



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

Presenter:

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Agenda

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



Objectives

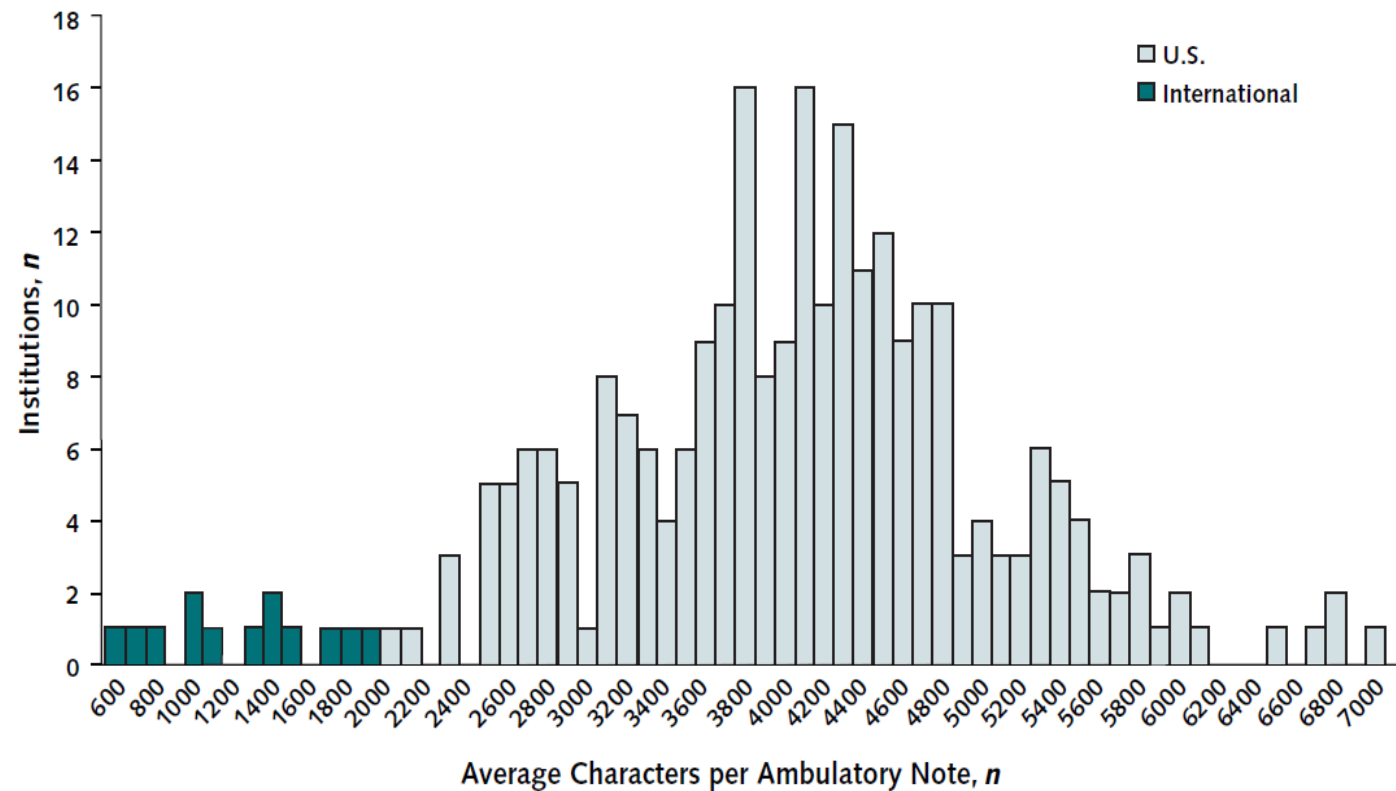
- **Discuss the importance of documentation**
- **Review Each MDM Level**
- **Review Prolonged Services**
- **Discuss Telehealth Services**

General Principles of E/M Documentation

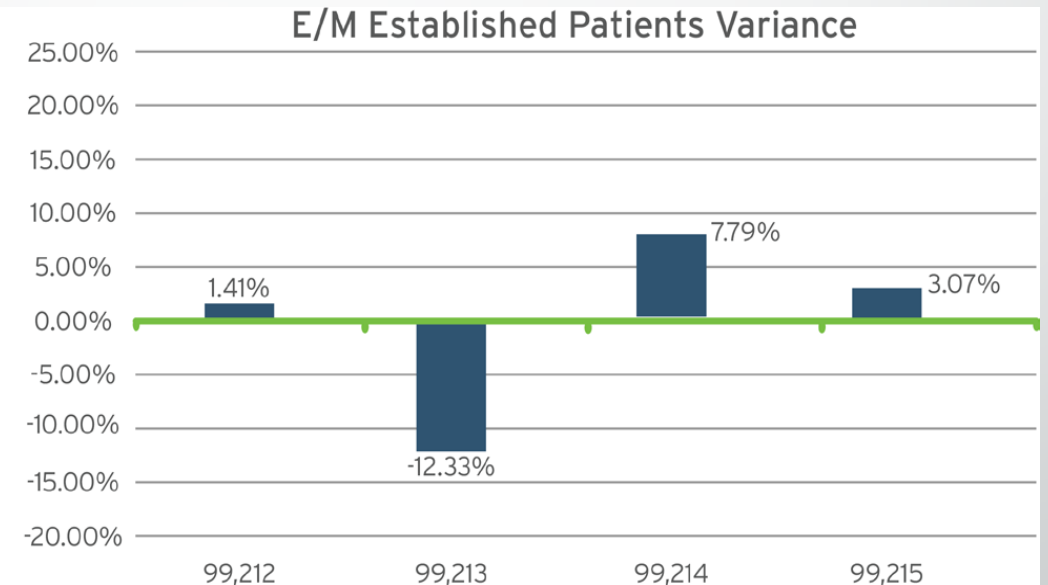
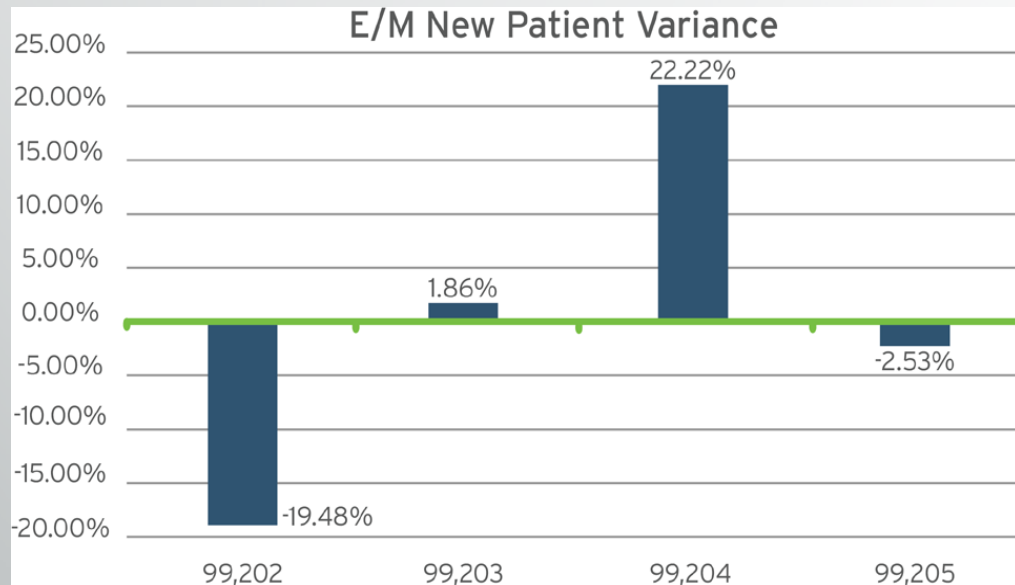
- Physicians write progress notes for many reasons:
 - To remind us what we found, said, and did
 - To communicate to other clinicians what we found, said, and did (aka continuity of care)
 - To allow us to get paid for services rendered
 - To engage patients in their care
 - To prove that we practiced 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	Risk of Complications and/or Morbidity or Mortality of Patient Management
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.				
NOTE: THIS COLUMN INCLUDES EXAMPLES ONLY!				
99211	Services at this level are provided by ancillary staff. *NOTE: /Incillary staff and providers must be employed by the same TAX ID number to meet supervisor requirements			
99202	Straightforward - or-	Minimal	Minimal or none	Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99212	Low	1 negligible or meager problem addressed	Minimal infer the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99203	-or-	Low	Limited	Below average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99213	Time:	1 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	(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	Examples ONLY: • Medications NOT requiring prescriptive authority • DME • Physical Therapy • Consult/Referral without elaboration
99204	Time:	Moderate	Moderate	Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99214	Time:	Moderate	Moderate	Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99215	Time:	High	High	Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99205	Time:	High	High	Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.
99215	Time:	High	High	Average risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.

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?



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Reminder



IMPORTANT: Fill out the evaluation

