ASCO's Coding Tip of the Month: Archived

November 2025 – Diagnosis and status codes

Accurate diagnosis codes, or ICD-10-CM codes, are essential for establishing medical necessity, as they provide payers with a full picture of the patient's condition and support the physician's rationale for medical decision making.

In addition to condition diagnosis codes, status codes may indicate additional parameters affecting the rationale for a patient's treatment or diagnostic testing and/or screening. These codes can be found in Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z codes) of the ICD-10-CM manual. Code families that may relate to factors affecting rationale in oncology include, but are not limited to:

- Z15.0 - Z15.068 Genetic susceptibility to malignant neoplasms
- Z17.0 – Z17.421 Estrogen and other hormones factor status
- Z19.1, Z19.2 Hormone sensitivity or resistance status
- Z79.0 – Z79.891 Long term drug therapies
- Z80.0 – Z80.8 Family history of malignant neoplasms
- Z85.00 – Z85.89, Z86.000 – Z86.018 Personal history of malignant neoplasms, in-situ, and benign neoplasms
- Z90.01 – Z90.89 Absence of organs (i.e., breast, cervix, uterus)
- Z92.21 - Z92.3, Z92.850 – Z92.86 Personal history of drug therapy, irradiation, cellular and gene therapy

October 2025 – Downcoding

Downcoding is the process in which a payer assigns a lower-level code to medical services, specifically evaluation and management visits, than those reported by the practitioner. Payers are utilizing claims data, like diagnosis codes, to determine whether the reported E/M code is reflective of an appropriate level of service. Payers may also be using algorithms to target "outlier" reporting by physicians based on peer comparison.

Payers are notifying providers of affected codes by pending claims for medical records review, denying with a level of service denial code, or reimbursing the level of service reported with the lower-level rate. Awareness of these applications may assist practices in identifying affected claims.

Some payers may have bypass procedures, however most claims will need to be appealed if the clinic believes the E/M service was correctly reported. The American Medical Association has published a

white paper detailed information about E/M downcoding programs and also offers an appeal template for those needing to appeal affected claims.

September 2025 – ICD-10-CM Updates

Diagnosis coding affects many aspects of practice reimbursement: authorizations, claims processing due to medical necessity, and audits are among the practice impacts. It's imperative to be aware of annual changes that affect oncology in a timely manner. ASCO has a resource for oncology relevant ICD-10-CM changes that go into effect October 1st, 2025. Make sure to update your systems before the effective date!

August 2025 – Proposed Rules

The Centers of Medicare and Medicaid Services (CMS) recently released their Proposed Rules for 2026 relating to the Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (OPPS). These rules indicate the changes Medicare is proposing for policies and reimbursement in both the physician office and hospital outpatient settings. To understand the implications for oncology, ASCO released ASCO in Action articles on both the PFS Proposed Rule and the OPPS Proposed Rule. Additional resources are forthcoming.

July 2025 – Medical Decision Making for Evaluation

When choosing a level of service for office visits and other related evaluation and management codes, two of three categories must be met or exceeded in order to assign a specific level of service?

A high-level problem of risk of morbidity or mortality does not necessarily equate to a high level of medical decision-making without a high level of either problem addressed OR data. ASCO's resource on Medical Decision-Making Simplified has more information to better understand the levels and how to select an appropriate level for your evaluation and management service. This and other related resources can be found on ASCO's Coding and Reimbursement page.

It's critical to clearly communicate the thought process and rationale used in the documentation of a service ("showing your work"). Documentation not easily understood to all who read the note can lead to prior authorization and claims denials, down coded visits, along with other ramifications.

June 2025 - Documentation

The Centers for Medicare and Medicaid Services recently updated their Fact Sheet "Complying with Medical Record Documentation Requirements". Updated language reiterates that sufficient

documentation in the provider records "must verify that services performed were compliant with CMS policies and required the level of care billed". In fact, CMS found in that insufficient documentation was the cause of 59.8% of all improper payments made by Medicare in 2024.

Documentation insufficiencies, particularly for office visits, may result from errors such as the documentation not supporting the reported level of service, failure to meet the signature requirements for payment, or inadequate documentation for the billed date of service.

When medical records are requested, it is the responsibility of the billing provider to submit the requested documentation. Lack of proper or complete documentation can invalidate the services reported, potentially resulting in claim denials or overpayment issues.

May 2025 – Intra-arterial

There has been confusion on how to report drug refills for hepatic arterial infusion, since the drugs used may be either therapeutic or chemotherapeutic. It's important to note that the descriptor for 96522 (refilling and maintenance of an implantable pump or reservoir for systemic drug delivery) is the same regardless of the type of systemic drug being used to refill the pump or reservoir. This service would be separate from the implantation of the pump and an initial fill of the pump and reported with other appropriate codes dependent on relation to encounter.

April 2025 – Telehealth updates

On March 14th, Congress passed a continuing resolution to not only fund the federal government, but the action also extends telehealth flexibilities through September 30th, 2025. In doing so, all Medicare beneficiaries, regardless of geographic location, will continue to have access to covered telehealth services in their homes. Private payers may have their own telehealth reporting and coverage policies, so please check individual payers for guidance. Please refer back to ASCO's February 2025 Coding Tip of the Month, available in the Coding Tip of the Month Archive, for a high level of overview of E/M telehealth reporting to Medicare.

March 2025 – Subcutaneous chemotherapy administration

With the emergence of multiple subcutaneous chemotherapy formulations of drugs originally formulated for intravenous infusion administration, it's important to know the appropriate administration codes for these subcutaneous administrations. There are currently only two CPT® codes available to report subcutaneous chemotherapy administration. "Chemotherapy" administration may also apply to highly complex drugs and highly complex biologic agents.

96401: Subcutaneous or intramuscular chemotherapy administration; non-hormonal
96402: Subcutaneous or intramuscular chemotherapy administration; hormonal

These codes are agnostic to time, which means time is not a factor in code selection. Refer to the latest publication of the *CPT® Professional Edition* for more information.

February 2025

While the CPT Editorial Panel created a set of new audio/visual and audio-only telehealth evaluation and management visit codes to be used in 2025, CMS is not reimbursing for these codes. Instead, Medicare is allowing two-way, real-time audio only telehealth service if the provider is technically capable of providing audio-visual telehealth. Providers reporting telehealth services for Medicare beneficiaries should utilize the appropriate E/M services (99202-99215) with an appropriate POS. A modifier may be needed to indicate audio only or Federally Qualified Health Centers/Rural Health.

Congress extended Medicare telehealth flexibilities until March 31st, 2025. All Medicare beneficiaries, regardless of geographic location, will continue to have access to covered telehealth services in their homes. Non-behavioral physician specialties, including oncology clinicians, can continue to provide telehealth also. Please check other payers for telehealth policies for coding and coverage guidance as these policies may differ.

January 2025

Effective January 1, 2025, rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will be required to report service-based codes for care management services individually rather than with HCPCS code G0511 (general care management for rural health clinic or federally qualified health center only, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner, per calendar month). CMS is allowing a six-month transition period through July 2025. Refer to ASCO's G0511 resource for more detailed information and links to resources.

December 2024

The end of the year is here, and changes are coming in 2025. ASCO has multiple resources to help practices prepare for the new year. For coding updates, ASCO publishes resources on its Coding and Reimbursement page detailing oncology-related changes to the code sets, including (but not limited to):

- Quarterly HCPCS code updates
- Annual ICD-10-CM (diagnosis) code updates effective October 1st
- Annual American Medical Association (AMA) CPT code set changes effective January 1st and published in the AMA CPT Professional edition.
- On demand webinars summarizing updates and changes.

October-November 2024

No tips.

September 2024

CPT stands for Current Procedural Terminology, and each code goes through the AMA CPT Editorial Panel for review before being added to the CPT code manual.

Reimbursement value recommendations are developed through a process administered by the AMA's RVS Update Committee (RUC) and, if approved, are sent to Center for Medicare and Medicaid Services (CMS) for consideration. CMS details their decision on whether to apply those recommendations or alternate considerations each year in their Proposed and Final Rules for the Physician Fee Schedule (PFS) and Hospital Outpatient Prospective Payment System (OPPS).

ASCO is represented in both the CPT and RUC by volunteer advisors, who dedicate a significant amount of time engaging in these important processes.

CPT Editorial Panel

- Dr. Joseph Merchant (Primary)
- Dr. Rahul Seth (Alternate)

RVS Update Committee

- Dr. Elizabeth Blanchard (Primary)
- Dr. Arturo Loaiza-Bonilla (Alternate)

ASCO provides a summary of oncology related coding updates each year in the fall. Learn more about how the CPT and RUC's work impact the Medicare Physician Fee Schedule in the ASCO Webinar "2025 Physician Fee Schedule Proposed Rule and the Impact on Oncology".

August 2024

In November 2023, the Office of the Inspector General (OIG) identified over a 90% error rate in audited cancer diagnosis coding. The associated audit resulted in $479,487 in Medicare Advantage overpayments.

According to ICD-10-CM guidelines, a code from category Z85 to indicate a personal history of cancer should be assigned if the following criteria are met:

- Primary malignancy has been eradicated or excised from its site.
- No further treatment to the site.
- No evidence of existing primary malignancy at the site.

A secondary site, either through extension, invasion, or metastasis may be indicated as a primary diagnosis with a Z85 History of code used as a secondary diagnosis.

To report cancer diagnoses accurately, it's imperative to indicate whether the cancer is active or as a history status (indicated by Z codes). Most of the cancer diagnoses identified as being coded in error were reported as active cancers, and documentation indicated a history of cancer instead. The OIG has provided a toolkit to help decrease improper reporting of high-risk diagnosis codes.

July 2024

In 2023, CMS implemented a policy which required drug waste to be indicated with either a JZ or JW modifier and is covered by ASCO's Drug Waste Modifier resource. As of **January 1, 2024**, CMS also requires 340B entities to report either modifier *JG or* **TB** for separately payable drugs to indicate the drug was acquired using the 340B program. Entities may use their current modifier or transition to the TB modifier early.

JG: drug or biological acquired with the 340B drug pricing program discount, reporting by select entities
TB: Drug or biological acquired with 340B drug pricing program discount

Starting January 1st, 2025, the use of the TB modifier is required by all 340B entities. CMS published resources available to help navigate 340B modifier reporting: Use of the 340B Modifier, Billing 340B Modifiers for OPPS FAQs, and Revised Part B Inflation Rebate Guidance: Use of the 340B Modifier. ASCO's drug waste modifier resource, found on ASCO's Coding and Reimbursement page, also includes information on the TB modifier requirement for 2025.

June 2024

A patient with social determinants of health (SDOH) can have a significant impact on the ability to diagnose and treat a condition as well as impact the patient's overall health. To capture SDOH information, the appropriate diagnosis codes should be reported when providing related services (for example, office visits, care management services, and navigation services). SDOH health diagnosis codes (Z55-Z65) are found in the Z codes section of the ICD-10-CM code set. Categories include education, employment, financial circumstances, housing, psychosocial circumstances, and language and literacy.

Additional information on social determinants of health can be found in ASCO's Connecting and Reporting Social Determinants of Health resource in addition to ASCO's webpage on Health Equity Initiatives.

May 2024

Incident-to services are provided by personnel including but not limited to physician assistants and nurse practitioners in non-institutional settings. Inpatient services are subject to split or shared billing depending on payer policy.

Incident-to Rules:

- Services integral to physician's professional services.
- Services must be of a type commonly furnished in an office or clinic.
- APP must be employed by the physician or practice either directly, contracted, or in a leased capacity.
- Direct supervision required.
- Established patients and conditions only; physicians must establish the care, diagnosis, and course of treatment for any condition to which the APP's services follow.

The services would be reported under the supervising practitioner's NPI, and payment would be based on the full physician PFS rate. If conditions are not met, services would be billed under the APP's NPI and subject to a reduced rate. Not all payers allow incident-to billing. Please refer to individual payer policy for coverage.

April 2024

A visit in the hospital setting that is "split" or "shared" by a physician or non-physician practitioner is subject to split/share billing guidelines. In 2024, CMS finalized their guidelines to split/shared billing to reflect changes enacted in the 2024 AMA CPT manual. In 2024, split/share service levels are determined by:

- Time: The practitioner spending the majority of time with the patient.
- Medical decision-making: The reporting provider performs the substantive portion of the medical decision-making, as defined by guideline instruction.
- Modifier -FS should be appended to the split/shared visit code.

ASCO's Coverage and Reimbursement resource on Split/Share E/M Services was updated to include more details on split/share billing, including updates, reporting criteria for time and medical decision making, and documentation requirements. Not all payers accept split/share billing. Please refer to individual payer policy for coverage.

March 2024

A new code covered in ASCO's Care Management and SDOH G Comparison resource is *G0136*, established by Medicare this year to capture the *administration of a Social Determinants of Health (SDOH) Risk Assessment tool*. G0136 accounts for 5-15 minutes of administering the tool, and time may also contribute to other navigational services as indicated by Medicare.

Many practices may be utilizing a tool during navigational services, and this code now allows the assessment to be reported for reimbursement. It's important to note the risk assessment tool used **must be a standardized, evidence-based tool.**

February 2024

Effective January 1st, 2024, the visit complexity add-on code is effective for payment under the Medicare Physician Fee Schedule. According to a recent ASCO in Action article, depending on the level of service reported a provider may see visit reimbursement increase from 7.3% to 69%.

G2211: Visit complexity add-on code for an office and/or outpatient evaluation and management service

The billing practitioner must provide ongoing medical care acting as a continuing focal point of all needed healthcare services AND/OR as part of care related to a single, serious or complex condition, like cancer. See the visit complexity add-on code resource below for more information.

January 2024

According to a study cited in the 2020 ASCO Educational Book on end-of-life conversations, only 26% of respondents living with cancer had discussed end-of-life care with their doctor. Facilitating discussions of goals of care, palliative care, and advance care planning into the oncology care plan is a key standard of Oncology Medical Home and the ASCO Certified program and support quality cancer care from diagnosis to end of life.

To report Advance Care Planning services, there are two associated codes:

99497: Advance care planning including explanation and discussion of advance directives by the physician or qualified health care professional, first 30 minutes
99498: Each additional 30 minutes

ASCO has multiple resources available to assist practices with the implementation and reporting of advance care planning services available throughout its website, not just on the

Coding and Reimbursement page. We've included a full glimpse of all ASCO resources and articles on the topic in our Practice Administration Guide.

Advance Care Planning practice administration guide
Coding Snapshot: Advance Care Planning
Practice Leadership Call – March 2022: Advance Care Planning
ASCO Educational Book – Bringing Death to Life: The Need for Honest, Compassionate, and Effective End-of-Life Conversations

December 2023

In the CMS 2024 Final Rule for the Physician Fee Schedule, several codes were created to report activities to address social determinants of health, care navigation, and visit complexity. ASCO has developed several new resources on these codes and services: Care Management and SDOH G Code Comparison resource, which evaluates the similarities and differences between the Care Management CPT code family and the new Community Health Integration, Principal Illness Navigation, and SDOH Risk Assessment codes, and a one-page resource on the new G2211 Visit Complexity Add-on Code.

November 2023

Codes to report procedures, supplies, and diagnoses are updated on a regular basis. HCPCS codes, which describe supplies such as drugs that are infused or injected, are updated quarterly by the by Centers for Medicare and Medicaid Services. ICD-10-CM codes, other known as diagnosis codes, are updated annually effective October 1st. The American Medical Association (AMA) annually publishes the CPT code set in the AMA® CPT Professional Edition which goes into effect January 1st each year. ASCO's resources covering the coding updates can be found on this page under "Coding and Reimbursement Updates".

October 2023

A significant, separate E/M service may be reported on the same day as chemotherapy using a modifier 25 if documentation and clinical circumstances support both the E/M service and chemotherapy are significantly separate procedures.

NCCI edits are in place for all evaluation and management services (99202-99215) when billed with any infusion and/or injection administration codes (CPT codes 96360-96542). Therefore, practices need to refer to the edits *for each code pair* (infusion/injection and evaluation and management codes) to determine if a modifier is allowed to bypass the NCCI edit in place. Links to resources on NCCI edits can be found on the ASCO Practice Central Medicare Program page.

Private payers may have their own policies regarding reporting of evaluation and management procedures on the same date as minor procedures.

September 2023

In last month's Tip of the Month, prolonged services for physicians and other qualified health care professionals on the date of service were discussed. However, there are other situations where prolonged services can be reported.

- When the prolonged services are provided by a physician/qualified healthcare professional on a date *other than the date of the encounter*:

  If prolonged services without direct patient contact occur on a date other than the face-to-face evaluation and manage service, codes 99358 and 99359 *(prolonged evaluation and management before/after direct patient care for the first hour and each additional 30 minutes)* can be used to report those prolonged services even if time wasn't used to select the level of the E/M. It must relate to a face-to-face E/M that either will or has occurred and related to ongoing patient management. Note these codes are not actively paid by CMS.

- When clinical staff time accounts for the prolonged services in office/outpatient setting:

  Clinical staff face-to-face time accounting for prolonged services should be reported with 99415 and 99416 *(Prolonged clinical staff time during an evaluation and management service for first hour and each additional 30 minutes).* This requires direct supervision AND direct patient contact on the date of the encounter by the physician or other qualified health care professional. The staff time does not have to be continuous but only the face-to-face time should be counted. Time counted towards services other than evaluation and management service cannot be used towards prolonged services.

August 2023

When an evaluation and management level of service is based on time and the total time is over that of the maximum time indicated in the description of the service, prolonged service codes may be reported. AMA CPT guidelines allow prolonged services to be reported once the

maximum required time of the primary service has been exceeded. CMS instructs 15 minutes beyond the *total* time of the primary service must be met to report any prolonged services.

Office and outpatient: 99417, G2212

Non-office and outpatient: 99418, G0316 (Hospital inpatient and observation), G0317 (Nursing facility), G0318 (Home or residence)

Refer to ASCO Practice Central's resources for more details and examples of prolonged services for **office** and **hospital services** for examples. The resources can be found on this page along with other resources on selecting codes based on time.

July 2023

New patients are defined under CPT guidelines as not having received any face-to-face services from the physician or other qualified health care professional of the same specialty and subspecialty who belongs to the same practice group within the past three years. Advanced practice providers and covering providers are considered the same specialty and subspecialty as the physicians they are working with.

Practice location does not affect this definition. If the provider changes practices and the provider OR another provider of the same specialty in the new group has provided any professional services to the patient within three years, the patient would be considered established.

Payers may have their own guidelines; therefore, it will be important to check their policies.

June 2023

When the patient is presenting for chemotherapy, immunotherapy, or radiation therapy, the primary diagnosis code should be an encounter code which reflects the therapy the patient is receiving at that encounter.

Example:

Z51.0 Encounter for antineoplastic radiation therapy
Z51.11 Encounter for antineoplastic chemotherapy
Z51.12 Encounter for antineoplastic immunotherapy

If the patient is presenting for a follow-up after the treatment has been completed, the provider would report the correct encounter for the follow-up diagnosis code as primary.

Example:

Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm

In addition to the primary diagnoses above, the appropriate diagnosis codes related to the conditions requiring care would also be reported for the services provided.

May 2023

Specificity in diagnosis is crucial in the documentation and reporting of oncology diseases. One area of frequent confusion is the indication of primary versus metastatic cancer. For a primary cause of cancer caused by a neoplasm, the diagnosis would be reported with a code belonging to the range of C01-76 in Chapter 2 Neoplasms of the ICD-10-CM manual. If the cancer has spread to a secondary site, it should be documented and reported with a code found in the range of C77-79. Documentation should specify where both primary and secondary sites of neoplasm are located (unless they are unknown).

April 2023

A November 2022 report from the Office of the Inspector General showed that 67% of the Advance Care Planning services audited were not properly documented. For example, in some cases time spent on ACP services was not documented or did not distinguish from time spent on concurrent services. ASCO's Advance Care Planning Practice Administration and Reimbursement Guide can assist with ensuring your practice is knowledgeable about the documentation and reporting requirements of these services.

March 2023

Reporting guidelines instruct to code to the highest level of specificity. Having multiple bone marrow testing codes available, providers must select the code that most closely describes the procedure being performed. Take note that there are three codes describing a bone marrow biopsy and/or aspirate procedure:

- 38220 - bone marrow aspirate(s) alone
- 38221 - bone marrow biops(ies) alone
- 38222 – bone marrow biops(ies) and aspirate(s)

The above codes are not to be reported with one another if performed at the same site. These codes would **only** be reported together if performed at different sites and would require an

appropriate modifier to indicate this. Bilateral procedures should not be reported with multiple units or lines and require an appropriate bilateral modifier, unless otherwise instructed by payer policy.

February 2023

As part of the 2023 OPPS final rule, CMS is requiring all 340B entities to report a modifier on separately payable Part B drugs. The following modifiers should be reported with drugs acquired through the 340B program:

- Drug Wastage
    - JW: Report with discarded drug amount (not including overfill amounts)
    - JZ: Report for non-wasted amount of drug
- Provider Indicators
    - TB: Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals
    - JG: All other 340B covered entities

The JW modifier is required for all providers beginning January 1, 2023, and the JZ modifier no later than July 1, 2023, in all outpatient settings. The provider indicator modifiers must be used no later than January 1, 2024. The information is mentioned in the ASCO Practice Central resource on 2023 Coding Updates. You can find additional information in Chapter 17 of CMS' Claims Processing Manual as well as CMS' Hospital Outpatient Prospective Payment Final Rule.

January 2023

ASCO compiles all the latest coding updates for our members in one central location – ASCO Practice Central's Coverage and Reimbursement page. ASCO provides updates as applicable as well as summaries of updates that come out on a quarterly and annual basis. For the most recent updates effective in January 2023, check out the 2023 Coding Update resource combining CPT, ICD10-CM, and HCPCS updates, in addition to the January 2023 Quarterly HCPCS update.

December 2022

CMS released the Physician Fee Schedule Final Rule in November. The rule serves as a federal document and provides guidance on coverage and reimbursement topics pertaining to

healthcare services. An overview of the rule, including items relevant to oncology can be found on the November 17th recording of ASCO's Practice Leadership calls and on the ASCO in Action page.

Details regarding coding updates are available in ASCO's 2023 Coding Updates Guide, which includes both CPT and CMS information.

November 2022

Each quarter, CMS publishes updates to the HCPCS coding system. ASCO provides a summary of these updates with codes particularly pertinent to oncology. These can include the newest approved drug codes, revisions to pass-through status, and sometimes PLA (Propriety Laboratory Analysis) codes. The latest update is effective October 1st. ASCO's summary for this HCPCS update and all other updates for 2022 are available on the Coding and Reimbursement page.

October 2022

The American Medical Association recently published the 2023 AMA CPT Professional Edition. Any updates in the CPT manual will go into effect on January 1st, 2023. Included in the 393 CPT changes are:

- Revisions to the Evaluation and Management Services guidelines and codes
- New sections for Digital Pathology Services and Artificial Intelligence
- New codes for Proprietary Laboratory Analyses (PLA) services and Genomic Sequencing Procedures
- Updates to radiology services
- Revisions to remote therapeutic monitoring services and codes

More details can be found in the "2023 CPT Update" resource on the Coding and Reimbursement page.

September 2022

For 2023, several categories of diagnoses relating to oncology have been updated in addition to codes created for better accuracy and specificity. The changes are connected to blood diseases, social determinants of health, long term drug codes for chemotherapy and immunotherapy, additions for patient non-compliance, and the creation of a category for caregiver non-compliance. Additionally, there are revisions to the unclassified codes for peripheral T-cell

lymphoma and myelodysplastic disease. For more details and specifics on these changes, see the ASCO resource "2023 ICD-10 Update".

August 2022

Providers can now bill for total time spent on both face-to-face and non-face-to-face activities for office and outpatient evaluation and management services (with some exceptions). Be sure to document the time spent on the service and corresponding activities in the note to support the E/M service selected. For more information on selecting an E/M service based on time, see the ASCO resource "2021 Evaluation and Management Changes: Selecting a Code Based on Time".

July 2022

While chemotherapy patients do require some monitoring, not all chemotherapy plans fall under the classification as a drug requiring intensive monitoring. Drugs requiring intensive monitoring should have a high risk of morbidity. Monitoring can be done by lab test, physiologic test, or imaging but must be done for assessment of adverse effects, not for therapeutic efficacy.

June 2022

While a chemotherapy requiring intensive monitoring for toxicity may result in a high level of risk for comorbidity for the treatment management, the office visit may not result in a level 5 office visit. Office visits are based on the lowest level of two out of the three MDW sections when based on medical decision making.