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Coding and Billing: Practical Tips and Updates

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Why is this important?

Starting October 1, 2025, Aetna expanded the "Claim and Code Review Program" which downcodes E/M service claims for level 4 or 5 visits (99204 and 99205, 99214 and 99215) based on a **retrospective** audit.

- Inclusion in the program lasts for a year, and practices can request early removal from the program by successfully appealing 75% of downcoded claims.

Starting October 1, 2025, Cigna was supposed to implement a new "Evaluation and Management Coding Accuracy" reimbursement policy" which automatically downcode E/M service claims for level 4 or 5 without reviewing clinical documentation.

- Providers who submit a higher proportion of level 4 or 5 claims will be targeted.
- Only way to get appropriate reimbursement is through an appeal with submission of the full medical record.

On October 1, 2025, Cigna announced a **temporary pause** to the downcoding policy.

AASM members can download and personalize a template letter to send to each payer, encouraging reversal of the policies.

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Medicare Final Rule: January 1, 2021
Office Visit - Total Calendar Day times

	CPT Code	Total Calendar Day Time
New	99202	15-29
	99203	30-44
	99204	45-59
	99205	60-74
	99211	N/A
Established	99212	10-19
	99213	20-29
	99214	30-39
	99215	40-54

- History and physical exam are **not** required (only what is medically necessary)
- Coding is based on either medical decision making (MDM) or total time spent on the **same day** of the encounter
- Total time includes both time with a patient and any pre/post work (not >50% time spent counseling and coordinating care)
- Document the exact number of minutes spent (not the range)
- If you spend 74 minutes or more for a new patient, and more 54 minutes or more for an established patient, you can use **G2212** (prolonged services) for every 15 minutes increment of time.

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Medical Decision Making (MDM)

Determined by 3 elements

- Number and complexity of problem or problems addressed during the visit
- Amount and complexity of data reviewed and analyzed during the visit
- Risk of complications, morbidity, and mortality of decisions made during the visit. Things to consider: diagnosis, tests/procedures ordered, treatments

Only 2 of the 3 MDM elements are needed for a level of service

Overall goal of these changes is to simplify documentation and reduce note bloat.

If you are using MDM to determine level of service, there is no need to document time spent on the day of the scheduled visit.

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Time

Include the total time spent with activities associated with the visit on the same calendar day.

- No need to document the time spent on each activity
- Good practice to document what activities were included in the total time calculation.
  Example: *Total time spent today caring for the patient was *** minutes. This includes time spent before the visit reviewing the chart, time spent with the patient during the visit, time spent ordering medications, tests, or procedures, and time spent after the visit on documentation.*

Activities to include
Face to face time with the patient
Previsit chart/record review
Counseling and education the patient/family/caregiver
Ordering medications, tests, procedures
Referring/communicating with other HCPs
Writing the note after the visit
Care coordination
Independent interpretation of results and communicating back to the patient

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Low Complexity MDM

Tests and notes:
- each unique note/result/order counts as one item
- unique based on an existing CPT code

Independent historian:
- can be a family member, caregiver, or provider (e.g. pharmacist, EMT, etc.)

If you read your own studies, or sleep studies are read by colleagues in your group, you get credit for ordering the test only. You cannot get credit for reviewing the test in a follow up visit.

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Level 3 New patient example

Reason for visit: Snoring and fatigue

50 year old male with a history of snoring and witnessed apneas. He is fatigued all the time no matter how much he sleeps. His wife was present during the visit, who confirmed that he snores loudly which bothers her, and she is worried when she sees that he stops breathing during sleep, usually on his back.

The plan is to order a sleep study to evaluate for sleep apnea.

Reason for level 3

- One stable, chronic illness
- Input from an independent historian (wife) – alternative scenario – review PCP note and CBC (to see if he was anemic)
- Order sleep study – low risk of morbidity

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Level 3 Follow up patient example

Reason for visit: Moderate OSA

50 year old male with a history of moderate OSA that was diagnosed with a sleep study 2 months ago. He finally got his AutoCPAP machine a month ago, and he is trying to keep the mask on after he falls asleep. You review his PAP compliance for the past 30 days, and there is a high mask leak. He has a full face mask.

The plan is to order a nasal mask to see if that help decrease the mask leak.

Reason for level 3

- One stable, chronic illness

Needs to be 2 out 3 categories, and the lower level category wins.

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Moderate Complexity MDM

Tests and notes:
- Independent interpretation of a study you did not bill for
- Reason for or against a treatment/therapy counts
- Prescription drug management
- Social determinants of health

Social Determinants of Health (SDOH)
- may raise risk of complications, morbidity or mortality because treatment options and/or diagnosis capabilities may be limited.
- patient is unable to get a sleep study or a PAP machine due to a high deductible

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Social Determinants of Health

Z55.00	Low (health) literacy
Z56.x	Job problems
Z59.0	Homelessness
Z59.10	Inadequate housing
Z59.41	Food insecurity
Z60.4	Social isolation
Z63.6	Family member needing home care
Z78.9	Language barrier

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 1/24/2024, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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Level 4 New patient example

Reason for visit: Mild sleep apnea and obesity

45 year old female with a history of mild sleep apnea and a 40 pound weight gain. She is trying to use CPAP but is struggling to fall asleep with the mask on. She is thinking about bariatric surgery, and was told that she needs to use CPAP before surgery. You review the sleep study report and raw data from an outside lab, and agree that the patient has mild sleep apnea. You discuss that weight gain may have made her sleep apnea worse.

The plan is to have the patient work on using CPAP while awake before retrying it in bed.

Reason for level 4

- One chronic illness with worsening (due to weight gain)
- Independent review of sleep study from an outside lab

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Level 4 Follow up patient example

Reason for visit: Moderate sleep apnea and obesity

25 year old male with a history of moderate sleep apnea and obesity. He is sleeping better since using AutoCPAP. Now he has energy to go to the gym 4 days a week. He also has stopped drinking regular pop.

The plan is to continue AutoCPAP 5-15cmH2O. You send an order for replacement tubing, filters and mask. You encourage the patient to continue watching what he eats in addition to exercise.

Reason for level 4

- Two stable, chronic illnesses
- You continue AutoCPAP and send prescription for resupply
- If the visit was for just sleep apnea, this would be a level 3 visit (unless the patient was not compliant with PAP therapy and was still symptomatic)

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Level 4 Follow up patient example

Reason for visit: Narcolepsy with cataplexy

26 year old female with a history of Narcolepsy Type 1 who started taking modafinil 200mg once a day a month ago. Modafinil helps her stay awake, but she has headaches that are not going away. She also was concerned about the interaction with birth control which she wants to start. You discuss other treatment options including other wake-promoting agents and the oxybates. You also answer her questions about work-place accommodations.

The plan is to change medication to solriamfetol.

Time of visit: 39 minutes

Reason for level 4

- One chronic illness with side effect from treatment
- You prescribe a new medication
- If the total time on the day of the visit was 40 minutes or more, then that would be a level 5 visit based on time

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Level 4 Follow up patient example

Reason for visit: Severe OSA

58 year old female with a severe OSA who is using AutoCPAP 10-20cmH2O with excellent PAP compliance. She reports that she is having an urge to move her legs when she gets into bed which is preventing her from falling asleep. Moving her legs helps get rid of the urge to move temporarily, but when she stops it comes back. She had this intermittently when she younger, but now it is happening every night.

The plan is to continue AutoCPAP, and to start low dose gabapentin. The patient tells you that she may not be able to pick up the medication because she just got laid off and barely has enough money for food

Reason for level 4

- One undiagnosed new problem (RLS)
- You prescribe a new medication but the patient cannot pick it up due to food insecurity

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High Complexity MDM

Decision: high risk associated with reason for or against a treatment/therapy counts - most visits in sleep medicine will not meet this criteria

Best way to bill for a level 5 LOS for a new or follow-up visit is to bill by time.

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G2211

- New code G2211, has been available for use since Jan 1, 2024.
- Background: In 2020, CMS proposed creating a new code to be used in patient encounters to reflect the **time, intensity, and practice expense** associated with building longitudinal relationships with patients, and/or coordinating care across the healthcare spectrum. It was intended for primary care, but specialties can use this code.
  - Go-live was scheduled for 1/1/2021, but implementation was postponed until 2024 due to the pandemic.

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G2211

- G2211 may be submitted by a PCP or a specialist, serving either as “a focal point for all needed services, or are part of ongoing care of a patient’s serious or chronic condition.”
  - Should be evident in review of the medical record.
  - No additional statement is recommended at this time, although guidelines may change.
- G2211 may be reported in association with 99202-5, 99211-5, and telehealth E+M codes.
- G2211 may not be reported when reporting an additional service with modifier 25.

Patients should have Medicare or Medicare Advantage insurance. Commercial payors have different policies for this code.

- Reimbursement $16.04, subject to geographic location
- wRVU = 0.33

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Updated Unattended Sleep Testing Codes

AASM partnered with the following organizations:

American Academy of Neurology (AAN)
American College of Chest Physicians (CHEST)
American Thoracic Society (ATS)

Rationale:
1. Enable reporting for multiple sleep disorders
2. Accommodate newer technologies
3. Align with current clinical practice

Updated Unattended Sleep Testing CPT code set was presented at the RUC meeting in April 2025, and was submitted by the AMA for the 2027 PFS

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Confidentiality

The AASM staff and Advisors are prohibited from sharing the following, due to confidentiality agreements:

- **CPT code descriptors**
  - AMA CPT staff still has time to make edits to the language, if needed
- **RUC recommended values for the code family**
  - Although values have been accepted by the RUC, CMS determines the final values in the Physician Fee Schedule Rulemaking process

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New Code Structure

Six codes

- 3 codes - Technical Component Only
- 3 codes - Physician Work Only
- 3 complexity levels: Low, Moderate, High

The appropriate code will be based on the number of channels that are utilized and the number of parameters that can be derived from the collected data.

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Status of Existing Codes

Will be deleted as of Jan 1, 2027:

- CPT 95800, 95801, 95806

CMS G codes (G0398, G0399, G0400):

- Recommended for retirement by RUC
- G codes are meant to be temporary
- CPT codes are intended to replace them

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Conclusion

1. Determine LOS based on documentation of either:
   - MDM (2 out of 3 columns): Number and complexity of problems, Amount and complexity of data reviewed/analyzed, Risk of decisions
   - Total time spent on calendar day of the visit (includes non face-to-face time)
     - Precharting
     - Note-writing and order placement
     - Communication with other providers outside of your billing provider group
2. Most sleep visits will be a level 3 or 4 based on MDM or time
3. Level 5 visits usually will be based on time
4. If you spend 74 minutes or more for a new patient, and more 54 minutes or more for an established patient, add **G2212** (prolonged services) for every 15 minutes increment of time.
5. Use G2211 if appropriate

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