Badger Health and Associates, LLC

Presents:

2026 CMS/ITU Outreach and Education
Indian Health Services – Albuquerque Area

You Should Know: 2026 Evaluation and Management Guideline Updates

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Agenda

- Purpose of Documentation
- MDM and Time Guidelines
- Review of 2026 CPT Updates
  - Prolonged Services
  - Telehealth
- Questions

Objectives

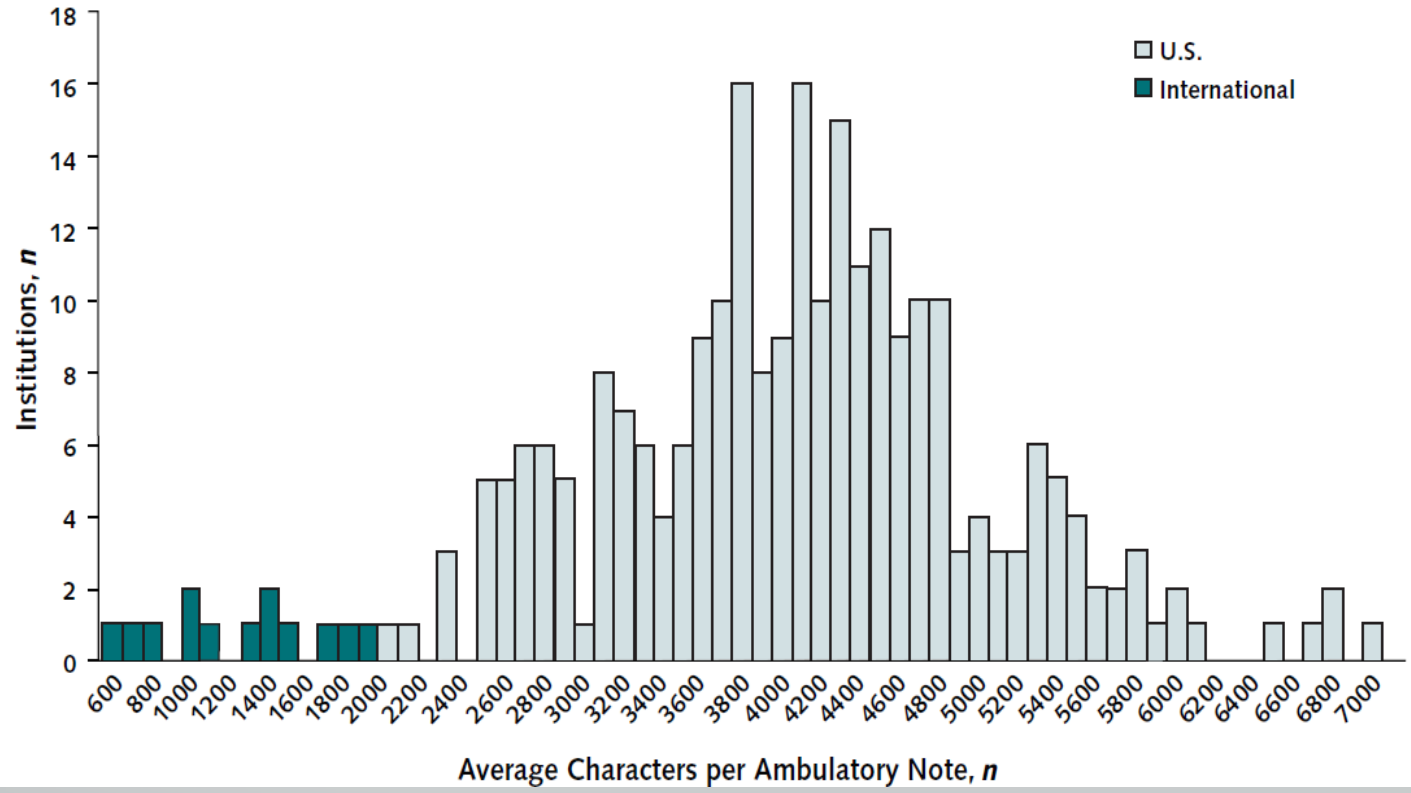
- Discuss the importance of documentation
- Review Each MDM Level
- Review Prolonged Services
- Discuss Telehealth Services

General Principles of E/M Documentation

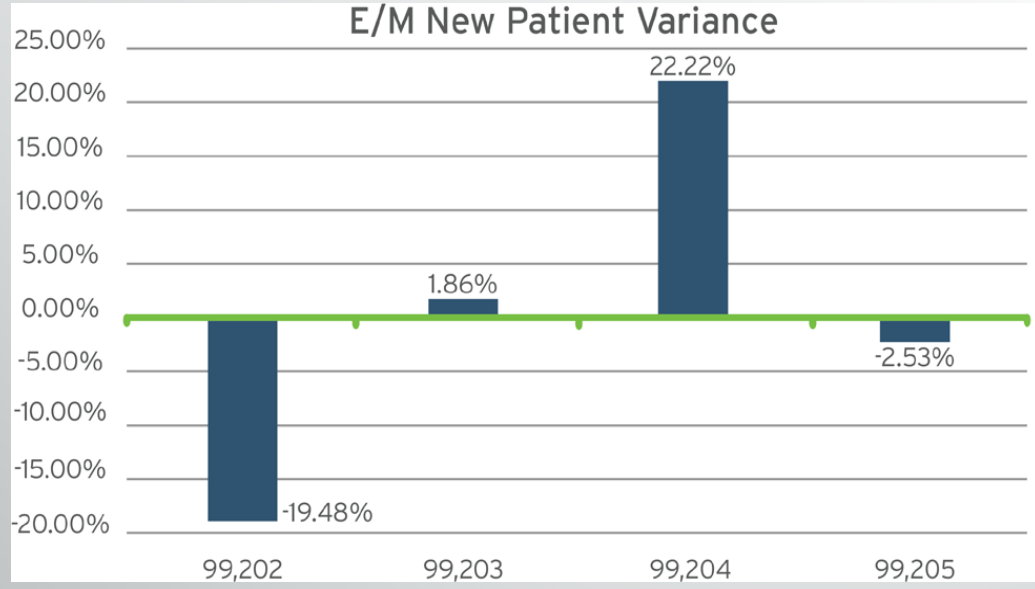
- Physicians write progress notes for many reasons:
  - To remind us what we found, said, and did
  - To communicate to other clinicians what we found, said, and did (aka continuity of care)
  - To allow us to get paid for services rendered
  - To engage patients in their care1
  - To prove that we practiced quality care
  - To help defend against a medical liability claim

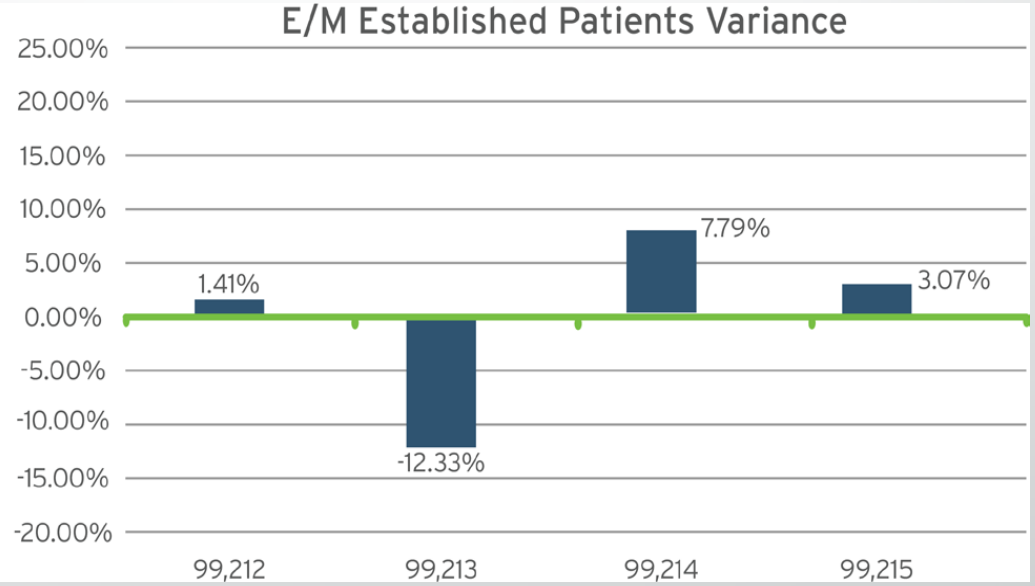
General Principles of E/M Documentation

Figure. Average characters per ambulatory progress note in U.S. and international health systems.



General Principles of E/M Documentation





Challenges and Opportunities

- Appropriate documentation of prescription drug management
  - make a direct connection between the medication
- Purposes of medical decision making
  - You cannot count labs at both the time of the order and the follow-up appointment when reviewed.
- Physicians should only include relevant information in their notes, incorporating specific results when appropriate or simply referencing them in summary form.

Challenges and Opportunities

DOCUMENT THIS

- I spent 32 minutes today (include activities to justify what was time consuming, as needed)
- Patient returns for follow-up of hypertension and diabetes
- Due to the patient's extreme fatigue, I will order a thyroid panel
- Decrease Lipitor as patient has lost 75 lbs. and through diet modifications has reduced cholesterol levels

NOT THIS

- 50% of the time spent in today's visit was counseling and coordination of care
- Patient returns for follow-up
- Will order labs for further workup
- Med list reviewed

Focus on Medical Decision Making (MDM) and Time

- The 2026 Evaluation and Management (E/M) coding guidelines, released by the AMA and CMS, emphasize strict alignment between documentation and billing, requiring clear selection of either Medical Decision-Making (MDM) or total time on the date of service.
- Removed ambiguous terms (e.g. “mild”) and defined previously ambiguous concepts (e.g. “acute or chronic illness with systemic symptoms”).
- Also defined important terms, such as “Independent historian.”
- Re-defined the Data MDM element to move away from simply counting tasks to focusing on tasks that affect the management of the patient (e.g. independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/QHP).

Key 2026 MDM and E/M Updates

- **Focus on Active Management:** MDM guidelines now emphasize that chronic conditions must be actively evaluated, treated, or managed during the encounter to support higher complexity.
- **Data Complexity Refinement:** Data ordering alone does not increase MDM level; data must be analyzed, and independent interpretation or discussion with external clinicians must be clearly documented.
- **Risk Assessment:** The 2026 updates focus on whether the provider's decisions meaningfully altered the risk of complications or morbidity, rather than just the presence of a high-risk condition.
- **Documentation Focus:** Guidelines encourage highlighting clinical judgment and complexity in documentation rather than relying on rigid checklists

Medical Decision Making-Based Coding and Billing

- MDM consists of 3 elements:
  - Number and complexity of **problem(s) addressed** during the encounter
  - Amount and/or complexity of **data** reviewed and analyzed
  - **Risk** of complications and/or morbidity or mortality related to patient management decisions associated with the visit

Focus on Medical Decision Making (MDM) and Time

CPT®	New 99202	Established 99212	New 99203	Established 99213	New 99204	Established 99214	New 99205	Established 99215
Time (min)	15-29	10-19	30-44	20-29	45-59	30-39	60+	40+
MDM	Straightforward		Low		Moderate		High	
History	Medically appropriate		Medically appropriate		Medically appropriate		Medically appropriate	
Exam	Medically appropriate		Medically appropriate		Medically appropriate		Medically appropriate	

MDM-Based Coding: Problems Addressed

- Document complexity and acuity clearly
- Include differential diagnoses considered
- Explain reasoning for treatment decisions

MDM-Based Coding: Data Reviewed and Analyzed

- Specify independent interpretations performed
- Document consultations with specialists
- Note review of external records or test results

Understanding Independent Interpretation in E/M Coding: Three Essential Requirements

- Independent Interpretation into three essential requirements to ensure compliance and appropriate coding:
  - **Personal Review of the Test**
  - **Documentation of the Provider's Own Interpretation**
  - **Demonstration of Impact on Patient Care Based on AMA's Definition of "Analyzed"**

Documentation of the Provider's Own Interpretation

- After personally reviewing the test, the provider must **document their own interpretation** in the patient's medical record.
- **Best practices for documentation to ensure the key elements are addressed would be to include:**
- **Findings:** Specific observations noted during the review.
- **Assessment:** The provider's professional judgment regarding these findings.
- **Conclusion:** How these findings influence the patient's diagnosis or treatment plan.

MDM-Based Coding: Risk

- Address potential complications explicitly
- Document medication management considerations
- Include procedure-related risks when applicable

Key Take Away

- Focus on clinical reasoning rather than quantity of documented elements.

LAV DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM}

Expansion by AMA Effective January 1, 2023: 99202 - 99215 OFFICE/CLINIC BASED SERVICES

Note: The following is a modification of the original AMA MOM Chart. This chart has been modified to provide more general terms and also include more specifications from the guidelines.

Code	Level of Service (Based on 2 out of 3 Elements of MDM) -OR-Time	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Work Performed & Analyzed During the Encounter *Directions for this column are noted in each area of risk row. This column is the column that requires scoring. Choose the risk area with the highest score.*	Risk of Complications and/or Morbidity or Mortality of Patient Management ***NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!***
99211	Services at th s level are provided by ancillary staff. *NOTE: /Jncillary staff and providers must be employed by the same TAX ID number to meet supervisior requirements			
99202 99212	**Straightforward - or-** 3 29 I 99212 10 - 19	**M,·n,·mal** · I negligible or meager problem addressed	**M'm1mal or none** Minimal infers the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	**Neg11glo1e risK tnat 111ness, runct1ona1 1mpa1rment, or organ aamage will occur rrom tne** management options and/or treatment plan considered and/or established. Example ONLY: low up/-8M

99203
99213
	Low
	-or-
	Time:
	99203: 30 - 44
	99213: 20 - 29
	99243: 30
		Low
		• **2** or more negligible or meager problem addressed;
		• **or**
		• **1** stable chronic problem addressed;
		or
		• **1** acute, direct or well-defined problem addressed or injury;
		or
		• 1 stable, acute illness;
		or
		• 1 acute, direct or well-defined problem addressed or injury requiring inpatient or observation admit
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents (Work commonly associated with E&M services)
			• **Documentation noting 2 of the following were performed:**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  o Example: Review of admission to the ED or IP since previous visit
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  o Example: PCP reviews testing ordered and performed by the cardiologist
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT
			  o Example: If the 26 component is NOT billed by the provider- the order can be allowed. However, the order and independent interpretation could NOT be combined.
			• **or**
			Category 2: Encounter including an additional historian(s)
			**Documentation: Who is the historian, information historian provided, and best practices- why historian was required*
				Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Medications NOT requiring prescriptive authority
				• DME
				• Physical Therapy
				• Consult/Referral without elaboration

99204
99214
	Moderate
	-or-
	Time:
	99204: 45 - 59
	99214: 30 - 39
	99244: 40
		Moderate
		• **1** (or+) chronic complaint(s) that is not stable, or noted as progressing/worsening, or side effects of treatment;
		or
		• **2** (or+) stable chronic problems addressed;
		or
		• **1** new problem undiagnosed potentially high risk;
		or
		• **1** acute complaint with unanticipated symptoms;
		or
		• **1** acute complex injury
			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: (REFER TO EXAMPLES ABOVE):**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT;
			  • encounter including an additional historian(s)
			or
			Category 2: Independent interpretation of tests
			• Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported);
			  o Example: Provider request Chest Xray- reviews the images and provides an interpretation within the E&M at the time of service that impacts care. Radiology will provide an over-read at a later time which will be billed.
			or
			Category 3: Discussion of management or test interpretation
			• Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)
			  o Example: Provider makes the decision to send the patient to the ED. The provider calls the ED provider to discuss
				Average risk that illness, functional 1mpa1rment, or organ aamage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority
				• Decision or consideration of a minor* procedure with documented patient or procedure risk factors.
				• Decision or consideration of a major* procedure without documented patient or procedure risk factors.
				• Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient
				• Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option
				*AMA: Minor and Major are at the discretion of the provider as documented
				*CMS: Minor 0-10 global I Major 90 day global

99205
99215
	High
	-or-
	Time:
	99205: 60 - 74
	99215: 40 - 54
	99245: 55
		High
		• **1** (or +) chronic problem(s) severely triggered, progression, or side effects of treatment;
		or
		• **1** acute or chronic problem or injury that places danger/ risk to life or bodily function
			Extensive (REFER TO EXAMPLES ABOVE):
			(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:**
			  • Evaluate external records from an external provider (may not divide per test/per CPT);
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT;
			  • encounter including an additional historian(s)
			or
			Category 2: Independent interpretation of tests
			• Rendering provider documents an independent interpretation of a test that has been or will be formally read and billed by another provider. A formal report is NOT required (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Documentation identifying direct dialogue between external providers or other appropriate sources (not separately reportable) regarding the management or test interpretation of the patient (asynchronous allowed)
				Above average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
				Examples ONLY:
				• Long/short term *intensive* monitoring to prevent toxicity (NOT monitoring efficacy)
				• Decision or consideration of a major* procedure with documented patient or procedure risk factors.
				• Decision or consideration of an major* surgery performed with minimal delay/immediate
				• Decision or consideration for hospitalization or alternative levels of care
				• Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery
				• Administration of controlled substance via IM, IV, or SubQ
				*AMA: Minor and Major are at the discretion of the provider as documented
				*CMS: Minor 0-10 global I Major 90 day global

Time-Based Coding

- If you choose to bill based on time, you must meet or exceed the specific time thresholds for that code on the **date of the encounter**

- **Total Time**: Includes both face-to-face and non-face-to-face time (e.g., reviewing tests, documenting, or communicating with other professionals).

Activities that count towards time

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Ordering medications, tests, procedures
- Referring and communicating with other health care professionals
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination

Key 2026 Prolonged Service Details

- **Time Requirement:** Must exceed the maximum time of the base code (e.g., 99205, 99215) by at least 15 minutes.
- **Outpatient (Office) Services:** CPT 99417 applies specifically to 99205 and 99215.
- **Medicare HCPCS is G2212**
- **Time Thresholds:** The full 15-minute increment must be met; a partial increment (e.g., 5-10 minutes) is not billable.
- **Documentation:** Time can be met through direct face-to-face or non-face-to-face care on the same day as the visit.

Proper Documentation for Prolonged Services

- The start and end times of the prolonged service.
- A detailed explanation of the additional services provided during the prolonged period.
- A clear description of the medical necessity for the prolonged service.
- The primary E/M service code with which the prolonged services code is billed.

Key Telehealth Changes & Extensions for 2026

- **Extension Timeline:** The Consolidated Appropriations Act, 2026 extended pandemic-era waivers, which were set to expire, until December 31, 2027.
- **Location and Audio-Only:** Medicare patients can remain at home (or any location) for non-behavioral/mental telehealth services. Audio-only communication remains permitted for specific services.
- Consents and Modalities**:** Annual verbal consent must be documented.
- **Documentation Content:** Notes must include: Patient and provider locations.
  - The platform/technology used.
  - Start and stop times (for time-based billing).
  - Explicit consent documentation.

Clinical Example 1: CPT Code Level 99204 (New Patient)/99214 (Established Patient)

Patient is a 65 yo with CHF, DM and HTN. Patient presents with leg swelling and erythema that began four days ago. Patient indicates there is some pain in the leg and is feeling feverish; however, there is no fever on vital signs. Exam is suggestive of purulent cellulitis. Records from PCP are reviewed and reveal history of MRSA. The patient indicates no allergies. A complete blood count, comprehensive metabolic panel and a wound culture are ordered. The patient is prescribed five days of oral doxycycline. Adverse effects of doxycycline are discussed with the patient. The case and management are also discussed with patient's PCP. Patient is to return to office in one week or sooner if problem worsens.

Medical decision-making for this case has now progressed to a moderate level. The problem is now a single new problem that involved discussion with another provider and review of historical records. The risk has now increased to a moderate level given the patient was given a prescription that may often lead to side effects; therefore, code level 99204 or 99214 is indicated.

Clinical Example 2: CPT Code Level 99205 (New Patient)/99215 (Established Patient)

Patient is a 65 yo with CHF, DM and HTN. Patient presents with leg swelling and erythema that began four days ago. Patient indicates there is pain in the leg. The patient is feeling very sick and is unable to provide a history. The patient's daughter is called and indicates that patient has had a fever, malaise and severe leg pain. Exam indicates a patient who appears very sick and has leg erythema and severe tenderness. Patient has no allergies. Vital signs reveal hypotension and tachycardia. Decision is made to send patient to the emergency room for hospitalization and emergent surgical evaluation for possible necrotizing fasciitis. CBC, CMP and blood cultures are ordered. It is recommended that patient is started on IV vancomycin and piperacillin-tazobactam with vancomycin level monitoring. The case is discussed with the ER and surgical attending physicians. Patient is transported to the ER for admission.

Medical decision-making for this case is at the highest level given that the patient has a very complex problem that could threaten life or body function. The data reviewed is now more complicated in nature and involves speaking with an independent historian (the patient's daughter), ordering tests and discussions with other providers. The risk has now increased to the high level given the patient needs to be hospitalized and started on IV antibiotics, and there is consideration of emergency surgery; therefore, code level 99205 or 99215 is indicated.

Questions?

References

- 2026 CPT Professional Edition - ama
- E/M Office visit compendium 2021- ama
- CMS Patients over Paperwork
  https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html
- AMA Office Evaluation and Management (E/M) CPT Code Revisions
  https://edhub.ama-assn.org/module/2736085?resultClick=1&bypassSolrId=J_2736085
- AMA CPT Evaluation and Management
  https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- AMA CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes
  https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- AMA Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)
  https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf
- Centers for Medicare and Medicaid Services; Pub. 100-4 Chapter 12
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
- CMS MLN Evaluation and Management Services
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- COMPLYING WITH MEDICAL RECORD DOCUMENTATION REQUIREMENTS
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf
- News: AMA on track to revise E/M codes, set new documentation guidelines
  March 21, 2019 CDI Strategies - Volume 13, Issue 12
  https://acdis.org/articles/news-ama-track-revise-em-codes-set-new-documentation-guidelines
- CPT Code 99213 Office or Other Outpatient Visit Fact Sheet
  https://www.cgsmedicare.com/partb/mr/pdf/99213.pdf
- Clinician Letter Reducing Burden Documentation and Coding Reform
  https://www.cms.gov/About-CMS/Story-Page/Clinician-Letter-Reducing-Burden-Documentation-and-Coding-Reform-.pdf
- Novitas-Solutions Medical Scorecards
  https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004968

References

- 2026 American Academy of Family Physicians
- Centers for Medicare & Medicaid Services
- NAMAS The physician educator
- **CPT® Evaluation and Management (E/M) revisions FAQs**
- **American Medical Association**

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Reminder

IMPORTANT: Fill out the evaluation