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Part B News
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In this issue

PBN Perspectives

Vaccine mandate stays; check providers' status and respond as needed

Five months after the Supreme Court cleared the way for the federal health care employee vaccination mandate, chances for a reprieve are dwindling. To avoid possible penalties, make sure your eligible providers are either vaccinated or have undergone the proper process for exemption; also, be sure to keep your records in order.

After months of legal struggle, the Supreme Court cleared the health care worker vaccine mandate on Jan. 7, 2022 (*PBN 1/17/22*). Though physician practices are not among the facilities cited in the mandate, members of practice clinical staff may be required to immunize when they work in those facilities. In the guidance for hospitals, for example, CMS specifies that the requirement applies to "individuals who provide care, treatment or other services for the hospital and/or its patients, under contract or by other arrangement."

All deadlines for the full COVID-19 vaccination have passed, with Texas' March 21, 2022, deadline being the last. CMS considers employees to be fully vaccinated if they have had two Moderna or Pfizer shots, or one Johnson & Johnson shot, or if they have received "a [COVID] vaccine listed by the World Health Organization (WHO) for emergency use that is not approved or authorized by the FDA or … received a [COVID] vaccine during their participation in a clinical trial." (CMS does not currently require health care personnel to get boosters.)

CMS announced it would send surveyors around to check on compliance, although it remains unclear whether inspections have begun. Should non-compliance be found, the agency

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reserves the right to terminate some institutions from Medicare; however, CMS adds that its "primary goal is to bring health care facilities into compliance."

Chances of reversal low

Some stakeholders still hold out hope that the mandate will be reversed. The Attorneys General of 10 states have a petition before the Supreme Court asking for reversal on several grounds, including that CMS did not properly create its rule implementing the mandate and that the health care worker shortage in many places, especially in rural areas, has been exacerbated by the mandate, making it counterproductive.

Experts find these arguments unlikely to succeed, pointing out that some states have their own health care worker vaccination mandates that are even more stringent than CMS' but still have passed legal muster. Peter J. Glennon, founder of the Glennon Law Firm in Rochester, N.Y., points out that the New York state vaccine mandate, which does not even allow for religious exemptions, has survived a legal challenge via *Dr. A, et al., applicants v. Hochul* in the Supreme Court.

Also, vaccines among health care workers are on the rise, softening the impact of a mandate. A survey by the Kaiser Family Foundation, for example, finds that between the announcement of the CMS mandate in August 2021 and March 27, 2022, nursing facility staff vaccination rates increased nationally from 63% to 88%.

Keep tabs before CMS does

Aaron W. Tandy, partner and head of the employment law section at Pathman Schermer Tandy LLP in Miami, says that while the employees who resist inoculation have been the focus of mandate coverage, it's facilities that are covered by it — and they will be held responsible for adherence.

Recordkeeping is imperative, especially with the threat of CMS surveys. Mark F. Kluger, labor and employment lawyer and co-founding partner at Kluger Healey in Fairfield, N.J., says that may be easy in larger facilities that "are really used to vaccine recordkeeping from flu and MMR vaccine requirements" mandated by either state law or their own institutional standards; they can just add another field to those documents.

But Glennon warns that recordkeeping responsibilities must be clearly assigned — for example, "who's responsible to create the record, who's responsible to create the system, who's responsible to manage the system [and] who's responsible actually to gather the data." If assignments are unclear, the requirements might be mishandled.

Lisa Gingeleskie, Esq., a partner with Lindabury, McCormick, Estabrook & Cooper, P.C. in Westfield, N.J., suggests you start by naming specific proofs of compliance you will require, such as "record of immunization from a health care provider or pharmacy, a copy of the COVID-19 Vaccination Record Card [or] a copy of medical records documenting the vaccination," and maintain copies of those.

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Richard Scott, 267-758-2404
Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Julia Kyles, CPC, x6015
Editor
jkyles@decisionhealth.com

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Proper process for non-vaccinators

Requests for exemption and accommodation must be submitted in writing "with sufficient details so that a decision can be issued," says Domenique Camacho Moran, a partner in the labor and employment practice of Farrell Fritz in New York City. "To minimize the risk of inconsistent decisions, practices may want to centralize the evaluation of exemption requests by designating a single individual or small team to consider the request and decide whether an exemption is warranted."

Moran advises creating a process for employees to request an exemption or temporary delay on religious or medical grounds based on applicable federal non-discrimination and civil rights laws and other protections, such as Title VII and the Americans with Disabilities Act (ADA).

"It's incumbent on the employees themselves to ask for that exemption," says Jacqueline Voronov, a labor and employment lawyer with Hall Booth Smith, P.C. in Saddle Brook, N.J. "The employer doesn't need to go chasing employees to confirm whether they want to seek an exemption. If an employee hasn't made a request for an exemption, the employer is within its rights legally to terminate their employment based on the employee's failure to abide by the mandate."

Nonetheless, you should notify your employees of the option and make sure your process is airtight, Voronov says. "The number one thing that usually comes back to bite employers is when they don't have written policies in place and they make things up as they go along," she says. "If rules are applied arbitrarily, an employee might say, you're only making me do this, you're not making somebody else in another protected class do it, so you're targeting me because of my protected characteristic. And that's when discrimination claims arise."

Voronov says the accommodation process under the mandate is similar to a typical ADA process (*PBN 6/8/20*). When an employee requests a religious accommodation, for example, the employer "has to assess whether the employee's asserted belief is a sincerely held religious belief or simply a personal choice; the latter would disqualify the employee from an exemption."

You would engage in an "interactive process" with the employee, which should be familiar to human resources professionals who have dealt with requested accommodations before. Finally, Voronov says, the employer must determine whether there is an accommodation that can be made without imposing an undue hardship on the facility.

If an employer has reason to doubt the belief, observance or practice is genuine, they can seek additional supporting information, but "they can't simply presume somebody is not a practitioner simply because they don't believe them," Tandy says.

If the accommodation is sought on medical grounds, "employers can ask for medical records and other information to identify the precise limitations resulting from the disability and the potential reasonable accommodation that could overcome the limitations," Tandy adds. If this passes, the employee still has to clear the undue-hardship barrier. Note: Employers are also not required to alter the essential functions of the job to provide an accommodation under ADA, Tandy says.

Can they sue?

This doesn't mean an employee dismissed for failure to comply won't come after you. A lawyer in Minnesota, for example, has filed what he says is the first in an intended series of lawsuits on behalf of workers fired by the Mayo Clinic, which terminated employees because they failed to observe the Clinic's own vaccination requirements.

Among the claims in the first complaint by ex-employee Shelley Kiel: that the Clinic told employees "it is anticipated that a small number of staff will have qualifying religious exemption"; that the basis for medical exemptions was too narrow; that the medical exemptions they did allow were "conditioned upon submission to invasive, supervised weekly testing"; and that "there was no case-by-case analysis or individualized interactive process to discuss Plaintiff Kiel's exemption request or possible accommodation."

But if you follow your protocol in good faith, you stand a good chance of getting support from the courts if a denied accommodation leads to a challenge, according to Kluger. "There are a couple of cases from Boston hospitals out of the First Circuit that have upheld the undue-hardship defense for denying exemption requests under Title VII," he says. "And those cases upheld the hospitals' determinations that granting religious exemptions was an undue hardship."

"I've been advising clients, and the First Circuit really laid out, that there's a difference between working in health care and working in other places," Kluger says, "and in the former case the public needs to have a sense of confidence that their health care workers are vaccinated — and allowing unvaccinated workers in health care tends to reduce public confidence that the health care system is safe." — *Roy Edroso (redroso@decisionhealth.com)* ■

RESOURCES

- CMS, "External FAQ: CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule," updated Jan. 20, 2022: www.cms.gov/files/document/cms-omnibus-covid-19-health-care-staff-vaccination-requirements-2021.pdf
- CMS, "Guidance for the Interim Final Rule -- Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," revised April 5, 2022: www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/revised-guidance-interim-final-rule-medicare-and-medicaid-programs-omnibus-covid-19-health-care
- CMS, "Guidance for the Interim Final Rule -- Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," revised April 5, 2022: www.cms.gov/files/document/qso-22-07-all-revised.pdf
- Supreme Court decision, Dr. A, et al., applicants v. Hochul: www.supremecourt.gov/opinions/21pdf/21a145_gfbi.pdf
- "Nursing Facility Staff Vaccinations, Boosters, and Shortages After Vaccination Deadlines Passed," Kaiser Family Foundation, May 16, 2022: www.kff.org/medicaid/issue-brief/nursing-facility-staff-vaccinations-boosters-and-shortages-after-vaccination-deadlines-passed

Billing

Critical care compliance: Find solutions to 5 key challenge areas

Medicare's revised rules for critical care services (**99291-99292**) created new ways that providers can team up and treat patients. They also spurred new ways to code and bill for the work.

During a May 17 webinar hosted by DecisionHealth, Scott Kraft, CPMA, CPC, a compliance auditing specialist for Knoxville, Tenn.-based DoctorsManagement, gave an auditor's-eye-view of the new rule and detailed important compliance tips, including how to report work by multiple providers and when to unbundle critical care services. (*For an illustrated guide, see image, p. 6*).

Follow-up care: Now reserved for teams

The new critical care rules apply to physicians in the same specialty and group who combine their time to meet the requirements for initial care code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 30-minute add-on code 99292. The services "may be [performed] as part of continuous staff coverage or follow-up care to critical care services furnished earlier in the day on the same calendar date," according to CMS 100-04, chap. 12, §30.6.12.4.

When the combined time of two physicians is less than 74 minutes, "the billing entity still has to roll all of that time up into one unit of 99291, which obviously has to be billed under one of these providers," Kraft said during the webinar.

There is no set rule for how practices divide the physicians' time. "It really is about when you roll up what you're billing to Medicare, you have to combine the time of the physicians and bill it using the appropriate units of 99291 and 99292," Kraft said. Medicare will issue one payment, and the practice would need to decide how to pay each physician and how they receive the credit for their work, Kraft explained.

Split/shared services: Mandatory for teams

The new follow-up care rule applies to work by physician teams. When a physician and a qualified health care professional (QHP) from the same group team up, you must bill their services under the new split/shared rule for critical care services (*PBN 11/22/21*).

"I recommend to my clients that each provider who participates in a critical care service under the split/shared model document the amount of time that each provider spent," Kraft said. That allows the coder to look at the note and determine who spent more time on the visit and bill the visit under that provider's name with modifier **FS** (Split [or shared] evaluation and management visit).

(continued on p. 6)

Have a question? Ask *PBN*

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for your. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Benchmark of the week

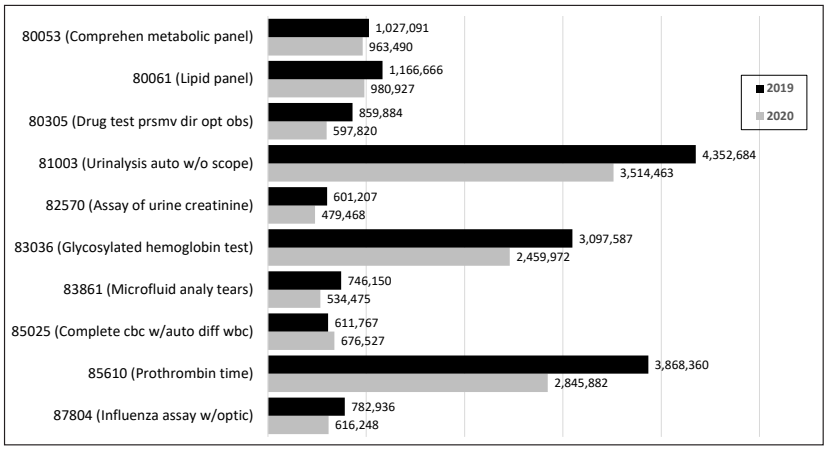
Reporting, revenue for common in-house lab tests dipped in 2020

The fallout from COVID-19 didn't stop at procedures and services. In 2020, practices reported fewer low-complexity, high-volume lab tests, resulting in a loss of more than $30 million, according to *Part B News* analysis of Medicare Part B claims data for 2019 and 2020.

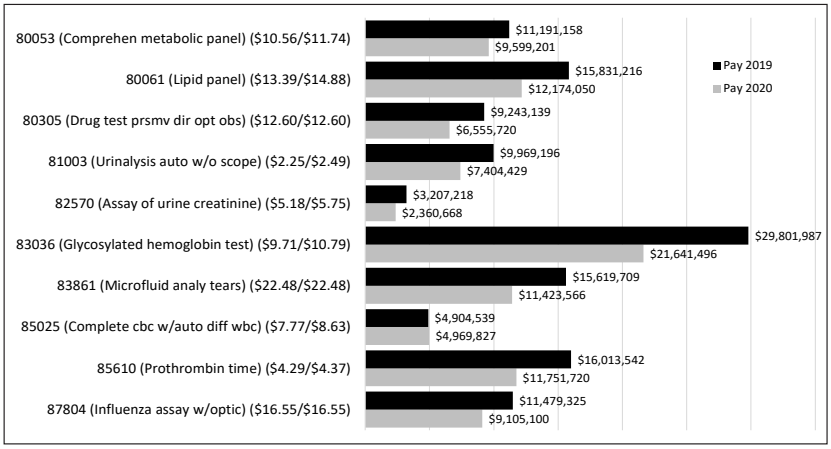
The reporting slump was seen nearly across the board for CPT pathology/laboratory codes that practices reported with modifier **QW** (Clinical Laboratory Improvement Amendment [CLIA] waived test) in place of service 11 (Office). That includes nine out of 10 lab services that had the highest utilization in 2019. The decline mirrors the downturn in outpatient E/M visits (**99201**-**99215**) during the first year of the COVID-19 pandemic (*PBN blog 11/23/21, PBN 1/24/22*).

The first chart details the utilization figures between 2019 and 2020, highlighting common tests, such as prothrombin time (**85610**) and A1C (**83036**), that shed tens of thousands of claims during the two-year period. The second chart, which includes the national fees for 2019 and 2020 respectively, shows that several tests lost millions of dollars in revenue. For instance, comprehensive metabolic panel (**80053**) lost nearly $1.5 million in payments year to year. Only the automated complete blood count test (**85025**) bucked both trends and showed a slight increase. – *Julia Kyles, CPC* (*jkyles@decisionhealth.com*)

Utilization for in-office lab tests reported with modifier QW, 2019-2020



Payments for in-office lab tests reported with modifier QW, 2019-2020



Source: Part B News *analysis of 2019-2020 Medicare claims data*

RESOURCES

- CPT Errata & Technical Corrections**:** *www.ama-assn.org/system/files/cpt-corrections-errata-2022.pdf*
- CPT Assistant, July 2021
- CPT Assistant, Feb. 2022

(continued from p. 4)

Concurrent care: For multispecialty teams

Concurrent care occurs when providers in different specialties perform medically necessary critical care services for the same patient on the same day. For example, if a cardiologist and a neurologist both render critical care, "the expectation from the documentation would be that each of them is providing medically necessary critical care services based on their specific area of expertise [and] based on conditions that are present with the patient," Kraft explained.

The specialists can be from the same group or different group, but each specialist's work must meet all the requirements for a critical care service, and they can't count time for work that duplicates one another's.

Same-day E/M services: Critical care must follow

Medicare retained the policy that allowed one or more practitioners to report a critical care service after another E/M service on the same day, so long as the E/M service took place before the patient needed critical care. When a patient receives a critical care service in the morning, "I can't come back at 5 o'clock and say, 'It's great the patient has stabilized, let's add a [subsequent hospital care visit] onto this'," Kraft cautioned.

Practitioners should clearly note that critical care service was necessary because the patient's condition deteriorated. Your practice should not rely on time stamps or the electronic medical record to establish the timing of the services, Kraft said. A time stamp or chart entry "can be a metric of when the documentation was completed, versus when the patient was actually seen."

The revised policy clearly instructs practices to append modifier **25** (Significant, separately identifiable E/M service) to the critical care claim.

Global period: Providers must define their work

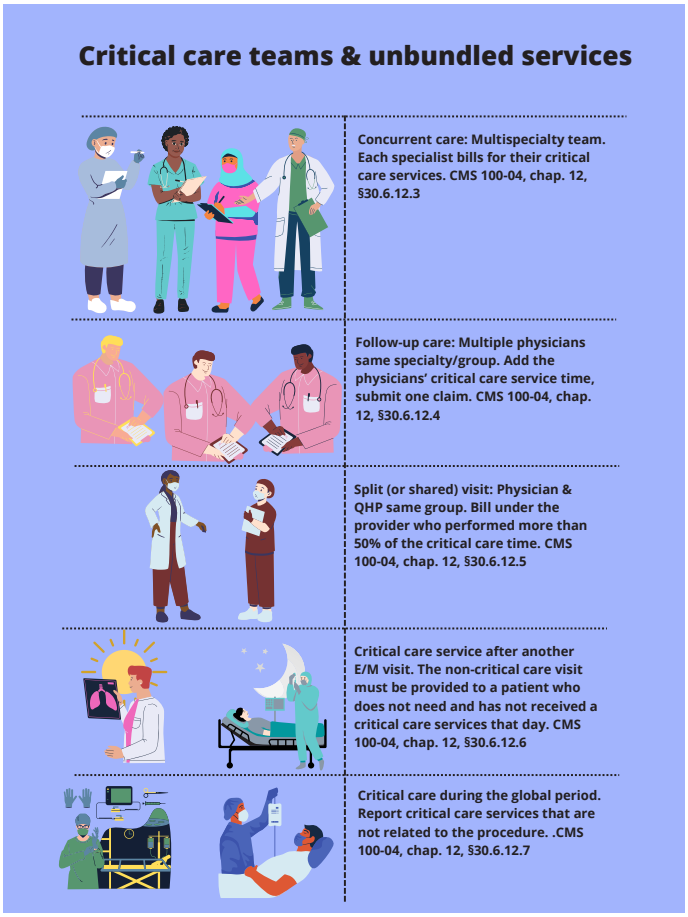
Medicare also carried over its policy for reporting critical care services during the pre-, intra- and post-operative period of a global procedure. In addition to streamlining its policy, the new rule introduced modifier **FT**, which you will add to Medicare claims for unrelated critical care services during the global period. Private payers may have different requirements for the use of modifier FT (*PBN 1/31/22*). Whether the provider is the hospitalist, the intensivist or the surgeon, the documentation for the critical care services must show that it is unrelated to the procedure, Kraft said. But based on his experience, the lines can be blurry.

"Hospitalists and intensivists cannot bill for services that would ordinarily be part of a global period from a work perspective and expect to be paid for them because they're the intensivist and not the surgeon," Kraft said. They will need to demonstrate that the critical care services were not related to the surgery, surgical recovery or complications of the surgery.

If you code for surgeons, be on the lookout for muddled charts. For example, you may find that a surgeon reports 35 minutes of critical care services but documents normal global period work and critical care services during the same encounter. A coder could not assume that the surgeon spent at least 30 minutes of her time on unrelated critical care services, Kraft said. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCE

- CMS 100-04, chap. 12, §30.6.12: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*



***Editor's note**: The on-demand version of **Critical Care 2022: Make Sure Your Medicare Claims Meet the New Coding and Billing Rules** is available. The recording has been approved for 1 AAPC CEU and 1 BMSC CEU. Learn more: https://codingbooks.com/ympda051722.*

Ask Part B News

Admit service dogs within reason, but 'emotional support' doesn't fly

***Question**: I have read the* Part B News *story about service animals in the practice (PBN 4/9/18). Since that story was published, I have seen a lot of coverage of "emotional support" animals and wonder if shared public spaces like the doctor's office are required to accommodate them as well.*

Answer: Emotional support animals have had some legal rights extended to them and their owners by federal regulation in recent years. In 2020, the U.S. Department of Housing and Urban Development (HUD) issued guidance clarifying that "persons with disabilities may request a reasonable accommodation for service animals and other types of assistance animals, including support animals, under the FHA [Fair Housing Act of 1968]." HUD's definition of support animals includes those that provide "therapeutic emotional support for individuals with disabilities."

Also, the U.S. Department of Transportation (DOT) interprets the 1986 Air Carrier Access Act (ACAA) as allowing, but not mandating the acceptance of, emotional support animals on trains and airlines.

But note: Both HUD and DOT make distinctions between animals that address a "disability" and those that do not. So, too, does the U.S. Department of Justice's (DOJ) Civil Rights Division, which implements Title III of the Americans with Disabilities Act (ADA), addressing nondiscrimination on the basis of disability by public accommodations and in commercial facilities. While disabled people have an ADA right of access for "service animals" and people with a psychiatric disability have the same right as regards "psychiatric service animals," those who are not disabled don't have the same rights for emotional support animals.

The DOJ site ADA.gov clarifies in a FAQ: "Emotional support, therapy, comfort or companion animals" are not service animals because "they have not been trained to perform a specific job or task" for disabled people. A psychiatric service dog, on the other hand, is "trained to sense that an anxiety attack is about to happen and take a specific action to help avoid the attack or lessen its impact."

The DOJ notes that some state laws may mandate acceptance of non-service support animals. But according to the University of Michigan's Animal Law Center, most state laws on public accommodations for animals are clear that the animal must address a disability. In fact, there are state laws, such as California's AB-468, that require sellers and trainers of emotional support dogs to state in writing to clients that "the dog does not have the special training required to qualify as a guide, signal or service dog" and "is not entitled to the rights and privileges accorded by law to a guide, signal or service dog."

It's still true that, in most cases, you can't require proof that the patient's animal isn't a service animal. You can ask about the owner's disability and the animal's relationship to it, but if they claim a disability and you decide to call them on it, you may get yourself in trouble if you guess wrong.

"I think of it a little like a soup kitchen or public food pantry," says Matt C. Pinsker of the Pinsker Law Firm in Glen Allen, Va. "These places don't check each person's personal finances prior to allowing them access to the food. It is an understanding on the honor system that these are for the needy, and not for persons just trying to save money."

Bear in mind that you are not required to let a patient's animal menace or cause harm to other patients, no matter what the animal's official designation is. — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- U.S. Department of Housing and Urban Development, " Subject: Assessing a Person's Request to Have an Animal as a Reasonable Accommodation Under the Fair Housing Act," Jan. 28, 2020: www.hud.gov/sites/dfiles/PA/documents/HUDAsstAnimalNC1-28-2020.pdf
- U.S. Department of Transportation, "Service Animals (Including Emotional Support Animals)" www.transportation.gov/individuals/aviation-consumer-protection/service-animals-including-emotional-support-animals
- DOJ Civil Rights Division, "Frequently Asked Questions about Service Animals and the ADA," July 2015: www.ada.gov/regs2010/service_animal_qa.html

Ask Part B News

Ensure appropriate documentation for modifier 25

***Question**: What is the best way to determine if an E/M service is above and beyond the physician work normally associated with a procedure to justify the use of modifier **25** (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service)?*

Answer: You have to look at the original reason for the scheduled service and compare it to the service or services that were actually performed. If additional E/M services were provided, coders must ask themselves if the services were incidental to the original service, or if they were done for an entirely separate reason. If the services were incidental, modifier 25 isn't needed.

Was the E/M service performed to get patient vitals? To find out if the patient was eating well? To check if he or she had any reactions to the last treatment? These reasons would be incidental to the visit service. However, if the services were performed for an entirely different purpose than the original visit, then using modifier 25 may be appropriate.

For example, a patient with lymphoma comes in for his weekly chemotherapy infusion and all is going well until near the end of the visit when he experiences a severe reaction. The physician may have to perform an additional E/M service to determine the cause of the reaction. In this case, coders would report an E/M service that would be validated with modifier 25. The E/M service wasn't part of the initial visit service.

Always go back and look at the documentation. Make sure that you can justify appending certain modifiers to the E/M service. — *Sarah Gould, CPC* (sgould@hcpro.com)

***Editor's note**: This question was answered by Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS, president and principal consultant for SLG Inc., in Raleigh, N.C., during the 2022 HCPro webinar **NCCI Modifier Review: Navigate Chapter-specific Coding and Reporting Guidance**. Learn more: www.codingbooks.com/yhha042822.* ■

COVID-19

AMA announces CPT codes for Pfizer booster, Sanofi-GSK candidate vaccine

The AMA recently announced an editorial update to the CPT code set for COVID-19 vaccines that includes new codes for Pfizer-BioNTech's booster vaccine and Sanofi-GlaxoSmithKline's (Sanofi-GSK) vaccine candidate.

On May 17, the Food and Drug Administration (FDA) announced its approval of Pfizer-BioNTech's COVID-19 vaccine booster. It explained that it authorized "the use of a single booster dose for administration to individuals 5 through 11 years of age at least five months after completion of a primary series with the Pfizer-BioNTech COVID-19 vaccine."

The CPT product code for Pfizer's COVID-19 vaccine is:

- **91307** (SARS-CoV-2 (COVID-19) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use).

CPT codes for the vaccine's administration are:

- **0071A** (Immunization administration by intramuscular injection of SARS-CoV-2 [COVID-19] vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose).
- **0072A** (… ; second dose).
- **0073A** (… ; third dose).
- **0074A** (… ; booster dose).

The Sanofi-GSK booster is designed for patients older than 18. It has been assigned the following CPT product and administration codes, which will go into effect if and when the drug is approved by the FDA:

- **91310** (SARS-CoV-2 [COVID-19] vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use).
- **0104A** (Immunization administration by intramuscular injection of SARS-CoV-2 [COVID-19] vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, booster dose).

A complete list of CPT codes for COVID-19 vaccines is available on the AMA's website (*see resources, below*). — *Sarah Gould, CPC* (sgould@hcpro.com) ■

RESOURCES

- AMA editorial update: www.ama-assn.org/press-center/press-releases/ama-announces-cpt-update-covid-19-booster-candidates
- AMA, COVID-19 code list: www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance