2025 CODING UPDATE

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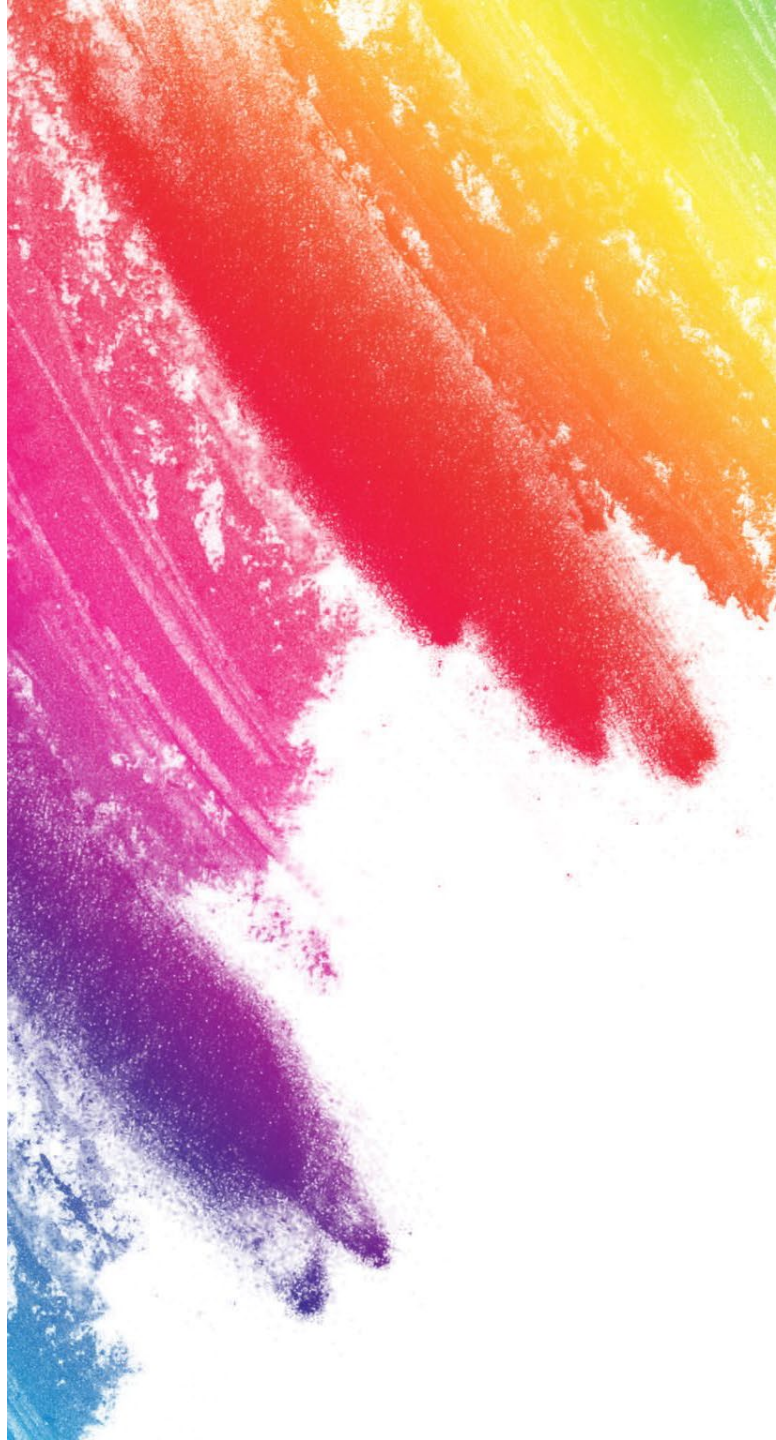

2025 CPT® Code Set Changes

420
Total
changes

11,321
Total codes
In 2025
code set

2025 CPT® Code Set Changes

	Added	Deleted	Revised	Code Count
Evaluation/Management	17	3	0	171
Anesthesia	0	0	0	276
Surgery (10000-69999)	33	13	5	5,880
Radiology	6	0	0	663
Pathology & Laboratory	14	6	5	1,674
Medicine	18	69	22	1,071
Category II Codes	0	0	0	565
Category III Codes	81	13	2	550
PLA Codes	101	8	4	471
Total	270	112	38	11,321

Evaluation and Management

- **Telemedicine Services**
  - **Telemedicine Audio-Video Evaluation and Management Services**
    - New Patient – 98000-98003
    - Established Patient – 98004-98007
  - **Telemedicine Audio-Only Evaluation and Management Services**
    - New Patient - 98008-98011
    - Established Patient – 98012-98015
    - Brief Synchronous Communication Technology Service (Virtual Check-In) - 98016

Telemedicine

- **Telemedicine Services Guidelines**
  - Codes describe real-time, interactive encounter between physician or other QHP and patient.
  - Based on level of MDM or total time for E/M performed on the date of the encounter.
  - Not used for routine telecommunications related to previous encounter (to communicate lab results).
  - May be used for follow-up of previous encounter when follow-up is required.

Telemedicine

►Telemedicine services are synchronous, real-time, interactive encounters between a physician or other qualified health care professional (QHP) and a patient utilizing either combined audio-video or audio-only telecommunication. Unless specifically stated in the code descriptor, level 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. 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 of care. Telemedicine services are not used to report routine telecommunications related to a previous encounter (eg, to communicate laboratory results). They may be used for follow-up of a previous encounter, when a follow-up E/M service is required, in the same manner as in-person E/M services are used. For example, telemedicine services may be used for a patient requiring re-assessment for response or complications related to the treatment plan of a previous visit. Except for 98016, these services do not require a specific time interval from the last in-person or telemedicine visit and may be initiated by a physician or other QHP as well as by a patient and/or family/caregiver. However, the telemedicine services must be performed on a separate calendar date from another E/M service. When performed on the same date as another E/M service, the elements and time of these services are summed and reported in aggregate, ensuring that any overlapping time is only counted once. If the minimum time for reporting a telemedicine service has not been achieved, time spent with the patient may still count toward the total time on the date of the encounter of an in-person E/M service.◄

Telemedicine

►**Synchronous Audio-Video Evaluation and Management Services**◄

►Codes 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007 may be reported for new or established patients. Synchronous audio and video telecommunication is required. These services may be reported based on total time on the date of the encounter or MDM.◄

Telemedicine

❑ Audio-Only

- ❑ CPT® 99441-99443 have been deleted
- ❑ Report Telemedicine Codes 98008-98015
  - ❑ Medicare does not accept 98008-98015.

►**Synchronous Audio-Only Evaluation and Management Services**◄

►Codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015 may be reported for new or established patients. They require more than 10 minutes of medical discussion. For services of 5 to 10 minutes of medical discussion, report 98016, if appropriate. If 10 minutes of medical discussion is exceeded, total time on the date of the encounter or MDM may be used for code level selection.◄

Telemedicine

►For audio-only codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, medical discussion is synchronous (real-time) interactive verbal communication and does not include online digital communication (except when via a telecommunication technology device for the deaf). The meaning of MDM has the meaning used in the E/M Guidelines and is a cognitive process by the physician or other QHP.◄

►If during the encounter, audio-video connections are lost and only audio is restored, report the service that accounted for the majority of the time of the interactive portion of the service. Ten minutes of medical discussion or patient observation must be exceeded in order to report the audio-only service.◄

Telemedicine

►For audio-only telemedicine services for established patients with 5 to 10 minutes of medical discussion, report brief communication technology service (eg, virtual check-in) code 98016. Code 98016 is reported for established patients only. The service is patient-initiated and intended to evaluate whether a more extensive visit type is required (eg, an office or other outpatient E/M service [99212, 99213, 99214, 99215]). Video technology is not required for audio-only visits. When the patient-initiated check-in leads to an E/M service on the same calendar date, and when time is used to select the level of that E/M service, the time from 98016 may be added to the time of the E/M service for the total time on the date of the encounter.◄

►For 98000-98015, the level of service is selected based on MDM or total time on the date of the encounter. For audio-only codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, the service must exceed 10 minutes of medical discussion. Code 98016 describes services for established patients with 5 to 10 minutes of medical discussion and is based only on the time of medical discussion and not MDM. Do not count time for establishing the connection or arranging the appointment, even when performed by the physician or other QHP. Services of less than five minutes are not reported.◄

Telemedicine

►Brief Synchronous Communication Technology Service (eg, Virtual Check-In)◄

►Code 98016 is reported for established patients only. The service is patient-initiated and intended to evaluate whether a more extensive visit type is required (eg, an office or other outpatient E/M service [99212, 99213, 99214, 99215]). Video technology is not required. Code 98016 describes a service of shorter duration than the audio-only services and has other restrictions that are related to the intended use as a “virtual check-in” or triage to determine if another E/M service is necessary. When the patient-initiated check-in leads to an E/M service on the same calendar date, and when time is used to select the level of that E/M service, the time from 98016 may be added to the time of the E/M service for total time on the date of the encounter.◄

Telemedicine

- **Brief Synchronous Communication Technology Service (Virtual Check-In) Guidelines**
  - Must be patient-initiated
  - Virtual check-in
  - Established patients only
  - Does not originate from a related E/M service from previous 7 days
  - Does not lead to E/M service within the next 24 hours or soonest available appointment
  - Time from 98016 may be added to time E/M service for total time when virtual check-in leads to E/M service on the same calendar date.
  - If time spent is less than 5 minutes, do not report 98016.
  - 98016 replaces G2012, and is accepted by Medicare.

Telemedicine

- **Related Coding Guidelines**
  - Prolonged services (99417) may be added when total time exceeds the time threshold by a minimum of 15 minutes. Additional units of prolonged service may be added for each additional full 15-minute increment.
  - Telemedicine Symbol (★) removed from Office or Other Outpatient codes 99202- 99205 and 99212-99215

Telemedicine and Medicare

- Medicare has assigned a status indicator of “I” to the new telemedicine codes with the exception of 98016.
- The American Relief Act was signed by President Biden on December 21st allowing for the extension of pandemic telemedicine flexibilities until March 31st. On March 18th, Congress extended the telemedicine flexibilities until September 30th.
- Audio-Only telemedicine services should be coded with Office/Other Outpatient codes (99212-99215) with modifier 93 and POS 10.
  - Audio-Only telemedicine rendered by a nonphysician (may not otherwise report EM services) is still coded with 98966-98968 based on the time spent in medical discussion.
- Audio-Visual telemedicine services should be coded with Office/Other Outpatient codes (99202-99205, 99212-99215) with modifier 95 and POS 10.
- Coding may be based on time or MDM whichever is most advantageous to the provider.
- See Appendix P and Appendix T for additional services that may be rendered via audio-visual or audio-only in the AMA 2025 CPT® manual.

Telemedicine and Medicaid

Arizona

- https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap08IndivPractitionerSvcs.pdf - See pages 54-56
- Bill the AIR with modifier GT

Telemedicine and Medicaid

Medi-Cal

- **DHCS Telehealth Frequently Asked Questions**
  - https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx#:~:text=Medi%2DCal%20covers%20synchronous%20telehealth,specialty%20mental%20health%2C%20and%20SUD
- **Telehealth Modifier Reference Sheet**
  - https://www.dhcs.ca.gov/provgovpart/Documents/TH-Modifier-Reference-Sheet.pdf

DHCS

Department of Health Care Services (DHCS) Telehealth Modifier Reference Sheet

Medi-Cal's telehealth policy gives providers flexibility to determine if a particular service or benefit is clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via video synchronous, audio-only synchronous and/or asynchronous telehealth. Below is a Telehealth Reference Sheet organized by delivery system with modifiers currently utilized.

Delivery System	Telehealth Modifiers Utilized	Modifier Description	Policy Reference/Notes
Medical (Fee-for-service (FFS)/ Managed Care)	**95**	Video synchronous (synchronous service rendered via a real-time interactive audio and video interaction.)	Medicine: Telehealth Provider Manual
	93	Audio-only synchronous (synchronous service rendered via telephone or other real-time interactive audio-only interaction)	
	GQ	Asynchronous interaction (Used to denote store-and-forward modality.)	

CPT® Update

- Anesthesia – no changes

CPT® Update

- **Surgery – 10000-69999**
  - **Integumentary System**
    - Skin Cell Suspension Autograft – 15011-15018
  - **Musculoskeletal System**
    - Hand, Wrist, and Forearm Repair or Reconstruction
      - New code – 25448
      - Revised code – 25447
  - **Cardiovascular System - No changes**

CPT® Update

- **Surgery – 10000-69999**
  - **Hemic and Lymphatic Systems**
    - Cellular and Gene Therapies - 38225-38228
  - **Digestive System**
    - Excision or destruction, open, intra-abdominal tumors or cysts – 49186-49190
  - **Urinary System**
    - Ablation transducer – 51721
    - Cystourethroscopy with insertion of temporary device – 53865
    - Ablation of prostate tissue – 55881-55882

CPT® Update

- **Surgery – 10000-69999**
  - **Endocrine System**
    - Ablation of thyroid nodules – 60660-60661
  - **Nervous System**
    - Stereotaxis – 61715
    - Fascial Plane Block – 64466-64474

Coding Tips – Evaluation and Management

- **G2211 – Visit complexity add-on code**
  - 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).

G2211 - FAQ

Q1: When can I report HCPCS code G2211?

A: All medical professionals who can bill Medicare for office/outpatient (O/O) evaluation and management (E/M) visits (i.e., Current Procedural Terminology (CPT®) codes 99202-99205, 99211-99215) may report the HCPCS code G2211 add-on code to O/O E/M base codes. HCPCS code G2211 may not be reported without reporting an O/O E/M base code visit, i.e., CPT® codes 99202-99205, 99211-99215.

HCPCS code G2211 captures the inherent complexity of the O/O E/M visit that is derived from the longitudinal nature of the practitioner and patient relationship. (CY 2024 physician fee schedule (PFS) final rule, 88 FR 78818, 78970)

Think about the relationship between you and the patient when deciding whether to bill HCPCS code G2211, including whether:

- You're the continuing focal point for all needed services, like a primary care practitioner (CY 2024 PFS final rule, 88 FR 78818, 78973-78974),
- You're providing ongoing care for a single, serious condition or a complex condition (e.g., sickle cell disease) (CY 2024 PFS final rule, 88 FR 78974).

There are many visits with new or established patients where the O/O E/M visit complexity add-on code would not be appropriately reported, such as when the care furnished during the O/O E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature; such as, but not limited to, a mole removal or referral to a physician for removal of a mole; for treatment of a simple virus; for counseling related to seasonal allergies, initial onset gastroesophageal reflux disease; treatment for a fracture; and where comorbidities are either not present or not addressed, and/or when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time (CY 2024 PFS final rule, 88 FR 78971).

G2211 - FAQ

Q2: In what office and outpatient settings can HCPCS code G2211 be billed?

A: All rules for reporting O/O E/M services (i.e., CPT® codes 99202-99205, 99211-99215) apply to billing HCPCS code G2211. Continue to use the codes in this family to report E/M services you provide to a patient in the office or other outpatient facility. HCPCS code G2211 is separately payable to the billing physician or practitioner in both facility and non-facility settings and is not limited to any physician specialties. HCPCS code G2211 cannot be billed with code sets for other E/M services (e.g., hospital inpatient, emergency department, home or residence, and nursing facility).

G2211 - FAQ

Q3: Can HCPCS code G2211 be billed when my patient sees another physician or practitioner in my group practice instead of me, including colleagues in the same specialty as me?

A: In this scenario, physicians and practitioners might consider whether the patient could have an ongoing relationship with a patient care team within the group practice that includes more than one physician or practitioner. We understand it is possible that team-based care practices may also serve as the continuing focal point for all needed services or provide ongoing care for a single, serious condition or a complex condition. In such circumstances when a patient sees another physician or practitioner in a team-based care practice, and if all other requirements of HCPCS code G2211 are met, it may be appropriate to report HCPCS code G2211.

G2211 - FAQ

Q4: Is it appropriate to bill HCPCS code G2211 using the Primary Care Exception

A: Physicians can bill under the primary care exception for lower-level O/O E/M services provided by resident physicians in certain primary care training settings. Physicians bill for these services by attaching the GE modifier to their claims for O/O E/M visits described by CPT® codes 99202-99203 & 99211-99213. The temporary policy we put in place during the COVID-19 Public Health Emergency to permit physicians to bill under the primary care exception for O/O E/M level 4-5 visits (99204-99205, 99214-99215) is no longer in effect. The HCPCS code G2211 add-on code can be billed for services furnished under the primary care exception if the criteria for billing HCPCS code G2211 are met.

G2211 - FAQ

Q5: Can HCPCS code G2211 be billed in an FQHC or RHC?

A: We generally pay Rural Health Clinic (RHC)s and Federally Qualified Health Center (FQHCs) an encounter-based rate. The service described by HCPCS add-on code HCPCS code G2211 is bundled into the RHC all-inclusive rate or FQHC prospective payment system payment rate along with the service described by the O/O E/M base code with which HCPCS code G2211 would be billed. There is no separate payment made to an FQHC or RHC for HCPCS code G2211.

G2211 - FAQ

Q6: Is HCPCS code G2211 denied when modifier -25 is on the claim for any service?

A: As finalized in the CY 2024 PFS final rule (88 FR 78974-78975) and summarized in MLN Matters Article MM13272, we'll deny payment for HCPCS code G2211 reported for an O/O E/M visit (CPT® codes 99202- 99205, 99211-99215) that has been reported with Modifier -25, on the same date of service, for the same patient, by the same physician or nonphysician practitioner. ***For the CY 2025 PFS, in response to practitioners' concerns, we are proposing to allow payment of HCPCS code G2211 when the O/O E/M base code is reported by the same practitioner on the same day as an AWV, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting (89 FR 61696-61697)***

G2211 - FAQ

Q7: What must be documented for HCPCS code G2211? What does a billing/treating practitioner state in the patient record for the medical necessity of reporting HCPCS code G2211?

A: ***We have not specified any additional medical record documentation requirements for reporting the HCPCS code G2211 add-on code.*** Our medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and the patient care relationship as appropriate. We would expect that information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses, the practitioner's assessment and medical plan of care, and/or other codes reported could serve as supporting documentation for billing HCPCS code G2211. Practitioners should consult their Medicare Administrative Contractor (MAC) regarding documentation requirements related to the underlying O/O E/M visit. Practitioners should also consult the Evaluation and Management Services Guide, MLN006764 August 2023.

G2211 - FAQ

Q8: What constitutes a serious or complex condition? What diagnosis must be used?

A: No specific diagnosis is required for HCPCS code G2211 to be billed. For the billing practitioner, it would be appropriate to report a health condition that is a single, serious condition and/or a complex condition for which the billing practitioner is engaging the patient in a continuous and active collaborative plan of care related to an identified health condition – the management of which requires the direction of a practitioner with specialized clinical knowledge, skill, and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals. We provide several examples to clarify the use of HCPCS code G2211 in the context of specialty care. For example, HCPCS code G2211 could be billed by an infectious disease physician who is part of ongoing care for a patient with HIV (a single, serious condition and/or complex condition), or a practitioner who is part- of ongoing care for a patient with sickle cell disease.

G2211 - FAQ

Q9: What is the definition of “longitudinal”? Does it matter if the patient comes in once a year, every other year, or every 5 years, as long as the patient has selected that physician as their primary care doctor and who they call when they need care?

A: The add-on code HCPCS code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship. Therefore, ***HCPCS code G2211 is not appropriate when the billing practitioner has not taken responsibility for ongoing medical care for a given patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time.*** No specific definition is provided for “longitudinal” for HCPCS code G2211 to be billed. As long as the practitioner-patient relationship aligns with Q1 above, HCPCS code G2211 can be billed to recognize the services that enable practitioners to build longitudinal relationships with their patient and address the majority of patient’s health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

G2211 - FAQ

Q10: Does patient cost-sharing apply to HCPCS code G2211?

A: Yes, the usual Part B patient coinsurance and deductible applies when HCPCS code G2211 is billed.

Q11: Can HCPCS code G2211 be reported during the same service period as care management services? Or, are these considered duplicative?

A: HCPCS code G2211 may be billed during the same service period as care management services. We do not believe HCPCS code G2211 necessarily would be duplicative of care management services since the concept of inherent complexity better recognizes the professional work that occurs during the visit, while the care management codes generally recognize services that happen outside of the visit.

G2211 - FAQ

Q12: Where can I find additional information?

A: These FAQs draw on policies for HCPCS code G2211 finalized in the CY 2024 PFS final rule (CY 2024 PFS final rule, 88 FR 78818) available at https://www.govinfo.gov/content/pkg/FR-2023-11-16/pdf/2023- 24184.pdf

For additional information, we refer readers to that final rule and to the Medicare Learning Network (MLN) Matters Articles MM13272 at https://www.cms.gov/files/document/mm13272-editsprevent-payment-g2211-office/outpatient-evaluation-and-management-visit-and-modifier.pdf and MM13473 available at https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatientevaluation-and-management-visit-complexity-add-code-g2211.pdf

Coding Tips – Evaluation and Management

- **Pelvic Exam – +99459**
  - For use when a pelvic exam is performed during an office visit or preventive medicine visit. May only be coded with 99202-99215, 99242-99245, 99383-99387, 99393-99397. Chaperone is not required in order to use the code.

Coding Tips – Evaluation and Management

- **Prolonged Services – 99417 (G2212), 99418 (G0316)**
  - Use when the physician/NPP documents time that exceeds the maximum required time by 15 mins.
    - Use 99417 or G2212 with 99215, 99205, 99245
    - Use 99418 or G0316 with 99223, 99233, 99236, 99255
  - Add additional units of prolonged service for each additional (full increment) 15 minutes.

Coding Tips – Evaluation and Management

❑ Preventive Medicine Services

- ❑ Preventive medicine services must contain an age-appropriate history, and exam as well as documentation of an age-appropriate discussion of anticipatory guidance/risk factor reduction.
- ❑ Well Child Checks must additionally include the recommended laboratory, vision, and hearing and developmental screenings.
- ❑ School and Sports Physicals are not payable by most insurances. It is recommended that if the patient is due for a WCC, the WCC should be performed. The forms are then completed as part of the encounter.
- ❑ DOT/CDL exams are not payable by insurance. If the patient needs an annual exam, a preventive service should be performed to include the anticipatory guidance/risk factor reduction.
  - ❑ The physician/NPP providing the service, must have an examiner's number from the Department of Transportation.

Coding Tips – Evaluation and Management

- **Preventive Medicine Services**
  - If developmental screening tools (e.g., MCHAT, ASQ, Vanderbilt) are used, they may be separately billable.
    - The provider needs to document the which tool was used and the score. If the score shows an abnormality, the provider must document a plan for future care.
    - The form needs to be signed and dated by the provider.
    - The form must then be sent to HIM and scanned to the encounter.
    - The Edinburgh Postnatal Depression Scale screening may be performed by the pediatrician/NPP at 1 mo, 2 mo, 4 mo and 6 mo visits.
      - Use CPT® 96161
      - Add Modifier 25 to the Preventive Medicine EM.

Coding Tips – Evaluation and Management

❑Preventive Medicine Services

❑Screening Labs

- ❑ Pap with HPV - Z11.51 **and either** Z01.411 **or** Z01.419
- ❑ Pap
  - ❑ High risk – Z72.51, Z72.52, Z72.53, Z77.29, Z77.9, Z91.89, and Z92.89
  - ❑ Low risk – Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89
- ❑ PSA - Z12.5
- ❑ Lipid Panel – Z13.6
- ❑ Glucose – Z13.1
- ❑ Hep B – Z11.59+
- ❑ Hep C - Z72.89 and F19.20
- ❑ HIV - Z11.4
- ❑ STI – Z11._
- ❑ FOBT – Z12.11
- ❑ A1c – Z13.1

Coding Tips – Evaluation and Management

- **Preventive Medicine Services**
  - Vision Screening – 99173
  - Hearing Screening – 92551
    - Use Z01.10 to identify normal screening
    - Use Z01.118 to identify abnormal screening
  - Fluoride Varnish – 99188

Coding Tips – Evaluation and Management

- **Preventive Medicine Services**
  - Smoking Cessation Counseling
    - Smoking cessation counseling is included in the preventive medicine service. However, smoking cessation counseling when documented during an office visit (99202-99215) may be coded.
      - Time must be documented
      - A brief summary of counseling including any barriers the patient has and any methods for coping with these issues;
      - Any pharmacological intervention, if recommended or prescribed.
    - 99406 – greater than 3 mins up to 10 mins
    - 99407 – greater than 10 mins
    - Use F17.210-F17.299 or Z87.891
    - Frequency Limitation – up to 8 sessions per year

Coding Tips – Evaluation and Management

- **Preventive Medicine Services**
  - **EM Service on the same day as a preventive medicine service.**
    - **Per CPT® 2025**

"If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate E/M service should also be reported."

"An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported."

Coding Tips – Integumentary

- **Excisions, Biopsies, Destructions**
  - Always wait for the pathology report to return before coding the service. This allows for accurate diagnosis and procedure coding.
  - The size and location of the excision needs to be documented. If it is not documented, the provider should be queried.
  - If multiple excisions are performed, code each excision separately, or with units as appropriate. Do not add the size of the excisions together.
  - When destruction of multiple lesions occurs, an exact number is needed to accurately code the procedure. This includes actinic keratosis, warts, skin tags, etc.

Coding Tips – Integumentary

- **Suture/Staple Removal**
  - +15853 – Removal of Sutures **or** Staples not requiring anesthesia
    - List separately in addition to E/M code
  - +15854 - Removal of Sutures **and** Staples not requiring anesthesia
    - List separately in addition to E/M code

Coding Tips – Integumentary

- **Podiatry Procedures**
  - Nail Care – Trimming vs Debridement
    - 11719 – Trimming of nondystrophic nails, any number
      - G0127 – Trimming of dystrophic nails, any number
    - 11720 - Debridement of nail(s) by any method(s); 1 to 5 nails.
    - 11721 - Debridement of nail(s) by any method(s); 6 or more nails.
  - Callus Removal
    - 11055 – Paring or cutting of benign hyperkeratotic lesion (corn or callus); single lesion
    - 11056 – 2 to 4 lesions
    - 11057 – more than 4 lesions

Coding Tips – Musculoskeletal

- **Casting and Splinting**
  - Documentation requirements
    - Documentation should include notation of any wounds that will be covered by the cast or splint. Neurovascular status also needs to be noted. Once the cast or splint is applied, the neurovascular status should be rechecked and documented.
  - Supplies – Q4001-Q4051
    - Coding is based on type of material – plaster vs fiberglass
    - Age of the patient – 0-10 years, 11 years +
    - Location of cast or splint

Coding Tips – Genitalia

- **Destruction of Lesions**
  - Destruction of lesions located on male or female genitalia are coded with CPT® codes 54050-54065 or CPT® codes 56501, 56515, 57061, 57065 depending on location.

Coding Tips – Optometry

- **Optometry**
  - May use the Eye Exam codes or Evaluation and Management codes
    - 92002 – new patient, limited exam
    - 92004 – new patient, comprehensive exam
      - A comprehensive exam requires documentation of all 12 components, a dilated eye exam as medically necessary, and initiation of diagnostic and treatment program.
    - 92012 – established patient, limited exam
    - 92014 - established patient, comprehensive exam

Comprehensive Eye Visit Code Checklist

Use this checklist for CPT codes 92004 and 92014.

History

☐ Chief complaint
☐ History
☐ General medical observation

Examination

Perform—and document—all 12 elements of the exam, unless patient age or trauma prevents you from doing so (in which case, document the reason).

☐ Visual acuity
☐ Gross or confrontation visual fields
☐ Extraocular motility
☐ Conjunctiva
☐ Ocular adnexa
☐ Pupil and iris
☐ Cornea
☐ Anterior chamber
☐ Lens
☐ Intraocular pressure
☐ Optic nerve discs
☐ Retina and vessels
☐ Dilation: As medically necessary. If not dilated, document why.

Initiation of Diagnostic and Treatment Program

Actions that could satisfy the codes' postexam requirements include, but are not limited to, the following:

☐ Prescription of medication, glasses, or contact lenses
☐ Arranging for special ophthalmological diagnostic or treatment services
☐ Consultations
☐ Laboratory procedures
☐ Radiology services
☐ Recommendation or decision for or scheduling or performance of a major (90-day global period) or minor (0- or 10-day global period) surgical procedure.
☐ Scheduling necessary follow-up of a medical problem
☐ Other: _____

_____

_____

_____

Coding Tips – Optometry

- **Optometry**
  - Determination of Refractive State
    - 92015
      - Medicare does not cover refraction – append modifier GY

Coding Tips – Optometry

- **Optometry**
  - OCT and Fundus Photos
    - Fundus photos
      - 92250
    - OCT
      - 92132 – Anterior Segment
      - 92133 – Posterior Segment
      - 92134 - Retina

Do not report 92250 with 92133 or 92134. Report only the OCT. 92250 may be reported with 92132.

Coding Tips – Medicine Section

- Know the types of immunizations currently available in your facility, especially when there are multiple CPT® codes for different formulas of the vaccine.

Influenza Vaccine Products for the 2024–2025 Influenza Season

Manufacturer	Trade Name (vaccine abbreviation)[1]	How Supplied	Mercury Content (mcg Hg/0.5mL)	Age Range	CVX Code	Vaccine Product Billing Code[2]
						CPT
AstraZeneca	FluMist (LAIV3)	0.2 mL (single-use nasal spray)	0	2 through 49 years	111	90660
GSK	Fluarix (IIV3)	0.5 mL (single-dose syringe)	0	6 months & older[3]	140	90656
	FluLaval (IIV3)	0.5 mL (single-dose syringe)	0	6 months & older[3]	140	90656
Sanofi	Flublok (RIV3)	0.5 mL (single-dose syringe)	0	18 years & older	155	90673
	Fluzone (IIV3)	0.5 mL (single-dose syringe)	0	6 months & older[3]	140	90656
		0.5 mL (single-dose vial)	0	6 months & older[3]	140	90656
		5.0 mL multi-dose vial (0.25 mL dose)	25	6 through 35 months[3]	141	90657
		5.0 mL multi-dose vial (0.5 mL dose)	25	6 months & older	141	90658
	Fluzone High-Dose (HD-IIV3)	0.5 mL (single-dose syringe)	0	65 years & older[4]	135	90662
CSL Seqirus	Afluria (IIV3)	5.0 mL multi-dose vial (0.25 mL dose)	24.5	6 through 35 months[3]	141	90657
		5.0 mL multi-dose vial (0.5 mL dose)	24.5	3 years & older[5]	141	90658
		0.5 mL (single-dose syringe)	0	3 years & older[3]	140	90656
	Fluad (aIIV3)	0.5 mL (single-dose syringe)	0	65 years & older[4]	168	90653
	Flucelvax (ccIIV3)	0.5 mL (single-dose syringe)	0	6 months & older[3]	153	90661
		5.0 mL multi-dose vial (0.5 mL dose)	25	6 months & older[3]	320	90661

Coding Tips – Medicine Section

- EKG Documentation
  - 93000 – includes tracing and interpretation
    - 93005 – tracing only
    - 93010 – interpretation
    - Documentation must include 3 of the following 5 elements:
      - Rhythm
      - Rate
      - Axis
      - Acute or chronic changes
      - Comparison (if available)

Coding Tips – Medicine Section

- Dietitian Visits
  - Medicare only covers Medical Nutrition Therapy for patients with diabetes, and renal disease.
    - Patients being referred for MNT must be referred by a physician (MD/DO).
  - Other payers may have their own coverage policies.
  - Diagnosis coding should include the reason for MNT, Z71.3, and the patient's BMI or BMI% (2-20yo).

Coding Tips – Medicine Section

- **Post-operative Visits**
  - Follow-up visits related to a procedure within a global period (010, 090 days) should be coded as 99024.
  - If the patient returns during the global period for a condition not related to the procedure, append modifier 24 to the E/M code.
  - G0559
    - Postoperative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:

Coding Tips – Medicine Section

- **Post-operative Visits**
  - G0559
    - Postoperative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:
      - Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.
      - Research the procedure to determine expected post-operative course and potential complication (in the case of doing a post-op for procedure outside the specialty).
      - Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.
      - Communicate with the practitioner who performed the procedure if any questions or concerns arise. (list separately in addition to office/outpatient evaluation and management visit, new or established).

2025 ICD-10-CM Updates

Guidelines

There are minimal changes to the ICD-10-CM Official Guidelines for Coding and Reporting for FY 2025:

- Section I.C.1.d.5(b) adds T81.49 and O86.09 to the list of sepsis codes that should be sequenced first.
- Section I.C.2.e.(2) revises the first sentence to reiterate that “If a patient admission/encounter is **chiefly** for the administration of chemotherapy, immunotherapy or external beam radiation therapy, assign ….”
- Section I.C.2.s adds C84.7B to the list of codes to assign for breast implant-associated anaplastic large cell lymphoma; and Section I.C.2.t revises the guideline for secondary malignant neoplasm of lymphoid tissue.
- Section I.C.4.1(a) adds the guideline for E10.A- *Type 1 diabetes mellitus, presymptomatic*.
- Section I.21.C.3 includes a revision to account for the descriptor change to Z17.

Note: There are additional changes within the Alphabetic Index and Tabular list, such as revisions, inclusion terms, and parenthetical notes.

2025 ICD-10-CM Updates

Effective 10/1/2024

420 Total changes

252 New Codes

36 Deleted Codes

13 Revised Codes

2025 ICD-10-CM Updates

Code updates by Chapter:

Chapter 1 – There are no new codes in this chapter for certain infectious and parasitic diseases but A77.41 is revised to correct the spelling of “chaffeensis.”

Chapter 2 – Several codes are converted to parent codes and expanded with fifth character ‘A’ to indicate cancer “in remission.” For example, under C81 *Hodgkin Lymphoma* there are seven new codes that describe the various types of this disease while in remission (C81.0A-C81.9A).

Chapter 3 – Just one new code is added here: D61.03 *Fanconi anemia*.

Chapter 4 – Under E10 *Type 1 diabetes mellitus*, new codes are added for presymptomatic diagnoses (E10.A-). There are also new codes for hypoglycemia levels (E16.A-), carcinoid syndrome (E34.00-E34.09), obesity class (E66.811-E66.813), disorders of citrate metabolism (E74.82-), and E88.82 *Obesity due to disruption of MC4R pathway*.

Chapter 5 – Under F50 *Eating disorders* there are several new codes for anorexia nervosa, restricting type (F50.010-F50.019), binge eating/purging type (F50.020-F50.029), bulimia nervosa (F50.20-F50.25), and binge eating disorder (F50.810-F50.819). Also new are F50.83 *Pica in adults* and F50.84 *Rumination disorder in adults*.

2025 ICD-10-CM Updates

Chapter 6 – There are several changes under G40 *Epilepsy and recurrent seizures* including the addition of G40.84 *KCNQ2-related epilepsy* and four child codes (G40.841-G40.844) to specify whether or not the disease is intractable, with status epilepticus. There are also new codes for serotonin syndrome (G90.81), other disorders of the autonomic nervous system (G90.889), and developmental and epileptic encephalopathy (G93.45).

Chapter 7 – In this chapter, five fifth-character codes under H44.2 *Degenerative myopia* are revised to remove the reference to bilateral “eye.”

Chapter 8 – There are no changes for diseases of the ear and mastoid process (H60-H95).

Chapter 9 – Four new codes (I26.03-I26.04, I26.95-I26.96) expand the I26 *Pulmonary embolism* subcategory, and two existing codes (I26.93-I26.94) are revised to add the term “thrombotic.”

Chapter 10 – Under subcategory J21 *Acute bronchiolitis* there are several new codes for nasal valve collapse. The sixth-character codes specify the location of the collapse (internal/external) and the seventh character codes describe state of the condition (static/dynamic/unspecified).

2025 ICD-10-CM Updates

Chapter 11 – In this chapter, there are several new fifth- and sixth-character codes under K60.3 *Anal fistula*, K60.4 *Rectal fistula*, and K60.5 *Anorectal fistula* to allow the practitioner to report whether the condition is simple or complex and initial, persistent, or recurrent.

Chapter 12 – Under L29 *Pruritus*, there are new codes for cholestatic pruritus (L29.81) and other pruritus (L29.89). And under L43 *Lichen planus*, six new fifth-character codes more fully describe lichen planopilaris (L66.10-L66.12, L66.19) and central centrifugal cicatricial alopecia (L66.81, L66.89).

Chapter 13 – There are several new codes for diseases of the musculoskeletal system and connective tissue. Under M51 *Thoracic, thoracolumbar, and lumbosacral intervertebral disk disorders*, there are new six-character codes that allow the practitioner to specify the location of pain more succinctly. And under subcategory M65 *Synovitis and tenosynovitis*, several fifth- and sixth-character codes are added to allow the practitioner to specify the location of the unspecified synovitis and tenosynovitis.

Chapter 14 – Other than the addition of an Excludes1 note under N39.0 *Urinary tract infection, site not specified*, there's nothing exciting going on here.

Chapter 15 – This chapter has a few note changes to codes in subcategory O24 *Diabetes mellitus in pregnancy, childbirth, and the puerperium*.

2025 ICD-10-CM Updates

Chapter 16 – There is the addition of one Excludes1 note under P72 *Other transitory neonatal endocrine disorders*.

Chapter 17 – In this chapter, there are three new codes for congenital malformations of aortic and mitral valves (Q23.81-Q23.82, Q23.88) and one new code for Kleefstra syndrome (Q87.86).

Chapter 18 – You'll find one new code here for anosognosia (R41.85). Patients with this condition are unaware of their health conditions or problems, often due to dementia or Alzheimer's.

Chapter 19 – Under subcategory T45 *Poisoning by, adverse effect of an underdosing of primarily systemic and hematological agents, not elsewhere classified*, there is new code T45.A *Poisoning by, adverse effect of and underdosing of immune checkpoint inhibitors and immunostimulant drugs*, followed by several new fifth- and sixth- character codes that specify the circumstances of the poisoning, adverse effect, or underdosing. And under T81.32 *Disruption of internal operation (surgical) wound, not elsewhere classified*, there are new sixth-character codes (T81.320-T81.329) to specify the wound location.

Chapter 20 – There are no changes in this chapter for external causes of morbidity.

2025 ICD-10-CM Updates

Chapter 21 – In this final chapter of ICD-10-CM, there are new codes for reporting genetic susceptibility to various diseases such as epilepsy and neurodevelopmental disorders (Z15.1) and obesity (Z15.2). Additionally, the descriptor for subcategory Z17 is revised to expand the scope of hormones to include progesterone and human epidermal growth factor and to specify receptor status. Also new for FY 2025:

- Z51.A *Encounter for sepsis aftercare*;
- Two new social determinants of health codes for insufficient health insurance coverage (Z59.71) or welfare support (Z59.72);
- Several codes (Z67.A-) for identifying blood types using the Duffy blood group system;
- Two codes (Z68.55-Z68.56) for identifying pediatric body mass index percentiles;
- A code for reporting family history of familial adenomatous polyposis (Z83.72); and
- Four codes for reporting a personal history of specific types of colon polyps (Z86.0100-Z86.0102, Z86.0109).

2025 ICD-10-CM Updates

External Cause of Injuries Index

In the ICD-10-CM External Cause of Injuries index, there are a few revisions, additions, and deletions to Sections A, E, P, and R. The affected entries are:

- Section A – Assault (homicidal) (by) (in) Y09
- Section E – Explosion (accidental) (of) (with secondary fire) W40.9; Exposure (to) X58
- Section P – Powder burn (by) (from)
- Rape (attempted) T74.2-; Recoil

- Most of the changes are typographic corrections such as correcting the spelling of “hangun” to “handgun” and “firearn” to “firearm.”

2025 ICD-10-CM Updates

Table of Drugs

Added to the ICD-10-CM Table of Drugs and Chemicals, under Hydroxyzine, is the substance “antiallergic,” reported with T45.0X-. Also added, under Immune, is “checkpoint inhibitors,” reported with T45.AX- and “Immunostimulant drug,” reported with T45.AX-. A six character is needed to identify the circumstances of the poisoning.

Table of Neoplasms

There’s just one revision to the ICD-10-CM Table of Neoplasms for FY 2025. Flexing the power of the comma, under Neoplasm, neoplastic, the entry “odontogenic – see Neoplasm, jaw bone” is revised to “odontogenic – see Neoplasm, jaw, bone.”

2025 All-Inclusive Rates

https://www.federalregister.gov/documents/2024/12/16/2024-29505/reimbursement-rates-for-calendar-year-2025

Inpatient Hospital Per Diem Rate (Excludes Physician/Practitioner Services)

Lower 48 States: $5,580.

Alaska: $5,074.

Medicare Part B Inpatient Ancillary Per Diem Rate

Lower 48 States: $1,074.

Alaska: $1,567.

Outpatient Per Visit Rate (Excluding Medicare)

Lower 48 States: $801.

Alaska: $1,209.

Outpatient Per Visit Rate (Medicare)

Lower 48 States: $718.

Alaska: $1,193.

Outpatient Surgery Rate (Medicare)

Established Medicare rates for freestanding Ambulatory Surgery Centers.

THANK YOU!

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