

# Helping Patient Care Make (More Than) Cent\$

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# Disclosure Information (Required)

☀ Darve Robinson, MD

☀ Presenter 1 Disclosures: No Disclosures

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☀ Presenter 2 Disclosures: No Disclosures

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☀ Presenter 3 Disclosures: No Disclosures

# Workshop Development Cohort

- Barbara Wigglesworth, CPC, CPMA, CDEO, CRC, CCS, CHC
- Greg Langan, DHSc, LSW, MPH
- Heidi Smith, CPC, CRC
- Jennifer Blake, M.S.Ed., CPC, CPMA
- Susan Holzberg, CPC

# Learning Objectives

- Analyze current clinical documentation for growth opportunities including new billing pathways established by CMS in CY 2025/2026.
- Develop a framework for implementing a new service line within your clinical department and assess for sustainability
- Formulate a team strategy to accurately map clinical effort into clinical revenue through value capture.

# Disclaimer

- Clinical Practice Location:
  - Southern New Jersey Region (close to the Philadelphia region)
  - Fee for Services; No shared Risk Care Model
  - Large Subspecialty Clinic at an Academic Medical Center
  - None of our primary locations are at a FQHC or have a rural medicine designation
- Please ensure regional clinical applicability and local payer policy before integrating the CPT or E/M Codes highlighted in this workshop.
- Focus of this discussion is Ambulatory Outpatient Clinical Care

# CPT Coding

- ☀️ “Current Procedure Terminology” Codes
  - ☀️ 5-digit numerical codes (00000-99999)
  - ☀️ Assigned by AMA to every procedure, operation, test, patient encounter
  - ☀️ When approved, each code is assigned an RVU value, which is used by Medicare and other payers to determine payment
  - ☀️ Industry standard for providing patient care since 1966

# Evaluation and Management

## ☀ E/M codes:

- ☀ Small sliver of the CPT spectrum (99202-99499)
- ☀ Used to cover cognitive services (in contrast to procedures)
- ☀ Generally used for office visits, hospital visits, and consultations
- ☀ Used in outpatient, inpatient, nursing homes, homes, and telehealth among other sites
- ☀ Represent about 40% of Medicare payments and 40% of Medicare claims

# Evaluation and Management: Coding by Time

- ☀ Includes face-to-face time and non-face-to-face time
  - ☀ Chart prep
  - ☀ Peer consultation
  - ☀ Care coordination
  - ☀ Chart review
  - ☀ Documentation

New patient	Time (minutes)	Established patient	Time (minutes)
99202	15-29	99212	10-19
99203	30-44	99213	20-29
99204	45-59	99214	30-39
99205	60-74	99215	40-54

# Evaluation and Management: Coding by MDM

- ✦ Medical Decision Making documentation should include:
  - ✦ Making a diagnosis
  - ✦ Assessing status (chronic/acute, at goal/not at goal, stable/not stable)
  - ✦ Selecting treatment options
- ✦ Problems in MDM should match diagnoses linked to the claim

# Evaluation and Management: Coding by MDM

- ☀️ MDM split into 3 elements:
  - ☀️ Number and complexity of problems addressed (“COPA”)
  - ☀️ Amount and Complexity of Data Analyzed and Reviewed (“Data”)
  - ☀️ Risk of Complications and/or Morbidity/Mortality of Patient Management (“Risk”)
- ☀️ Each element has 4 levels corresponding to 9920x/9921x
- ☀️ To qualify, documentation must reflect  $\geq 2$  of 3 elements for that level

# Low level MDM: 99203/99213

## Elements of Medical Decision Making

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + 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
<b>Straightforward</b>	<b>Minimal</b> • 1 self-limited or minor problem	<b>Minimal or none</b>	<b>Minimal risk of morbidity from additional diagnostic testing or treatment</b>
<b>Low</b>	<b>Low</b> <ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems;</li> <li>OR</li> <li>• 1 stable chronic illness;</li> <li>OR</li> <li>• 1 acute, uncomplicated illness or injury</li> <li>OR</li> <li>• 1 stable acute illness</li> <li>OR</li> <li>• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care</li> </ul>	<b>Limited (Must meet the requirements of at least 1 of the 2 categories)</b>  <b>Category 1: Tests and documents</b> <ul style="list-style-type: none"> <li>• Any combination of 2 from the following:                             <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source;</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test</li> </ul> </li> </ul> OR  <b>Category 2: Assessment requiring an independent historian(s)</b> (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	<b>Low risk of morbidity from additional diagnostic testing or treatment</b>  Examples only: <ul style="list-style-type: none"> <li>• Over-the-counter drugs</li> <li>• Minor surgery with no identified risk factors</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• IV fluids without additives</li> </ul>

# Moderate level MDM: 99204/99214

## Elements of Medical Decision Making

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + 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
Moderate	<p><b>Moderate</b></p> <ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;</li> <li>OR</li> <li>• 2 or more stable chronic illnesses;</li> <li>OR</li> <li>• 1 undiagnosed new problem with uncertain prognosis;</li> <li>OR</li> <li>• 1 acute illness with systemic symptoms;</li> <li>OR</li> <li>• 1 acute complicated injury</li> </ul>	<p><b>Moderate</b> <i>(Must meet the requirements of at least 1 out of 3 categories)</i></p> <p><b>Category 1: Tests, documents, or independent historian(s)</b></p> <ul style="list-style-type: none"> <li>• Any combination of 3 from the following:               <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source;</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test;</li> <li>• Assessment requiring an independent historian(s)</li> </ul> </li> </ul> <p>OR</p> <p><b>Category 2: Independent interpretation of tests</b></p> <ul style="list-style-type: none"> <li>• Independent interpretation of a test performed by another physician/ other qualified health care professional (not separately reported);</li> </ul> <p>OR</p> <p><b>Category 3: Discussion of management or test interpretation</b></p> <ul style="list-style-type: none"> <li>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</li> </ul>	<p><b>Moderate risk of morbidity from additional diagnostic testing or treatment</b></p> <p>Examples only:</p> <ul style="list-style-type: none"> <li>• Prescription drug management</li> <li>• IV fluids with additives</li> <li>• Therapeutic nuclear medicine</li> <li>• Decision regarding minor surgery with identified patient or procedure risk factors</li> <li>• Decision regarding elective major surgery without identified patient or procedure risk factors</li> <li>• Closed treatment of fracture or dislocation without manipulation</li> <li>• Diagnosis or treatment significantly limited by social determinants of health</li> </ul>

# High level MDM: 99205/99215

## Elements of Medical Decision Making

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + 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
High	<p><b>High</b></p> <ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;</li> <li>OR</li> <li>• 1 acute or chronic illness or injury that poses a threat to life or bodily function</li> </ul>	<p><b>Extensive</b> (<i>Must meet the requirements of at least 2 out of 3 categories</i>)</p> <p><b>Category 1: Tests, documents, or independent historian(s)</b></p> <ul style="list-style-type: none"> <li>• Any combination of 3 from the following:               <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source;</li> <li>• Review of the result(s) of each unique test;</li> <li>• Ordering of each unique test;</li> <li>• Assessment requiring an independent historian(s)</li> </ul> </li> </ul> <p>OR</p> <p><b>Category 2: Independent interpretation of tests</b></p> <ul style="list-style-type: none"> <li>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</li> </ul> <p>OR</p> <p><b>Category 3: Discussion of management or test interpretation</b></p> <ul style="list-style-type: none"> <li>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)</li> </ul>	<p><b>High risk of morbidity from additional diagnostic testing or treatment</b></p> <p>Examples only:</p> <ul style="list-style-type: none"> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision regarding elective major surgery with identified patient or procedure risk factors</li> <li>• Decision regarding emergency major surgery</li> <li>• Decision regarding hospitalization or escalation of hospital-level care</li> <li>• Decision not to resuscitate or to de-escalate care because of poor prognosis</li> <li>• Decision regarding parenteral controlled substances</li> </ul>

# Modifiers

- ✦ Modifiers are 2-digit codes appended to CPT codes to indicate that a service was altered
- ✦ “25” modifier is added to E/M codes to indicate a procedure was performed on the same day as an E/M
  - ✦ Must provide clear and distinct documentation supporting the separate code

# Modifiers

- ☀ Other Healthcare Common Procedure Coding System (HCPCS) modifiers of interest to Addiction Medicine (“Level II” codes):
  - ☀ GC modifier: Used to indicate services performed by a resident or fellow under supervision of a teaching physician
  - ☀ HF modifier: Used to indicate services performed in specialized addiction treatment or substance use program

# G codes

- ☀️ HCPCS codes used primarily for Medicare billing
- ☀️ Report professional services, procedures, and functional limitations that lack specific CPT codes
- ☀️ Used by Medicare for risk adjustment and reimbursement
  - ☀️ Frequently adopted by other insurers
- ☀️ Examples:
  - ☀️ G2211: Chronic complex management
  - ☀️ G2212: Prolonged (>54 min) care on the day of service

# Z codes

- ☀ **Diagnoses** (ICD10 Codes) used to describe factors influencing health status and social determinants of health (SDOH)
- ☀ Very common in patients with SUD
  - ☀ **Z55-Z65:** Socioeconomic and psychosocial factors (SDOH), including education, employment, housing, and social environment.
- ☀ Can support Moderate MDM!

## Risk of Complications and/or Morbidity or Mortality of Patient Management

### Moderate risk of morbidity from additional diagnostic testing or treatment

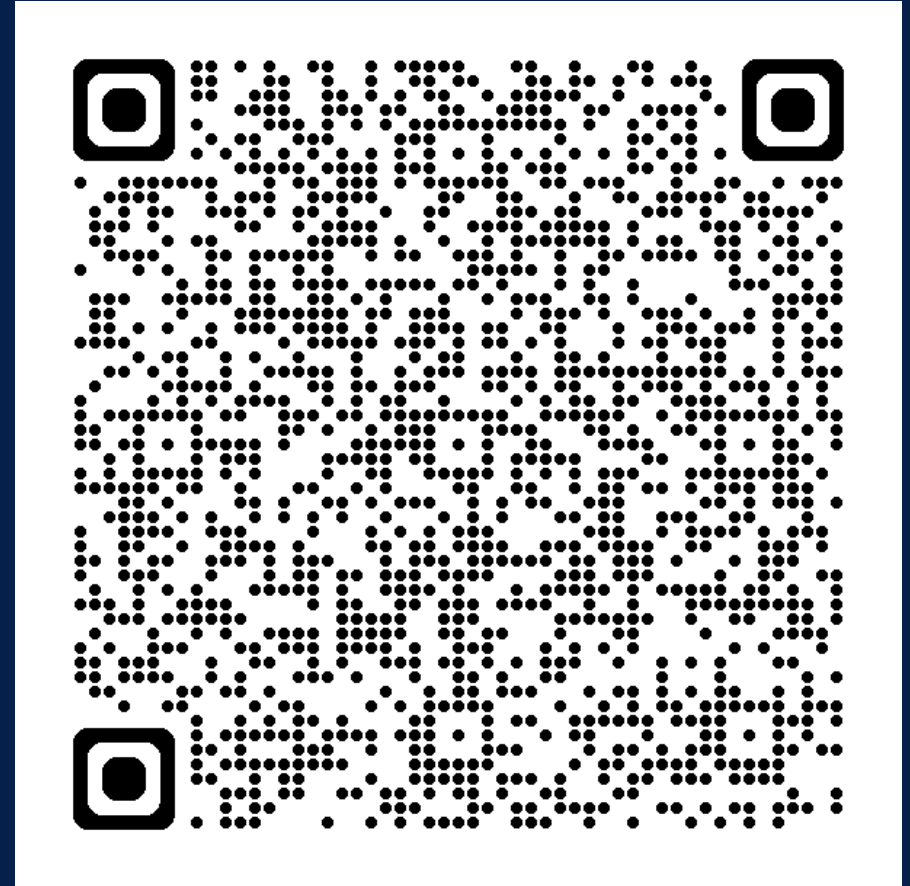
Examples only:

- Prescription drug management
- IV fluids with additives
- Therapeutic nuclear medicine
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Closed treatment of fracture or dislocation without manipulation
- Diagnosis or treatment significantly limited by social determinants of health

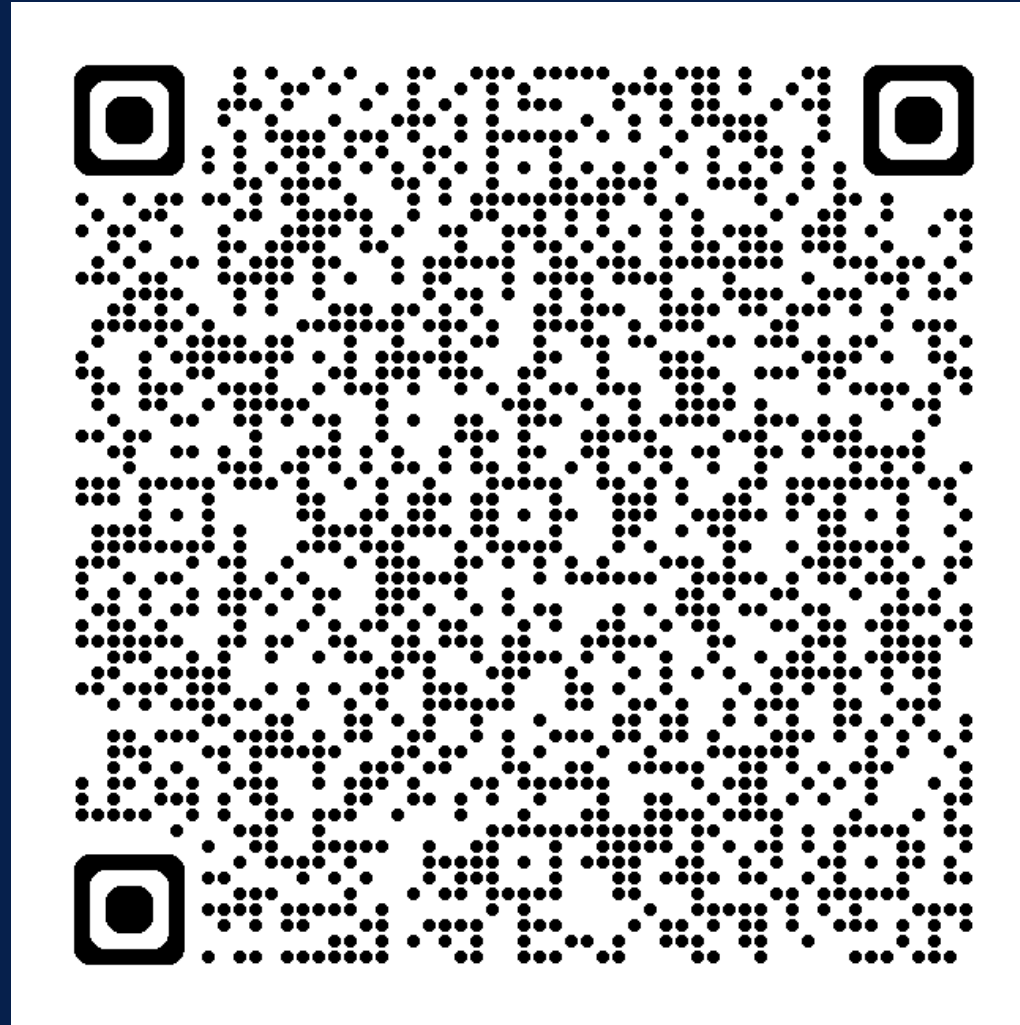
# Activity 1: Note Review

In groups at your table, look at the following clinical note and answer the following questions:

- 1) What is the level of service for this visit and why?
- 2) Have there been any separate billable CPT services documented in this clinical note? What were those CPT services?



# Activity 1: Enhanced Note



More insights at  
[asamcoding.work](https://asamcoding.work)

# Activity 2: Effort Mapping

The following slide has a list of activities that were performed during the clinical care of a patient:

- In your groups, talk about how you would categorize all the activities, and what CPT codes/procedures would be applicable?
- These are the “buckets”:
  - **Separate CPT Codes**
  - **Not Billable**
  - **Standard E/M**

# Activity 2: Effort Mapping

In-office LAIB  
injection

Calling  
patient with  
Lab Result

Completion of  
Prior  
Authorization

Smoking  
Cessation  
Counselling

Teaching  
Physician  
Trainees

Harm  
Reduction  
Counselling

Screening for  
Sexual  
Transmitted  
Infections

# Effort Mapping Solution

In-office LAIB  
injection

Smoking  
Cessation  
Counselling

Calling  
patient with  
Lab Result

Completion of  
Prior  
Authorization

Teaching  
Physician  
Trainees

Harm  
Reduction  
Counselling

Screening for  
Sexual  
Transmitted  
Infections

# Notable Addiction Medicine Billing Codes

- G2211
- In Office Injection Administration - 96372
- Smoking Cessation – 99406/99407
- Depression Screening - 96127
- Teaching Physician Trainee – GC modifier
- Modifier 25 Code
- Interprofessional Consultation Code
- Telehealth

More insights at  
[asamcoding.com](https://asamcoding.com)



# Combining CPT + E/M Codes

- Key principle: Documentation should include the details to support the 2 separate services on the same date of service.
- Examples:
  - Smoking cessation Counseling + Nicotine use disorder management
  - Buprenorphine injection and opioid use disorder management
- For services that involve time, document separate time appropriately

# Interprofessional Consultation

- **Opportunity:** You can bill for completing an addiction consultation about a patient's care without the patient present
- **Payor:** Rules vary by payor; Medicare uses G-codes; Commercial and Medicaid use CPT equivalents.
- **Compensation:** The requesting/treating physician can also bill for time preparing for the consultation
- **Strict Requirements:** Advanced consent from patient, a written report of consult, no face-to-face visit with the patient within 14 days of consultation.

# Telehealth Billing and Coding

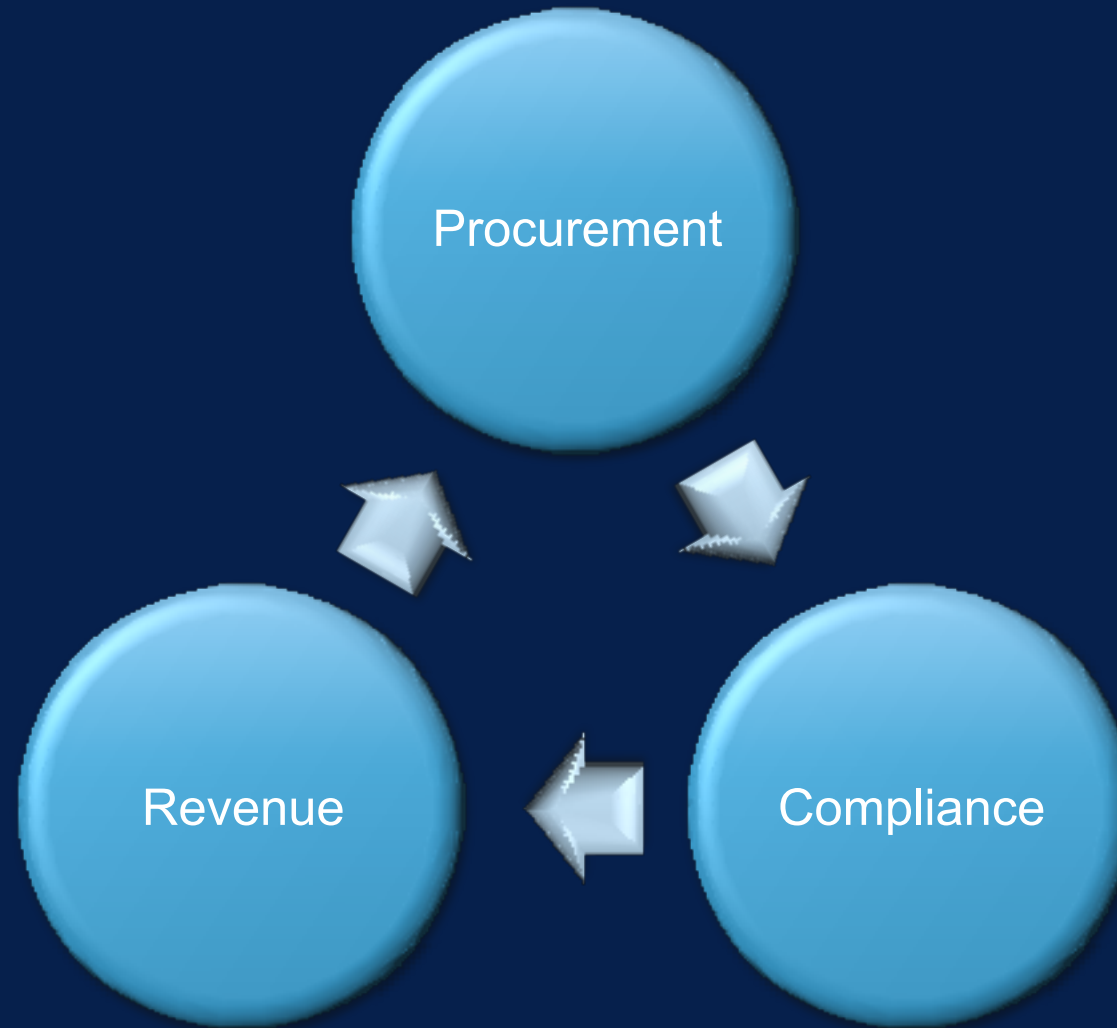
- **DEA Extension:** The ability to prescribe buprenorphine via telehealth is extended through 12/31/2027\*
- **Medicare:** Behavioral telehealth requires an in-person visit within 6 months prior, then annually.
- **Billing:** Place of Service (POS) modifiers impact reimbursement—please confirm with individual payors their requirements
- **Documentation requirements:** Modality(Audio/Video or Audio only) Pt consent, location of the patient (state and location type ) and provider, and who else is present.
  - Audio only: Provider had the ability to be Audio/Video + why Audio only.

[Telehealth.HHS.gov](https://www.hhs.gov/telehealth)

\*State requirements could constrain this extension.



# Building a New Clinical Service Line



# Regional Reimbursement Rates

☀ NJ

☀ California

☀ Alabama

☀ Texas

☀ Ohio

☀ Colorado

☀ CPT included: Telehealth, IPC, Smoking Cessation, IM/SQ Admin

More insights at  
[asamcoding.work](https://asamcoding.work)  
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# Activity 3: Case Presentation

- Case 1: In a large multi-disciplinary group setting (including Pharmacy, Behavioral Therapist, and health navigation services) you complete patient visits for the participants. During one visit you administer their buprenorphine injection, complete tobacco cessation counselling, and collect and interpret a PH9 assessment.
- What services can you bill for in this clinical situation? How would you think about documentation.

# Case Presentation

- Case 2: You receive a call from a primary care colleague who is caring for a patient with sedative hypnotic use disorder who has not been evaluated by you in the last 7 days. During the conversation you were able to review the patient's chart, Prescription monitoring database, and the last set of urine toxicology prior to providing a written clinical recommendation.
- What services can you bill for during this visit? Would this change if you determine the patient needs to be seen in person at your addiction medicine clinic?

# Case Presentation

- Case 3: You are seeing a patient in your low access bridge clinic and perform a standard E/M service for their unstable, opioid use disorder during this visit. On chart review, you notice that the patient has a buprenorphine injection available to be administered by one of your practice partners who is working at the long-term addiction clinic close by and the patient heads there and get their injection.
- Can both providers bill for their various clinical services delivered during this date of service? How would one think through documenting and billing in this scenario?

# Final Takeaways/Summary

- Thoughtfully exploring and refining clinical documentation can be a tool for supporting sustainable clinical practice.
- Multidisciplinary partnerships are key for realizing new service lines and ensuring their long-term viability
- You already do so much awesome work! It is possible to capture that value add from major payors through an intentional coding strategy.

# Great Resources

- 1. Coding for Clinicians** from American College of Physicians
- 2. Coverage Guidance + Practice Management** section from American Society of Addiction Medicine
- 3. Family Practice Manager** from American Academy of Family Physicians (personal favorite 😊)

Full resource repository at [asamcoding.work](https://asamcoding.work)

