2025 E/M Modifier 25

David J Freedman, DPM, CPC, CSFAC, CPMA

Dr. David J Freedman

- Board Member, US Foot and Ankle Specialists (USFAS) and Vice-President Foot and Ankle Specialists of the Mid-Atlantic of the Mid-Atlantic (FASMA)
- Certified Professional Coder
- Certified Professional Medical Auditor
- Certified Surgical Foot and Ankle Coder
- Compliance Auditor
- Codingline Expert
- CAC member Maryland
- 39 years of Coding Experience
- APMA Coding Committee Chair since 2018 & member since 2004

Agenda Objectives

- Understand examples in documentation and learn to see the differences.
- Learn how to apply E&M since 1/1/2023 to pass an audit
- Discover some changes and nuances since implementation!
- Need to understand MDM vs time? Learn what is expected especially with extra time.

Disclosure

I disclose I do not have any relevant financial relationships held with organizations whose product or service is being discussed during this lecture and any commercial contributor to the activity.

Disclaimer

CPT codes and their descriptions and the policies discussed in this webinar do not reflect or guarantee coverage or payment. Just because a CPT code exists, payment for the service it describes is not guaranteed. Coverage and payment policies of governmental and private payers vary from time to time and for different areas of the country. Questions regarding coverage and payment by a payer should be directed to that payer. The coding advice here reflects only the opinions of the speaker. As the speaker, I do not claim responsibility for any consequences or liability attributable to the use of the information contained in this presentation

Reference

2023 E/M Guideline Changes

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

1) Office and Other Outpatient E&M
2) Hospital Inpatient and Observation Care E&M
3) Consultation E&M
4) Emergency Department E&M
5) Nursing Facility E&M
6) Home or Residence E&M

Medical Decision-Making Changed

MDM Level	# & Complexity of Problem(s) Addressed	Risk of Comp-Morbidity/Mortality of Management
Straightforward	1 self-limited or minor problem	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	• 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Low risk of morbidity from additional diagnostic testing or treatment
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	Moderate risk of morbidity from additional diagnostic testing or treatment • 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	• 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	High risk of morbidity from additional diagnostic testing or treatment • 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 b/c poor prognosis

MDM LEVEL	# & COMPLEXITY OF PROBLEM(S) ADDRESSED	RISK OF COMP OF MORBIDITY/MORTALITY OF MED MGMT
Straightforward	Minimal ● 1 self-limited or minor problem	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low ■ 2 or more self-limited or minor problems; or ■ 1 stable, chronic illness; or ■ 1 acute, uncomplicated illness or injury; or **■ 1 stable, acute illness;** **or** **■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	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	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	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	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 or escalation of hospital-level care** **■ Decision not to resuscitate or to de-escalate care because of poor prognosis** ■ **Parenteral controlled substances**

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LAY 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 MDM 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 listed in exchange 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 this level are provided by ancillary staff. *NOTE: Ancillary staff and providers must be employed by the same TAX ID number to meet supervision requirements			
99202 **99212**	**Straightforward - or-** 99202: 15 - 29 | 99212: 10 - 19 99242: 20	**Minimal** • **1** negligible or meager problem addressed	**Minimal or none** Minimal for the typical work of the encounter, but no additional order, review, or otherwise classified work of the provider to be categorized below	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Follow up PRN

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);
			  ○ 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;
			  ○ Example: PCP reviews testing ordered and performed by the cardiologist
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT
			  ○ 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);
			  ○ Example: Provider request Chest X-ray- 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)
			  ○ 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 impairment, or organ damage 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 | 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 | Major 90 day global

AMA CPT Definition:

- **Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care:** A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.
- **Stable, acute illness:** A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

AMA CPT Definition:

"Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions"

AMA CPT Definition vs Auditors Desires:

When your facility like a “Hospital believes the majority of our visits (if not all) should be 99202/12 & 99203/13.”

We do you have as a coding tool within the EMR to assist coding, but? Remember you also have the option to document the OV by time.

Each Level MDM:

CPT 99202 / 99212

Level: Straightforward: Need 2 out of 3:

Number and Complexity of Problems Addressed: 1 self-limited or minor problem

Amount and/or Complexity of Data to be Reviewed and Analyzed: minimal or none

Risk of Complications and/or Morbidity or Mortality of Patient Management - minimal risk of morbidity from additional diagnostic testing or treatment

CPT 99203 / 99213
Level: Low: Need 2 out of 3:

Number and Complexity of Problems Addressed:
Low :

2 or more self-limited or minor problems
OR
1 stable chronic illness
OR
1 acute, uncomplicated illness or injury

■ 1 stable, acute illness;
or
■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

Amount and/or Complexity of Data to be Reviewed and Analyzed:
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

Category 2: Assessment requiring an independent historian(s)

Risk of Complications and/or Morbidity or Mortality of Patient Management: Low risk of morbidity from additional diagnostic testing or treatment

CPT 99204 / 99214
Level: Moderate: Need 2 out of 3:

Number and Complexity of Problems Addressed:
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

Amount and/or Complexity of Data to be Reviewed and Analyzed
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

Category 2: Independent interpretation of tests - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

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)

Risk of Complications and/or Morbidity or Mortality of Patient Management - Moderate risk of morbidity from additional diagnostic testing or treatment

CPT 99205 / 99215
Level: High: Need 2 out of 3:

Number and Complexity of Problems Addressed
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

Amount and/or Complexity of Data to be Reviewed and Analyzed
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

Category 2: Independent interpretation of tests - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

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)

Risk of Complications and/or Morbidity or Mortality of Patient Management - High risk of morbidity from additional diagnostic testing or treatment

- **Decision regarding hospitalization or escalation of hospital-level care**
- **Decision not to resuscitate or to de-escalate care because of poor prognosis**
- **Parenteral controlled substances**

TIME:

On the day of the encounter

- **Preparing to see the patient (e.g., review of tests, calling a MD referral)**
- **Obtaining and/or reviewing separately obtained history (e.g.vascular MD's notes)**
- **Performing a medically appropriate examination and/or evaluation (YOU)**
- **Counseling and educating the patient/family/caregiver (YOU)**
- **Ordering medications, tests, or procedures(YOU)**
- **Referring and communicating with other health care professionals (YOU)**
- **Documenting clinical information in the electronic or other health record (YOU)**
- **Independently interpreting results and communicating results to the patient/family/caregiver (YOU)**
- **Care coordination (YOU)**

TIME:

CPT 99202 - 15-29 minutes
CPT 99203 - 30-44 minutes
CPT 99204 - 45-59 minutes
CPT 99205 - 60-74 minutes
CPT 99212 - 10-19 minutes
CPT 99213 - 20-29 minutes
CPT 99214 - 30-39 minutes
CPT 99215 - 40-54 minutes

TIME (Non MC):

►Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes

Initial Hospital Inpatient or Observation Care

CPT® code	MDM Level	Time (minutes)
99221	Straightforward or low	40
99222	Moderate	55
99223	High	75

Subsequent Hospital Inpatient or Observation Care

CPT® code	MDM Level	Time (minutes)
99231	Straightforward or low	25
99232	Moderate	35
99233	High	50

Time value (total time)

Time beyond –ADD-ON CPT 99418

CPT 99223 – 90 minutes

CPT 99418 – 90-104 minutes (15 min=1Unit)

CPT 99233 – 65 minutes

CPT 99418 – 65-79 minutes (15 min=1Unit)

CPT 99236 – 100 minutes

CPT 99418 – 100-114 minutes (15 min=1Unit)

Office or Other Outpatient Consultation

CPT® code	MDM Level	Time (minutes)
99242	Straightforward	20
99243	Low	30
99244	Moderate	40
99245	High	55

Inpatient or Observation Consultation

CPT® code	MDM Level	Time (minutes)
99252	Straightforward	35
99253	Low	45
99254	Moderate	60
99255	High	80

Initial Nursing Facility Care

CPT® code	MDM Level	Time (minutes)
99304	Straightforward or Low	25
99305	Moderate	35
99306	High	45

Subsequent Nursing Facility Care

CPT® code	MDM Level	Time (minutes)
99307	Straightforward	10
99308	Low	15
99309	Moderate	30
99310	High	45

New Patient Home or Residence Services

CPT® code	MDM Level	Time (minutes)
99341	Straightforward	15
99342	Low	30
99344	Moderate	60
99345	High	75

Established Patient Home or Residence Services

CPT® code	MDM Level	Time (minutes)
99347	Straightforward	20
99348	Low	30
99349	Moderate	40
99350	High	60

HCPCS G2212 Medicare
Time Plus=Threshold is either 69 or 89 mins?

- Use instead of CPT 99417 **Medicare -** G2212 - Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
- RVU=0.61, Example in VA=$30.61 Office and $29.34 Facility

Time above and beyond?

CMS delivers 4 more surprises

Providers will have wider coding and reimbursement options thanks to three more changes that CMS confirmed in the final rule:

1. "Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe," CMS writes in the final rule. Survey time is data that the AMA's RVS Update Committee (RUC) collects and uses to value codes. For example, the survey time for nursing facility services (**99304-99310**) "included the day before, the day of, and up to and including 3 days post the date of service," CMS writes in the final rule. However, the survey time for a same day admission and discharge visit (**99324-99326**) is the date of the encounter.
2. No frequency limits for prolonged services. You will not see medically unlikely edits (MUE) for the new G codes, according to several statements in the final rule. For example, "… there would not be any frequency limitation; therefore, we proposed that physicians and NPPs would be able to bill G0317 for each additional 15-minute increment of time beyond the total time for CPT codes 99306 and 99310."
3. In a change from the proposed rule, CMS will allow practices to report prolonged service time with cognitive assessment code **99483**.
4. The new prolonged service codes will be added to the list of telehealth services on a permanent basis. —*Julia Kyles, CPC (jkyles@decisionhealth.com)*

RESOURCES

- Final 2023 Medicare physician fee schedule (display version): https://public-inspection.federalregister.gov/2022-23873.pdf
- CY 2023 PFS Final Rule Physician Work Time (Zip file): www.cms.gov/files/zip/cy-2023-pfs-final-rule-physician-work-time.zip

Coding

Prolonged service threshold chart

Share this prolonged service code chart with coders to ensure accurate claims (*see story, p. 4*). The first column lists the primary E/M code, followed by the add-on HCPCS code that pairs with the primary code. The threshold column contains the minimum time required to report one unit of the add-on code.

The time period column gives the date or range of days for counting time for the visit. For example, "3 + date of visit + 7" indicates the coder can count time for work performed up to three days before the face-to-face encounter, the date of the face-to-face encounter and seven days after the encounter. However, the provider must document their time. —*Julia Kyles, CPC (jkyles@decisionhealth.com)*

Primary	Code	Threshold	Time period
New office/outpatient (99205)	G2212	89	Date of visit
Established office/outpatient (99215)	G2212	69	Date of visit
Cognitive assessment (99483)	G2212	100	3 + date of visit + 7
Initial hospital (99223)	G0316	105	Date of visit
Subsequent hospital (99233)	G0316	80	Date of visit
Admit & discharge (99236)	G0316	125	Date of visit + 3
Initial nursing facility (99306)	G0317	95	1 + date of visit +3
Subsequent nursing facility (99310)	G0317	85	1 + date of visit +3
New home (99345)	G0318	140	3 + date of visit + 7
Established home (99350)	G0318	110	3 + date of visit + 7

Source: Table 24: Required time thresholds to report other E/M prolonged services

G0316-$30.30
G0317-$29.98
G0318-$29.66

Problem addressed
For hospital inpatient and observation care services

- The problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

►Table 1: Levels of Medical Decision Making (MDM)◄

	►Elements of Medical Decision Making		
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** ■ 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** ■ **2** or more self-limited or minor problems; **or** ■ 1 stable, chronic illness; **or** ■ 1 acute, uncomplicated illness or injury; **or** ■ 1 stable, acute illness; **or** ■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 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)*	**Low risk of morbidity from additional diagnostic testing or treatment**
Moderate	**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	**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)	**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	**High** ■ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** ■ 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any 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)	**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 or escalation of hospital-level care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis ■ Decision regarding parenteral controlled substances◄

►The term "risk" as used in the definition of this element relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.◄

LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

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

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99211	Services at this level are provided by ancillary staff. *NOTE: Ancillary staff and providers must be employed by the same TAX ID number to meet supervision requirements			
99202 99212	**Straightforward - or-** 99202: 15 - 29 | 99212: 10 - 19 99242: 20	**Minimal** • **1** negligible or meager problem addressed	**Minimal 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	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Follow up PRN

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);
			  ○ 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;
			  ○ Example: PCP reviews testing ordered and performed by the cardiologist
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT
			  ○ 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);
			  ○ 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)
			  ○ 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 impairment, or organ damage 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 | 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 | Major 90 day global

LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: INPATIENT PLACE OF SERVICE

Note: The following is a modification of the original AMA MDM 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!*
	No IP Services fall under "minimal". There are other services that fall under SF, but they also fall under Low Level of Complexity as well. The same requirements are required with the exception of 99252 which has a time value of 35 minutes. Refer to the Low Complexity guidelines below.			
99252	**Straightforward** **- or-** **35 Minutes**	**Minimal** • **1** negligible or meager problem addressed	**Minimal 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	**Negligible risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.** Example ONLY: • Will Follow up on patient tomorrow. | Patient awaiting Discharge

99221
99231
99234
99253
	Low
	- or -
	99221 = 40 minutes
	99231 = 25 minutes
	99234 = 45 minutes
	99253 = 45 minutes
		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);
			  ○ Example: Review of previous admission IP
			  • review of prior test result(s) per unique test, i.e. per CPT- except tests ordered by the rendering provider;
			  ○ Example: Cardiology reviews testing ordered by the hospitalist
			  • ordering imaging, lab, psychometric, physiologic data testing per CPT
			  ○ 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
				• Awaiting discharge without further treatment plan

99222
99232
99235
99254
	Moderate
	- or -
	99222 = 55 minutes
	99232 = 35 minutes
	99235 = 70 minutes
	99254 = 60 minutes
		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);
			○ Example: Provider requests 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. The need for independent interpretation (medical necessity) should be included
			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)
			○ Example: Provider request consult and calls requesting services and discuss the patient with the on call provider
				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:
				• 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
				• Leaving AMA without high complexity risk documented

99223
99233
99236
99255
	High
	- or -
	99223 = 75 minutes
	99233 = 50 minutes
	99236 = 85 minutes
	99255 = 80 minutes
		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 | Major 90 day global

For a copy of this MDM chart, contact NAMAS by email at namas@namas.co or at 877-418-5564

Podiatric Examples

"Just add Modifier 25."

- Yes %
- No %

What are the rules ?
What is "significant"?
What is "separate"?

Podiatric Examples

"Just add Modifier 25." Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:

- It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

Podiatric Examples

“Modifier 25.” 992xx-25

- It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
- CPT 11750-pre-evaluation time is expected to be 17 minutes, pre-positioning time 3 min, pre-service scrub wait time 5 min, Sx 15min, immediate post Sx time 7 min=47min

Podiatric Examples

"Just add Modifier 25." Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:

- A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E&M service).

Podiatric Examples

"Just add Modifier 25." Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:

- The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service

Podiatric Examples

Who uses the terminology Paronychia?

- Yes %
- No %

What are the rules in ICD-10-CM when you search for "Paronychia"

see also Cellulitis, digit with lymphangitis

see Lymphangitis, acute, digit

Podiatric Examples

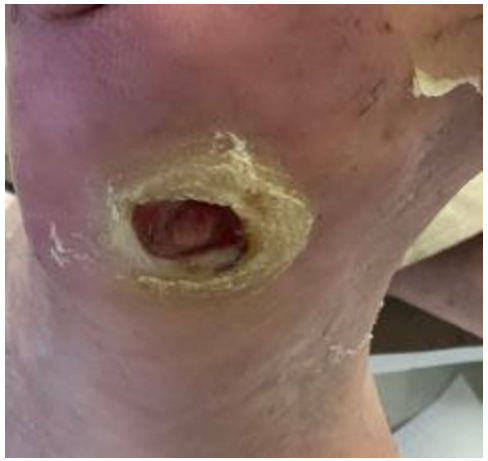
Infection (odds of minimal level 2? Minimal risk?)

- Mild/Low-some erythema-acute uncomplicated=L03.031 Cellulitis of right toe or L03.032 Cellulitis of left toe
- Moderate-erythema moving proximal to originating site-L03.115 Cellulitis of right lower limb or L03.116 Cellulitis of left lower limb
- Severe-erythema up the leg, febrile, at risk for loss of limb or life. L04.3 Acute lymphadenitis of lower limb

Podiatric Examples

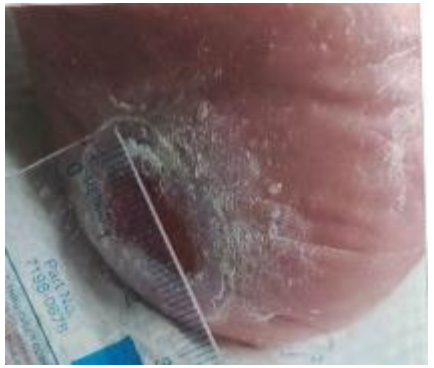
Do you classify this as an ulcer or open wound?

- If Acute it is an open wound, can't be an ulcer!



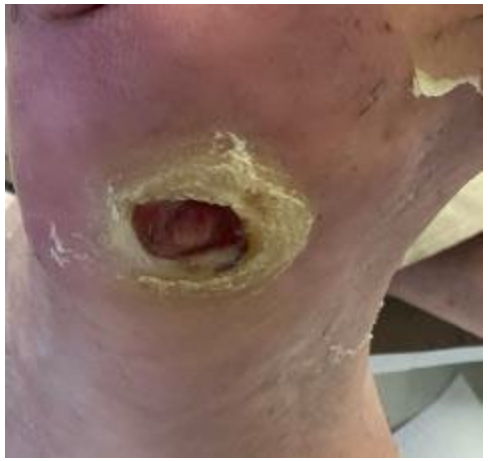
S91.30-A Unspecified open wound of foot (Category)

- If chronic it could be a non-pressure chronic wound L97, BUT if you consider it a pressure injury it is now a L89! Code first any associated gangrene (I96)



Podiatric Examples

Do you classify this as a chronic ulcer or open wound?



- IF L97 then Code first any associated underlying condition, such as: any associated gangrene (I96) , atherosclerosis of the lower extremities (I70.23-, I70.24-, I70.33-, I70.34-, I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-), chronic venous hypertension (I87.31-, I87.33-), diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622), postphlebitic syndrome (I87.01-, I87.03-) , postthrombotic syndrome (I87.01-, I87.03-) , varicose ulcer (I83.0-, I83.2-)

Podiatric Examples

Do you classify this as an ulcer or open wound?

- VLU is not a diabetic wound

or a pressure wound!

I87.31- Chronic venous hypertension (idiopathic) with ulcer OR

I87.33 Chronic venous hypertension (idiopathic) with ulcer and inflammation + Use additional code to specify site and severity of ulcer (L97.-)

Podiatric Examples

Ingrown Toenail L60.0 (**No such thing as a slant back!)**

- Minimal or self limited some pressure/pain = level 2? Diagnosis is? M79.674 Pain in right toe(s) or M79.675 Pain in left toe(s)
- Mild/Low-some erythema, pain/pressure
- Moderate-pain, inflammation, erythema moving proximal to originating site
- Severe-pain, inflammation, erythema up the leg, febrile, at risk for loss of limb or life.

Podiatric Examples

Injury – Hematoma/blister (odds of minimal = level 2?)

- Mild/Low-Hematoma/blister-acute uncomplicated-Diagnosis or worse?
- 1) S90.1---Contusion of toe without damage to nail (Category)
- 2) S90.2--- Contusion of toe with damage to nail (Category)
- 3) S90.3-xA Contusion of foot (Category)
- 4) S90.42-- Blister (nonthermal) of toe (Category)
- 5) S90.82-- Blister (nonthermal) of foot (Category)

Podiatric Examples

Injury – Hematoma/blister (odds of minimal = level 2?)

- Mild/Low-Hematoma/blister-acute
- Moderate-Hematoma/blister-acute (uncomplicated or complicated) but has erythema moving proximal to originating site or involving deeper tissue?
- Severe-Hematoma/blister-acute complicated but has erythema moving proximal to originating site erythema up the leg, febrile, at risk for loss of limb or life.

Podiatric Examples

Diabetes is a chronic disease what are Diagnosis the rules and must I follow?

- E10 Type 1 diabetes mellitus (NO Z rules)
- E08-, E09-, E13, & E11 Type 2 diabetes mellitus- Includes: diabetes (mellitus) due to insulin secretory defect, diabetes NOS, insulin resistant diabetes (mellitus)

Use additional code to identify control using:

- injectable non-insulin antidiabetic drugs (Z79.85)
- insulin (Z79.4)
- oral antidiabetic drugs (Z79.84)
- oral hypoglycemic drugs (Z79.84)

Podiatric Examples

ICD-10-CM Diagnosis the rules and must I follow?

- Yes, in most cases you must use the additional code when submitting an insurance claim if the ICD-10-CM guidelines say “Use additional code to identify…” – especially when the guideline is attached to a primary diagnosis code.
- The phrase “Use additional code to identify…” is an instructional note in the ICD-10-CM coding system. It tells the coder or biller that more detail is expected – and the additional code provides context or specificity, such as:
- Underlying cause
- Manifestation
- Control status (e.g., of diabetes, hypertension, asthma, etc.)
- Associated conditions or devices

Podiatric Examples

ICD-10-CM Diagnosis the rules and must I follow? Why it's important:

Insurance carriers use this additional information to:

- Validate medical necessity
- Confirm the severity or complexity of the condition
- Determine proper payment

Omitting required additional codes can lead to:

- Claim denials
- Requests for more information
- Delays in reimbursement

Example: Not including Z79.4 could potentially make the documentation look incomplete.

Podiatric Examples

Type 2 DM polyneuropathy is a chronic disease, and neuropathy is a comorbidity (odds of minimal = level 2?)

- Mild/Low-burning/numbness chronic stable-OTC medication option (topical or oral)-level 3
- Moderate-burning/numbness chronic stable or progressing requires prescription authority-level 4
- Severe-burning/numbness chronic unstable or progressing requires prescription authority and has another element PAD that you state concern for loss of limb – level 5

Podiatric Examples

Injury – Fracture (odds of minimal = level 2? Chip/avulsion fracture on toe?) vs CPT 28490-Closed treatment of fracture great toe, phalanx or phalanges; without manipulation

- Mild/Low-acute uncomplicated nondisplaced fracture
- Moderate-acute complicated displaced fracture involving adjacent tissue? Require ORIF?
- Severe-acute complicated displaced fracture involving adjacent tissue? Require ORIF? A risk for loss of limb or life.

Need questions answered join the forum: www.thedoctorline.com and coming this fall it will be www.codinghelpline.com

CPMApro-Certified Professional Medical Auditing
David J. Freedman, DPM, CPC, CPMA
Email: djfreedman@CPMApro.com
Mobile Phone: (240) 342-6048

Thank you