

Q3 2026

Coding & Documentation Insights

Preparing for 2027: Documentation, reimbursement and
audit readiness

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EXECUTIVE FOCUS · A MESSAGE FROM THE CODING TEAM

Strong notes will carry more weight in 2027.

Practices that document the full clinical story will be best positioned for 2027. The link between the exam room and what a payer pays keeps getting tighter.

Two forces are converging. The CY 2027 Medicare Physician Fee Schedule proposed rule would restructure G2211 and change how same-day E/M visits and procedures are paid.

Both are still proposals. Both point in the same direction: payers want documentation that stands on its own, service by service.

At the same time, the CPT 2027 code set takes effect Jan. 1 with 453 changes, including updates for orthopedics and gastroenterology.

No code, however well chosen, can stand in for a note that explains why a service was necessary and what was done.

2027 AT A GLANCE

453

CPT 2027 code changes, effective Jan. 1, 2027

16%

Proposed E/M increase under the new G2211 modifier

50%

Proposed payment for each same-day service after the most expensive one

Nov.

CY 2027 final rule expected

THE TAKEAWAY

Coders assign the codes. The provider's note tells the patient's story.

DOCUMENTATION

Payers read the note first and the code second.

Many denials and audit findings stem from notes that don't support the level of service reported, not from coding errors.

WHAT PAYERS LOOK FOR

- Medical necessity
- Patient complexity
- Clinical decision-making
- Longitudinal care management
- Appropriate use of procedures and services
- Consistency between diagnosis, findings and service billed

A chart can carry the correct CPT and ICD-10 codes and still be denied if the narrative doesn't justify them.

WHAT'S DRIVING THE SHIFT

Value-based contracts

Tie payment to demonstrated complexity.

Risk adjustment audits

RADV and similar reviews recoup payment when a chart doesn't support a diagnosis.

Payer analytics

Flag outlier billing patterns for manual review faster than before.

PROVIDER SELF-CHECK

- 01 Would another clinician understand why this service was necessary?
- 02 Is the patient's complexity clear in the note?
- 03 Is my medical decision-making documented?
- 04 Does the note distinguish this visit from a routine, lower-complexity encounter?
- 05 Could I defend this claim in writing using only what's in the chart?

THE TAKEAWAY

Good documentation looks the same as it always has. A thin note is just more likely to get caught.

G2211 UPDATE

Longitudinal care still **earns recognition.**

CMS continues to recognize the ongoing management of complex and chronic conditions.

The payment mechanics may change. The principle behind G2211 does not: continuous, relationship-based care takes added work.

WHAT'S PROPOSED FOR 2027

CMS proposes replacing the flat G2211 add-on code with two modifiers, called MOD1 and MOD2 in the proposed rule.

+16%

MOD1 would increase payment for the associated E/M visit at every level.

+32%

MOD2 would apply to clinicians in a Medicare Shared Savings Program ACO or LEAD Model ACO.

The comment period closed Sept. 14, 2026, and the final rule is expected in November. If finalized, the value of a longitudinal care visit would depend on a practice's ACO participation.

WHAT TO DOCUMENT FOR CHRONIC AND COMPLEX PATIENTS

- Ongoing chronic condition management
- Treatment adjustments
- Coordination with specialists
- Review of diagnostic results
- Patient-specific barriers to care
- Reasoning linking today's visit to the plan of care

THE DOCUMENTATION DIFFERENCE

BEFORE

"Diabetes follow-up."

AFTER

"Patient with poorly controlled type 2 diabetes requiring medication adjustment, review of recent lab results, discussion of adherence barriers and coordination of the ongoing management plan."

Why it matters: The second note shows complexity and active care management.

THE TAKEAWAY

What made this visit medically necessary and different from routine follow-up? Your note should answer it before an auditor asks.

SAME-DAY E/M AND PROCEDURES

Separate work deserves separate documentation.

Visits that pair an E/M service with a procedure, from joint injections to office-based endoscopy, remain a major focus of payer review.

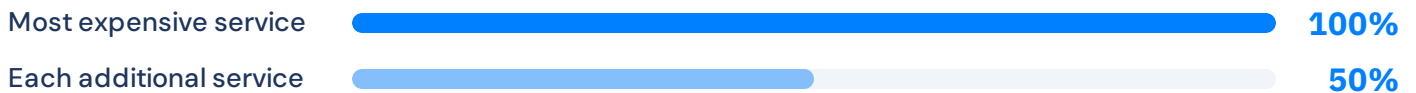
THE QUESTION AUDITORS ASK

Was a significant, separately identifiable E/M service provided?

It's the question behind modifier 25 and a frequent reason these claims are audited or denied.

A PROPOSAL THAT RAISES THE STAKES

For procedures with 0-, 10- or 90-day global periods, the CY 2027 proposed rule would pay the most expensive same-day service in full and every other same-day service at half. It's still a proposal, but it signals where same-day billing is headed.



DOCUMENT THE E/M SERVICE

- Presenting problem
- Independent assessment
- Medical decision-making
- Treatment options considered
- Why it was more than a pre-op check-in

DOCUMENT THE PROCEDURE

- Details and technique
- Risks discussed and consent
- Findings
- Post-procedure plan and follow-up

THE DOCUMENTATION DIFFERENCE

BEFORE

"Patient seen for knee pain. Knee injected."

AFTER

"Patient evaluated for worsening right knee pain despite conservative treatment. Imaging reviewed. Risks and benefits of treatment options discussed. Decision made to proceed with corticosteroid injection after evaluation and medical decision-making."

Why it matters: The second note shows an evaluation and a decision before the injection.

THE TAKEAWAY

When both halves are documented this clearly, modifier 25 reflects the note instead of covering for it.

ORTHOPEDIC SPOTLIGHT · SHOULDER ARTHROSCOPY

Every structure tells the story.

Arthroscopic shoulder procedures draw close payer review because of their complexity.

Denials often follow operative reports that don't clearly identify the anatomical structures treated, the pathology found, the separate procedures performed and the medical necessity for each.

WATCH THE BUNDLING EDITS

Debridement (CPT 29822 and 29823) is often bundled into more extensive work at the same joint unless the note identifies a separate, distinct structure.

When two procedures are truly distinct, modifier 59 or a more specific X modifier such as XS should be supported by the operative note, not just added to the claim.

OPERATIVE REPORT CHECKLIST

Findings

- Rotator cuff tears
- Labral pathology
- Biceps tendon abnormalities
- Cartilage defects

Procedures performed

- Debridement
- Repair
- Decompression
- Tenodesis
- Tenotomy

Medical necessity

Why each procedure was performed based on surgical findings, including why a debridement became a repair or why decompression was added if the plan changed during surgery.

THE TAKEAWAY

The operative report should tell a clear story from pathology identified to treatment rendered.

Specificity carries financial weight.

ERCP is one of the more complex procedure families to code and document.

Multiple possible interventions, multiple-endoscopy payment rules and sedation reporting all depend on what the note says.

CLINICAL INDICATION

Choledocholithiasis, biliary obstruction, pancreatic duct abnormalities or strictures.

INTERVENTIONS

Sphincterotomy, stone removal, stent placement, dilation or biopsy, and the target of each.

REPEAT PROCEDURES

Why the repeat was needed, the findings and any failed prior intervention.

REPORT EACH DISTINCT INTERVENTION

Report each distinct intervention with its own code, following CPT's family rules. Diagnostic ERCP (43260) is included in any therapeutic ERCP in the same session, and some interventions can't be reported together for the same lesion. Unbundling within the family is a frequent audit finding.

SEDATION

Moderate sedation is no longer bundled into endoscopy codes. It's reported separately whether the performing physician or another provider gives it, with different codes for each. Document who gave and monitored it and the intraservice time.

THE DOCUMENTATION DIFFERENCE

BEFORE

"ERCP performed."

AFTER

"ERCP performed for persistent biliary obstruction. Cholangiogram revealed retained common bile duct stone requiring sphincterotomy and stone extraction."

Why it matters: The second note names the indication, the finding and each intervention.

THE TAKEAWAY

Specificity supports every code reported. Make each intervention and its target easy to find.

CPT 2027

What's changing in CPT 2027.

The AMA released the CPT 2027 code set Sept. 9, 2026. It takes effect Jan. 1, 2027.

453

Total changes

299

New codes

74

Revised codes

80

Deleted codes

The coding mechanics for shoulder arthroscopy and ERCP (43260–43278) are not changing for 2027. Several nearby areas are.

ORTHOPEDICS

Sacroiliac joint fusion

27278 and 27279 revised to better distinguish fusion types

Spine osteotomy (22210–22216)

New guideline language clarifying reporting

Knee

New codes for a medial extra-articular shock absorber and an open osteochondral acellular scaffold implant; Category III code 0737T revised

Bone tumor ablation

New code

Skin cell suspension autograft

New codes replace deleted codes 15011–15018

GASTROENTEROLOGY AND DIGESTIVE SYSTEM

Endoscopic submucosal dissection

Two new codes for the upper and lower GI tract

Diaphragm repair

New code for thoracoscopic plication; 39545 revised to clarify the open approach

Congenital duodenal obstruction repair

New codes for open and laparoscopic repair; 44180 revised

THE TAKEAWAY

Final numbers for new codes are in the CPT 2027 codebook. Cross-check orthopedic and GI templates against it before Jan. 1.

AUDIT READINESS

Audits now start with **your patterns.**

Audits once focused on individual claims. Many payer reviews now begin with provider trends.

TRENDS THAT DRAW REVIEW

- Higher-than-expected level-of-service utilization
- Frequent modifier use
- Rising procedure volume
- Unusual diagnosis patterns
- Reimbursement above peers
- HCC recapture rates well above specialty peers without matching comorbidity documentation

Being above average isn't wrong. The documentation has to explain why your patients or your practice differ.

QUESTIONS TO CONSIDER

E/M services

Would your patient population explain your E/M level distribution against specialty peers?

Chronic disease

Does each problem list item have a status and a plan? A condition with neither is a common reason auditors recoup an HCC.

Procedures

Are operative and procedure notes complete and specific?

Medical necessity

Would another provider agree with the treatment decision based on the note alone?

COMPLIANCE CORNER: MEDICAL NECESSITY

Denials often happen not because a service wasn't performed, but because the note didn't establish why it was needed. The standard is the same for a commercial payer audit, a Medicare RADV review or an internal quality check. Document:

- Symptoms and severity
- Functional impact
- Previous treatment failures
- Clinical rationale
- Treatment plan
- Why lesser interventions weren't chosen

Providers often know these factors clinically but forget to include them in the note.

THE TAKEAWAY

If it isn't documented, it can't be defended.

YOUR 2027 READINESS PLAN

Ten steps to take **this quarter.**

Use this checklist to get ahead of the final rule and the new code set.

- ☐ Review documentation supporting chronic disease management.
- ☐ Confirm same-day E/M and procedure notes separate the two services.
- ☐ Verify operative reports describe all pathology identified and treated.
- ☐ Strengthen documentation of medical necessity.
- ☐ Review high-volume procedures for completeness and specificity.
- ☐ Monitor denial trends and provider-level audit findings.
- ☐ Compare provider E/M and HCC patterns to specialty peers at least quarterly.
- ☐ Track the CY 2027 final rule for G2211 and same-day payment policy.
- ☐ Cross-check orthopedic and GI templates against the CPT 2027 codebook.
- ☐ Consult coding or CDI when documentation questions arise.

THE BOTTOM LINE

Strong documentation supports accurate coding and payment, and it reflects the complexity of the care you provide every day. None of this requires changing how you practice medicine. It requires a note that captures what you already know clinically.

THE TAKEAWAY

Clear, complete and clinically meaningful documentation that tells the patient's story remains the best defense against denials and audits.

RESOURCES FOR 2027 READINESS

Support for the work ahead.

If this issue raised questions about your own documentation, our coding team can help you answer them.

Advantum's coding team and physician advisors work alongside practices preparing for the final rule and the new code set.

01

Coding audits

A review of your E/M levels, modifier use and HCC capture against specialty peers.

AUDIT READINESS · G2211

02

Provider documentation education

Specialty-specific sessions built around your own audit findings, from same-day visits to operative reports.

SAME-DAY E/M · ORTHO · GI

03

Medical coding and billing

Certified coders current on CPT 2027 who apply payer rules claim by claim.

CPT 2027

04

Denial management

Root-cause analysis of denial trends, so documentation gaps are fixed at the source.

MEDICAL NECESSITY

NEXT STEP

Contact your Customer Success Manager to schedule a documentation review.

READY FOR 2027?

Strengthen documentation. Protect revenue.

Whether you're preparing for the CY 2027 final rule, updating templates for CPT 2027 or tightening documentation before your next audit, Advantum's coding leadership and physician advisors help align documentation with payer expectations before revenue is at risk.

Contact your Customer Success Manager →

Schedule a documentation review or suggest a topic for a future issue.

ALSO FROM ADVANTUM

Prior Authorization & Eligibility Insights

Our companion briefing on payer rules and clean submissions. Ask your Customer Success Manager to add you to the list.

Sources: CMS, Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule fact sheet, July 14, 2026 (cms.gov); AMA, "AMA releases CPT 2027 code set," Sept. 9, 2026 (ama-assn.org); AMA CPT Editorial Panel Summary of Panel Actions, February, May and September 2025. Items describing the CY 2027 proposed rule reflect proposed, not final, policy. This newsletter is general education and does not replace the full text of the proposed or final rule, CMS guidance or a formal coding audit.