Document the work. Then choose the code.

Office/outpatient reference for clinicians. Use current payer rules and actual encounter documentation. This is a quick check, not a complete coding protocol.

01 / Office E/M: time or medical decision making

Established patients: **99213 = low MDM or at least 20 qualifying minutes; 99214 = moderate MDM or at least 30 minutes.** MDM needs two of three elements: problems, data, risk. Count only eligible physician/QHP work on the date of service; exclude separately reported services.

02 / G2211 and modifier 25

Do not use a blanket never-together rule. Medicare permits qualifying same-day preventive-service exceptions. Confirm the current eligible-service list, underlying E/M, and longitudinal-care requirements. A routine procedure does not automatically qualify.

03 / Annual Wellness Visit

Verify IPPE/AWV history and the payer-reported next eligible date. G0438 is the initial AWV; G0439 is subsequent. Do not assume a January reset. Complete required preventive-planning elements. Additional services need independent eligibility and documentation; do not automatically bundle add-ons.

04 / Transitional Care Management

99495: at least moderate MDM, face-to-face within 14 calendar days. **99496:** high MDM, face-to-face within 7 calendar days. Both generally require interactive contact within 2 business days. Review all CMS requirements, including medication reconciliation and the service period.

Use the free tools and read the full source guidance

rvudoc.com/resources/outpatient-coding-reference

Sources: CMS E/M guide, E/M visit policy, AWV guidance, and TCM booklet.

CMS E/M CMS G2211 CMS AWV CMS TCM