NEWS & INSIGHTS

Recent updates to E/M billing and coding

October 1, 2025
News & Insights

CMS revised an MLN Booklet on evaluation and management (E/M) services to clarify billing and coding requirements for critical care scenarios, hospital outpatient clinic visits, telehealth services, and more.

CMS added information on Healthcare Common Procedure Coding System (HCPCS) code G2211, which is used to capture the complexity of an office or outpatient (O/O) E/M visit. As of January 1, 2025, facilities can bill this add-on code when they report Current Procedural Terminology (CPT®) codes 99202–99205 or 99211–99215 with modifier -25 to describe services furnished by the same practitioner on the same day as one of the following:

- Annual wellness visit
- Vaccine administration
- Part B preventive service (including the initial preventive physical examination furnished in the O/O setting)

The agency also added guidance on the proper use of modifier -25, which is used to report a significant, separately identifiable E/M service provided by the same physician on the same date. Along with including a detailed definition of a significant, separately identifiable E/M service, CMS clarified payment for intravitreal eye injections performed on the same date as an O/O E/M visit.

The booklet now also includes more information on CPT codes 99291 and 99292, which are used to report critical care services. CMS added several if-then scenarios for both codes, as well as a critical care billing table that includes specific instructions for a variety of situations. For example, if multiple providers from different specialties furnish critical care services to a patient on the same day, each provider may bill CPT codes 99291 and 99292, if applicable. However, the services must be distinct and not duplicative.

CMS provided additional instructions on billing HCPCS code G0463 to report a hospital outpatient clinic visit for assessing and managing a patient. Facilities can bill G0463 on its own, or they can bill it as a visit code in addition to a procedure code. Non-excepted off-campus provider-based departments (PBD) should use modifier -PN to report services provided at their facility, and excepted off-campus PBDs should use modifier -PO.

Lastly, CMS added information on recent telehealth updates and upcoming flexibility expirations. For most telehealth services, the statutory limitations in place prior to the COVID-19 public health emergency will take effect again on October 1, 2025. As of January 1, 2025, an interactive telecommunications system may include two-way, real-time, audio-only technology for any Medicare telehealth service furnished to a patient in their home if the following criteria are met:

- The distant site physician/practitioner is technically capable of using an interactive telecommunications system
- The patient isn’t capable of or does not consent to using video technology

For dates of service in 2025, organizations are to continue billing telehealth services with the same place of service (POS) code that they would bill for an in-person visit. Facilities can use POS code 10 if the patient is in their home when the telehealth services are rendered or POS code 02 if they are not. POS code 10 will continue to be paid at the non-facility rate.

Revenue integrity professionals can view the updated E/M guidance for a complete list of codes added to the Medicare telehealth services list for 2025, as well as CMS’ guidance on telehealth and remote patient monitoring for additional information.

Editor's note: *This article originally appeared in Revenue Integrity Insider, NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Coding, Medicare news

Q&A: Responding to governmental audits

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News & Insights

Q: What departments should be involved in governmental audit response efforts?

A: Governmental audits are handled differently at every facility, but favorable results are more likely with a strong audit response that meets all additional documentation request (ADR) requirements.

“It is imperative that organizations determine who the right folks are to engage in the process,” says **Diane Weiss, CPC, CPB, CCP, CHRI,** vice president of revenue integrity and education at RestorixHealth in Metairie, Louisiana.

Some facilities split up auditing responsibilities across several departments (e.g., compliance, revenue integrity, HIM, billing), but others take a more centralized approach. Large health systems, especially those that experience a high volume of audits across several facility types and specialties, may need to use a combination of both approaches, according to **Dawn Crump, MA, SSBB, CHC,** vice president of revenue integrity at MRO in Norristown, Pennsylvania.

Regardless of structure, she recommends securing early engagement from HIM staff and release of information vendors.

“They can help get the appropriate documentation out of your facility and into the contractor’s hands as soon as possible,” she says.

She also notes that revenue integrity professionals are another key piece of the puzzle. Their expertise and involvement in internal auditing processes are helpful, as is their ability to identify areas of opportunity and compliance concerns before contractors do, she says.

“They can help their facility follow a more holistic approach instead of waiting for external auditors to point out opportunities and flaws,” she says.

Designating a point of contact (POC) for every audit is best practice. Organizations may choose to assign the same POC for certain types of audits or specific contractors.

“For some of our hospital partners, the POC is the lead compliance professional,” says Weiss. “For others, it is someone on the revenue integrity team.”

The POC should understand the contractor’s audit protocols and be a good communicator. When engaging with the auditor, the POC should prioritize transparency, cooperation, and timeliness.

Contractors appreciate when organizations are timely in not only responding to the ADR, but informing them of delays as well. Note that there are only limited reasons as to why an auditor would grant an extension. For example, an organization can’t ask for more time because it is understaffed, as all organizations are dealing with staffing problems, says Crump. Extenuating circumstances could lead to more flexibility, as long as the POC is transparent with the auditor.

“They can’t always go outside of their statement of work, but they will try to work with you if possible,” she says.

For example, in the aftermath of a cyberattack, a hospital may not be able to access its electronic health record to retrieve items requested in the ADR.

“In that scenario, your POC would inform the auditor that your organization is under breach protocol and is unable to meet the deadline,” says Crump.

Editor’s note: *This answer was excerpted from “Governmental audits: Ensuring a thorough, timely reply” in the October 2025 issue of the* NAHRI Journal*.*

Related Topics:
Auditing and monitoring, Compliance, Documentation improvement, HIM/HIPAA

Discover revenue integrity salary and staffing trends

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News & Insights

Planning the next steps in your career or for your revenue integrity department can be challenging—especially now. Understanding industry-wide trends and making data-informed decisions is critical to setting standards and expectations for staffing and salaries.

Earlier this year, the National Association of Healthcare Revenue Integrity (NAHRI) conducted its annual Revenue Integrity Salary Survey to gain insights on current trends in revenue integrity compensation, program management, and design. On October 21, join NAHRI for a free webinar to analyze the results of this year's survey and discover how to apply the information to your department and career. The webinar will also highlight how experience, location, education, and other factors can affect advancement opportunities.

During the webinar, attendees will hear expert insights from the following panelists:

- **Alison Davis, CPC, CEMC,** manager of revenue integrity at Carle Health in Urbana, Illinois
- **Sandra Giangreco Brown, MHA, BS, NREMT, CHRI, RHIT, CCS, CCS-P, CHC, CPC, CPCO, COC, COBGC, PCS,** vice president of revenue integrity and education at Spire Orthopedic Partners in Stamford, Connecticut
- **Irene Sachakov, CHRI, CRCR, CSPR, CSAF,** director of revenue integrity at Northeast Georgia Health System in Gainesville, Georgia

Non-NAHRI members are encouraged to attend. NAHRI members can access the full survey results in the *2025 Revenue Integrity Salary Survey Report*, which will be published later this year.

Don't miss your opportunity to gain valuable information on how to advance your revenue integrity career and program. Click here to register for the free webinar!

Report: Achieve claim management clarity with new strategies

October 22, 2025
News & Insights

As healthcare revenue cycle teams need to process more transactions than ever, it’s hard to find—and keep—great team members. Staff must stay current with claim-submission compliance and reduce cybersecurity risks while keeping customer data secure.

So, how do healthcare organizations balance it all? By selecting strategic processes, the right healthcare payments partner, and game-changing automation.

A recent report from Waystar provides a step-by-step strategic plan to help you achieve clarity in claim management processes. The report highlights claim management tactics proven to boost staff efficiency, time-saving tips, and methods for prioritizing denials with the highest likelihood of payoff. It also details results that healthcare organizations are experiencing with automation and offers strategies for streamlining claim management workflows.

Click here to download the report and learn how to leverage technology for clean claims, fewer denials, and faster, fuller payments.

Related Topics:
Billing and reimbursement, Denials and appeals

CMS issues claims processing hold update

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News & Insights

On October 21, CMS directed Medicare Administrative Contractors (MAC) to lift the claims processing hold issued earlier this month for certain services impacted by the government shutdown. The agency instructed all MACs to process claims with dates of service on or after October 1 for Medicare Physician Fee Schedule, ground ambulance transport, and federally qualified health center claims.

The hold is also lifted for telehealth claims that CMS can confirm are definitively for behavioral or mental health services, according to the update. However, the agency instructed all MACs to continue the processing hold for other telehealth services, as well as Acute Hospital Care at Home claims.

CMS reiterated that any organization that furnishes telehealth services not payable by Medicare on or after October 1 should consider providing beneficiaries with an Advance Beneficiary Notice of Non-Coverage.

CMS originally ordered the hold to prevent the need for reprocessing large claim volumes before lawmakers reach a resolution and end the shutdown. Organizations were authorized to continue submitting claims during the hold but were notified that payment would not be issued until it was lifted. On October 15, the agency clarified that it will continue to pay and process affected claims in a timely fashion "with the exception of select claims for services impacted by the expired provisions."

Revenue cycle professionals must monitor for additional claims processing updates and other instructions from CMS throughout the government shutdown. Review Medicare telehealth policies and ensure your team understands how the shutdown is impacting operations.

Editor's note: *A version of this article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
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