patient codes. Previously only established patients.
2. Replace codes 99441-99443 (telephone codes.)
3. Choose MDM or time for level.
4. They **REQUIRE** more than 10 minutes of "medical discussion".

Code	New or Established	MDM	Time in Min, must meet or exceed
98008	New	Straightforward	15
98009	New	Low	30
98010	New	Moderate	45
98011	New	High	60
98012	Established	Straightforward	10
98013	Established	Low	20
98014	Established	Moderate	30
98015	Established	High	40

CODE 98016

1. Established patients only.
2. “The service is patient-initiated and intended to evaluate whether a more extensive visit type is required.”
3. Video technology is not required.
4. Described services for established patients with 5 –10 minutes of medical discussion.

NEW CODES FOR TELEMEDICINE CENTERS FOR MEDICARE AND MEDICAID SERVICES **(CMS)**

1. CMS does **NOT** recognize new codes 98000-98015, at this point.
2. CMS does recognize CPT code 98016, in lieu of HCPCS code G2012.
3. Use modifier 93 for audio only, use modifier 95 for all other telemedicine.
4. Use Place of Service: 10 when patient is in their own home, and 02 when originating site is anywhere other than the patient's home.

*Congress extended the American Relief Act until September 30, 2025, with the signing of CR on March 15, 2025

NEW CODES FOR TELEMEDICINE COMMERCIAL PAYERS

1. Must contact local representatives for commercial payer plans to discern how to handle telehealth E/M.

2. BCBS of OK: Uses new codes 98000-98016

3. United Healthcare: Uses new codes 98000-98016

4. All other insurances need to be verified, including Medicare Advantage plans.

ONLINE DIGITAL E/M

1. Codes 99421-99423
2. Not new in 2025, for the code and code rules
3. What is new: “If within seven days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the physician or other QHP work devoted to the online digital E/M service is incorporated into the separately reported E/M service.”

*From the AMA 2025 CPT Code Book

‘RED FLAGS’ FOR TELEMEDICINE

-Document, document, document!!!

-Do not bill a Telemedicine service until you have reviewed all the CPT codes that are comprehensive to the CPT code performed. Ensure you have the appropriate code for the patient’s insurance.

-Pay close attention to the medical record documentation. You may be audited on more than one service.

THINGS THAT MIGHT PUT YOU ON THE 'RADAR'

1. Code distribution – CMS has begun evaluated the number of times a physician bills for the same code (as example 99213 to often per day, quarter, yearly, etc.)
2. Refund requirements could be required.
3. Modifier 59: used to identify procedures/services that are not normally reported together but are appropriate under the circumstances.
4. Failure to follow new rules for telehealth.
5. Medicare Credit Balance.

THINGS THAT MIGHT PUT YOU ON THE 'RADAR'

- CERT report shows 'Lab tests' score poorly. Lab orders could be taken back upon post-payment review.
  - Most due to documentation errors.
  - Highest identified were "Lab tests—bacterial cultures", 100% insufficient documentation.
  - "Lab tests—others", 87.7% insufficient documentation.

*Part B News, Decision Health, Vol 39, Issue 15, April 7, 2025

THINGS THAT MIGHT PUT YOU ON THE 'RADAR'

- New 2025 Rule for HIPAA: focusing on strengthening cybersecurity and enhancing patient rights.
  - Multi-Factor Authentication (MFA)
  - Enhanced Encryption
  - Strengthened Risk Analysis
  - Improved Incident Response
  - Elimination of "Addressable" Standards

THINGS TO KNOW IN 2025

1. Congress passed the CR on March 15, 2025, extending the American Relief Act until Sept 30, 2025. Under this new resolution, the physician fee schedule remained bleak. No increase and even a 2.8% cut.
2. First quarter 2025 saw an update for HCPCS with nearly 150 changes. Effective April 1, 83 added codes, 37 discontinued codes and 28 revised codes. Verify before billing!

*Part B News, Decision Health, Vol 39, Issue 13, March 24, 2025 and Issue 16, April 14, 2025

PLICO 2025

Refresher for E/M codes (Evaluation & Management codes)

The rules in 2024 for E/M codes (99202-99215) have basically not changed in 2025.
Evaluation and Management (E/M) codes
Clarification for documentation on E/M codes

PLICO 2025

- To determine which level of E/M codes can be billed, the organization has two options:
- **Time** (Must be medically necessary for the patient's condition)

Or

- **MDM** (Must have a medically appropriate history and/or exam. It is always up to the discretion of the providers to determine what is medically appropriate for their patient.)

DESCRIPTIONS OF SOME COMMON E/M CODES:

99211 – NOT EVALUATED
Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (NO Time)

99212 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making with (Straight Forward Complexity) (10 Min must be met or exceeded.)

99213 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. (Low Complexity) (20 Min must be met or exceeded.)

DESCRIPTIONS OF SOME COMMON E/M CODES:

99214 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. (Moderate Complexity) (30 Min must be met or exceeded.)

99215 -
Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. (High Complexity) (40 Min must be met or exceeded.)

MDM AMA Guidelines
History and/or Examination

1. Office or other outpatient services include a medically appropriate history and/or physical examination, when performed.

2. 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.

3. 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.

4. The extent of history and physical examination is not an element in selection of office or other outpatient services.

More on Considering History and Exam

- "The 2024 revisions to E/M coding criteria represent a significant shift in how healthcare providers document and bill their services."
- -By focusing on medical decision-making and total time spent on patient care, these changes aim to simplify the coding process while accurately reflecting the complexity of patient care in today's healthcare industry.
- -The primary goal of obtaining a medical history from the patient is to understand the state of health of the patient further and to determine within the history what is related to any acute complaints to direct you toward a diagnosis."

*From the AMA 2024 CPT Code Book

From the AMA CPT 2025 Code Book
Considering History and Exam

Code Shift: Importance of "Still documenting History and Exam"

"This shift acknowledges that the complexity of patient care is better reflected in the medical decision-making process rather than the traditional elements of history and physical examination."

*From the AMA 2025 CPT Code Book

MDM (Medical Decision Making) for all E/M codes

Medically Appropriate* History	Medically Appropriate* Exam	MDM (Medical Decision Making)
Reviewed, but not audited	Reviewed, but not audited	AUDITED! Drives the Code Selection

Medically appropriate means at the provider's discretion

Remember: Even though the history and exam won't count toward the E/M level, medical necessity dictates that providers will still have to perform a condition-appropriate history and/or exam for each patient they see. The 'counting of elements' or completing a template is no longer the focus.

Final Point To Consider

The provider must perform a history and/or exam that was appropriate in detail/content for the patient's presenting problem in their opinion.

Even with the relaxed history and exam criteria, it still comes down to standard of care when evaluating and treating patients. If what's documented doesn't meet that standard of care, the provider hasn't met the code criteria.

These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care.

Select the appropriate level of E/M services based on the following options:
1.) The level of the **MDM** as defined for each service, OR
2.) The use of billing by **time** for E/M.

Next are the requirements for MDM for choosing the E/M levels.

From the AMA CPT 2024 Code Book
Medical Decision Making

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

1. 1st Element: The number and complexity of problems that are addressed during the encounter.
2. 2nd Element: The amount and/or complexity of data to be reviewed and analyzed.
3. 3rd Element: The risk of complications and/or morbidity or mortality of patient management.

For each code level you MUST have met 2 of the 3 elements of MDM!!

1st element of MDM: Number & Complexity of Problems Addressed

Patient: Established					
CPT Code	**99211**	**99212**	**99213**	**99214**	**99215**
Medical Decision Making Level					
Level of MDM (Based on 2 out of 3 Elements of MDM)	**NA**	**SF**	**Low (L)**	**Moderate (M)**	**High (H)**
1st Element: Number & Complexity of Problems Addressed	NA	**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 NEW or -1 stable, acute illness; or -1 acute, uncomplicated illness or 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 prognosis; or ·1 acute illness with systemic symptoms; or ·1 acute complicated injury	**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
Created for services in 2024 by Medical Practice Consultants, Inc. (405) 848-8558 Information based on the AMA E/M 2024 Guidelines					

2nd element of MDM: Amount &/or Complexity of Data to be Reviewed and Analyzed

Patient: Established					
CPT Code	99211	99212	99213	99214	99215
Medical Decision Making Level					
Level of MDM (Based on 2 out of 3 Elements of MDM)	NA	SF	Low (L)	Moderate (M)	High (H)
2nd Element: 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.	NA	**Minimal or none**	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **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** (Must meet the requirements of at least 1 out 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)	**Extensive** (Must meet the requirements of at least 2 out 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)
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3rd element of MDM: Risk of Complications and/or Morbidity/Mortality of Patient Management

Patient: Established					
CPT Code	**99211**	**99212**	**99213**	**99214**	**99215**
Medical Decision Making Level					
Level of MDM (Based on 2 out of 3 Elements of MDM)	**NA**	**SF**	**Low (L)**	**Moderate (M)**	**High (H)**
3rd Element: Risk of Complications and/or Morbidity or Mortality of Patient Management	NA	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**Low risk of morbidity from additional diagnostic testing or treatment**	**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 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 ·Decision not to resuscitate or to de-escalate care because of poor prognosis NEW - Decision regarding parenteral controlled substances
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KEY ISSUES TO REMEMBER

1. Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
2. 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.
3. The volume of documentation should not be the primary influence upon which a specific level of service is billed.
4. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided to maintain an accurate medical record.
5. "Although the requirements around E/M documentation may have lessened or become more flexible, physicians should still carefully document the work that is being done and how to protect themselves from medical malpractice suits."
6. "The False Claims Act and other federal and state fraud and abuse laws remain in effect. Although the new E/M office visit coding guidelines allow greater flexibility, practices should continue to document appropriately and guard against inadvertent overbilling."

DISCLAIMER

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Presenter
Medical Practice Consultants, Inc.
Renee M. Brown, President
Office (405/848-8558)
Cell (405/990-3005)
renee@mpcinc.biz