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PBN Perspectives

As Biden admin. takes shape, expect closer scrutiny on compliance, HIPAA, billing

The advent of a new presidential administration is expected to bring changes in health care compliance enforcement: You should watch for the new wave of HHS, CMS and Department of Justice (DOJ) agencies to go after big health care-related crimes. They're also likely to scrutinize HIPAA and the big payments made to help providers over the COVID-19 hump.

In the days since his Jan. 20 inauguration, President Joe Biden has issued several executive orders pertaining to health care, including a COVID-19 vaccination program, and has publicized plans for health care reform, such as increased subsidies for the Affordable Care Act

Concrete progress on those fronts will largely depend on Congress and the actions of Biden's as-yet-unappointed department heads, including HHS Secretary nominee Xavier Becerra and Attorney General nominee Merrick Garland. Once the team is in place, however, you can expect policy adjustments that will lead federal auditors, investigators and prosecutors to pay closer attention to certain health care compliance areas than the previous administration did.

Accelerating focus on fraud, abuse

Experts think you'll see more high-level prosecutions of white-collar health care crime — and executives of health care entities being named in them — under Biden than under Trump.

The Trump Administration was not as zealous in pursuit of fraud as was the previous administration. In its last fiscal year, 2016, the Obama DOJ racked up $4.7 billion in False Claims Act recoveries, including $2.5 billion related to health care; in 2020, Trump's DOJ pulled in $2.2 billion in total False Claims Act recoveries, $1.9 billion of which was attributable to health care.

"The Trump administration wasn't as receptive to white collar prosecutions generally, and that carried over to health care fraud," says J.D. Thomas, former federal prosecutor and partner with Waller Lansden Dortch & Davis LLP in Nashville. "Frankly, I think you see that in the pardons he issued. There were a lot of names who had been convicted in some large and notable health care fraud prosecutions." Thomas cites a recent New York Times story about convicted health care fraudsters, such as Philip Esformes and Judith Negron, whom Trump released from prison in the final days of his tenure.

The shift from one administration to the next isn't always world-altering, says Ty E. Howard, a former state and federal prosecutor and current partner with Bradley Arant Boult Cummings LLP in Nashville and Dallas. "Sometimes we can overstate the [enforcement] changes that are caused by administration changes," he says.

However, Howard does think the focus of inquiries — and resources — could change under Biden. "The Trump administration put greater focus on violent crimes, street crimes [and] drug crimes," Howard adds. "And there's a finite amount of resources. So if you are devoting federal resources toward those things, there will be non-zero diminishment of resources for white-collar crime."

A major enforcement target would be telemedicine-type Medicare scams — that is, not innocent errors by providers billing telehealth procedures, but real criminal fraud.

"It's kind of low-hanging fruit," Howard says. Often including durable medical equipment, medical creams or genomic cancer testing, and "facilitated in some way by a quote unquote 'telemedicine consult,'" these scams harvest beneficiaries using telemarketers, overseas call centers or health fairs and use their data to charge for massive inappropriate or non-existent treatments.

Targeting telehealth

Howard refers to those cases as "first-wave enforcement," targeting overt and high-profile fraud, where the accent is on criminal intent, not the means of committing it. As he and his colleague Janus Pan wrote in a recent paper, such scams "are no more 'telemedicine fraud' than a bank robbery in which the robbers facilitate their crime through a getaway car is 'automobile fraud.'"

Howard expects that these prosecutions will be followed by "second-wave" enforcement targeting "more nuanced cases" of telehealth malfeasance. That may include instances of "less overtly wrongful conduct, premised more squarely on telehealth requirements generally," Howard predicts.

An example of such cases might include inappropriate use of telehealth for diagnosis or following the more casual standards for telehealth under the public health emergency (PHE) after it's declared over.

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Honing in on HIPAA

Speaking of telehealth, expect to see HIPAA as a major enforcement target, due in no small part to the telehealth boom. Experts have been warning for months that the telehealth flexibilities the federal government granted under COVID-19 and the resulting explosion in use would lead to some providers getting sloppy about safeguarding patients' protected health information (PHI) (*PBN 7/2/20*).

"Under the pandemic, there's been a tremendous amount of health care information that's been shared and put on telehealth platforms," Thomas says. "So I think that there is more vulnerability there."

Auditing provider relief funds

You may recall that the $120 billion in provider relief funds enabled by the CARES Act and distributed in stages during the PHE came with definite terms of use (*PBN 4/23/20*, *10/22/20*). For instance, providers faced reporting requirements and a mandate that the payments would not serve as reimbursement for business expenses or losses.

"There will be efforts to audit that," Thomas says.

Howard expects to see paycheck protection program loans — the low-interest, forgivable loans given by the Small Business Administration to COVID-affected businesses, including medical practices — come under scrutiny as well (*PBN 4/7/20*). This is because of "the volume of money and the speed with which it was dispensed," Howard says. "That creates an environment where there is more likely to be fraud. We've seen that before with big publicly-funded programs."

"In a matter of months, HHS has distributed on behalf of Congress close to $175 billion to nearly every health care provider to cover COVID-related expenses and losses," says Philo Hall, senior counsel in the health care and life sciences practice of Epstein Becker & Green firm in Washington, D.C. "Ensuring that those funds were appropriately allocated and claimed and that providers are adhering to the terms and conditions will produce several years of work for HRSA [U.S. Health Resources and Services Administration], OIG and DOJ."

Keep an eye on other targets

- **E/M coding.** Michael Bagley of Zenith Healthcare Solutions in New Braunfels, Texas, notes the new E/M rubric will undoubtedly lead to heavy auditor attention (*PBN 6/4/20*). "The monitoring of physicians claims will increase, especially if they bill by time only instead of adjusting the documentation and billing by medical decision-making and overall meeting of medical necessity for the service being provided," Bagley says.
- **Meaningful use.** Remember the meaningful use program? Thomas says payments made to providers to get their electronic health records (EHR) up to speed in the previous decade are still subject to audit under a six-year look-back period.
- **Workplace safety.** Biden has already asked the Department of Labor for "revised guidance to employers on workplace safety during the COVID-19 pandemic" under the Occupational Safety and Health Act (OSHA). Also, he has asked other departments, including HHS, to "explore mechanisms to protect workers not protected under the Act so that they remain healthy and safe on the job during the COVID-19 pandemic." Depending on how that shakes out, you may be obliged to reassign or relocate employees or improve protections against the virus (*PBN 4/16/20*).

Final warning

Howard advises that you keep your eyes open for early warnings of compliance trends at the audit level and even among non-governmental bodies from which government may take their cues.

"For example, say a provider gets contacted by their [state] Board of Medical Examiners about an issue," Howard muses. "He may say, 'I didn't realize [that was wrong], I'll agree to the sanction,' and not think much of it. Or you get an audit request from state Medicaid or a private insurer. These things can turn into investigations into civil and even in some cases criminal liability." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- White House, Jan. 21, "Executive Order on Protecting Worker Health and Safety," *www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-protecting-worker-health-and-safety/*
- New York Times, Jan. 21, "For Prosecutors, Trump's Clemency Decisions Were a 'Kick in the Teeth'": *www.nytimes.com/2021/01/21/us/politics/trump-pardons-medicare-fraud.html*

2021 E/M office visits

For E/M visits, review 6 questions and answers to clarify the new data review rules

Be careful about double counting tests and understand how to navigate labs and other test results as they pertain to the time and medical decision-making (MDM) elements of the revamped E/M office visit rules.

Practices want details about how to count tests under the new MDM guidelines, according to a series of questions presented during the CPT® and RBRVS 2021 Annual Symposium that took place virtually Nov. 17-20.

Use the answers provided by Barbara Levy, M.D., and Peter Hollmann, M.D., co-chairs of CPT/RUC Workgroup on E/M, to help educate staff and keep your coding accurate. Note that the questions and answers have been lightly edited for clarity.

Tests and follow-up visits

Question: *Do lab or other test results need to be available at the time of the visit to count as a data point? If we receive a test result two days after the visit, can we count a data point toward that E/M visit for review of the test?*

Answer: "The answer is yes, of course you can," Levy said. "The time rule is only for the date of the encounter. But for [MDM], we know that there's pre-service work and post-service work associated with the encounter and receiving a test result a couple of days later and responding to it are part of the post-service work of the encounter. So absolutely, ordering that test counts toward [MDM] in that particular encounter." (*See the "Data review" graphic, p. 6, for an illustrative guide.*)

Question: Could a provider receive credit for discussion of management or test interpretation — category 3 for moderate and extensive *data analysis — for cases presented to a tumor board? During the next visit, the doctor documents and discusses t*he tumor board's outcome with the patient.

Answer: Yes, that would count toward MDM. "Clearly, that's discussion among colleagues that's directly relevant to the care of the patient," Levy said.

You would not be able to report the tumor board meeting if coding based on time. "Time is only counted on the date of the encounter," Levy reminded. The time that the provider spends at the tumor board would not count toward the visit. "The likelihood, in my experience given that scenario, you likely would be coding by time," Levy added. Usually those are long conversations and you would have time opportunity to use prolonged services.

The discussion of the results with the patient would normally be part of the encounter, Hollmann said. When counting a tumor board meeting that occurs between visits, it is reasonable to consider that it counts as long "as it is clearly part of your [MDM] at that the next encounter," Hollmann said.

Order, review or both?

Question: *The provider orders tests during an encounter and the patient returns on a later date for the test results. Does the review of the results count toward MDM for the follow-up visit?*

Answer: No, the test review does not count toward the follow-up visit, Levy noted.

When a physician or other billing practitioner orders a test during an E/M visit, the order and review of the test result will count toward the MDM of the first encounter.

However, if the results of a test ordered during the first visit prompt the practitioner to order another test before the follow-up visit, and the practitioner discusses the results of the second test at a follow-up visit, then that may count toward MDM at the following visit.

"But a test counts as a test only one time," Levy explained.

Question: *The physician orders and reviews a strep screen for a patient. Does this count as both order and review?*

Answer: "The answer to the question is always no. You get credit for the order," Hollmann said. Practices should not double count tests and assign credit for the order and the review of a test.

(*continued on p. 6*)

Benchmark of the week

Toe procedures clipped, pathology code biggest winner under revised 2021 fees

As the fee schedule shake-up settles down, you can officially welcome thousands of codes that are seeing pay gains into your daily routine. Leading the charge is molecular pathology interpretation service **G0452**, with a 143% year-to-year increase in non-facility fees.

The increase brings per-claim payments for G0452 from $19.13 in 2020 to $46.41 in 2021, and it includes the 8% increase to the Part B conversion factor that CMS announced January 4. Second on the list of gainers is radiation treatment delivery code **77401**, up 77% year to year, followed by electrocochleography code **92584** (+62%) and two vein X-ray services, **75820** (+46%) and **75822** (+34%). The fees shown in the charts below reflect the revised conversion factor, which CMS finalized at $34.89 for the 2021 fee year.

But not all is on the upswing in 2021. As the chart below shows, amputation of toe code **28820** gets snipped at a 45% rate, falling from $581 in 2020 to about $318 in 2021. Toe procedures suffer again, as **28825** (Partial amputation of toe) incurs a 44% shearing. Payments for telehealth services provided at rural health clinics and federally qualified health centers take a sizable reduction, too, as **G2025** loses 42% of its allowable fees, falling to $54 per service. Several electrocardiogram services join the ranks of the downtrodden, with **93227, 93005** and **G0404** all taking losses of at least 23%.

Overall, despite the late push to rescind much of the fee losses associated with the previously released conversion factor, more than 2,200 services took fee cuts in 2021. Approximately 2,000 services stood flat or gained pay. — *Richard Scott* (rscott@decisionhealth.com)

Top 10 code losers, 2021 Part B fee schedule*

Code	Modifier	Description	2020 fee	2021 fee	% YTY change
28820		Amputation of toe	$581.40	$317.88	-45%
28825		Partial amputation of toe	$555.78	$311.25	-44%
G2025		Dis site tele svcs rhc/fqhc	$92.03	$53.74	-42%
93227		Ecg monit/reprt up to 48 hrs	$27.07	$18.84	-30%
93005		Electrocardiogram tracing	$8.66	$6.63	-23%
G0404		Ekg tracing for initial prev	$8.66	$6.63	-23%
91200	26	Liver elastography	$14.44	$11.17	-23%
74300	26	X-ray bile ducts/pancreas	$18.41	$14.31	-22%
93225		Ecg monit/reprt up to 48 hrs	$25.98	$20.24	-22%
94669		Mechanical chest wall oscill	$29.95	$23.38	-22%

**Fees based on revised 2021 conversion factor of $34.89, per 1/4/21 CMS announcement*

Top 10 code gainers, 2021 Part B fee schedule*

Code	Modifier	Description	2020 fee	2021 fee	% YTY change
G0452	26	Molecular pathology interpr	$19.13	$46.41	143%
77401		Radiation treatment delivery	$24.90	$43.97	77%
92584		Electrocochleography	$75.07	$121.43	62%
75820	26	Vein X-ray arm/leg	$35.37	$51.64	46%
75822	26	Vein X-ray arms/legs	$53.05	$71.18	34%
37239		Open/perq place stent ea add	$1,510.35	$1,990.30	32%
G6001		Echo guidance radiotherapy	$119.46	$156.67	31%
91132		Electrogastrography	$330.58	$428.14	30%
95830		Insert electrodes for eeg	$513.56	$662.27	29%
91133		Electrogastrography w/test	$354.40	$451.52	27%

**Fees based on revised 2021 conversion factor of $34.89, per 1/4/21 CMS announcement*

Source: Part B News *analysis of revised 2021 Medicare phyisican fee schedule payment data*

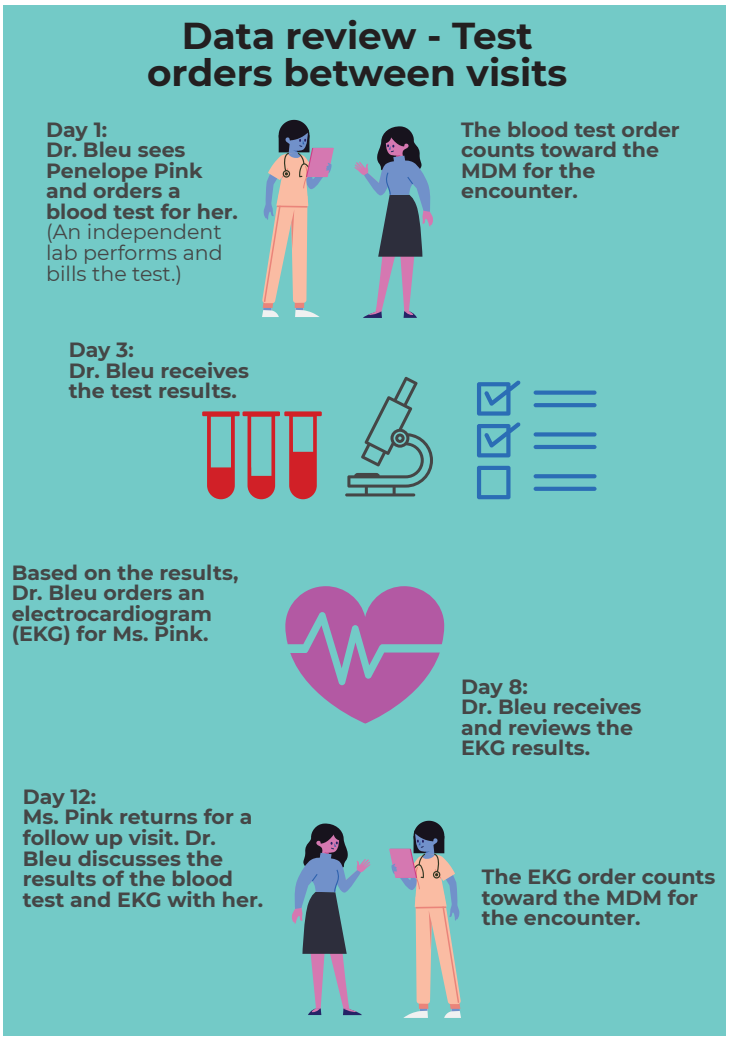
(*continued from p. 4*)

In-house tests

Question: *If one doctor orders a test that is performed in the practice, but a second doctor bills for the test, can the first doctor count the test order toward MDM for his visit? Does it matter if the ordering and billing doctors are of different specialties?*

Answer: This type of question gets into "who is me," Hollmann noted. If the physicians are in the same working unit, same specialty and it's the same day, "that's you," Hollmann said, and urged attendees to use common sense. Practices should not count a test toward MDM if the ordering practitioner's practice also performed and billed for the test. Medicare and private payers could view that type of coding as abusive or fraudulent.

Keep an eye out for more guidance from Medicare and private payers. For example, Medicare is still working on an update to its documentation guidelines for E/M services.



Question: *Can we count a lab test toward MDM if the test is performed by our practice and the results come the same day? Will it make a difference if the provider bills for the test?*

Answer: You cannot count it in the MDM, Hollmann cautioned. "Our goal was to make sure we weren't stimulating people [to order] tests that they were then going to get paid for," he said. However, practices can and should bill for separately reportable in-house tests, Hollman added. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Practice management

When furloughs are on the table: 6 strategies to put your employees first

If you want to use employee furloughs to decrease payroll pressure during a difficult financial stretch, make sure you're observing the law and making it easy and desirable for your employees to come back.

More than 10 months into the pandemic, many physician practices still face declines in patient traffic. An overwhelming majority of practices (82%) said they had experienced decreased patient volume due to COVID-19 in 2020, according to the 2020 DecisionHealth Medical Practice Staff Salary and Trends Survey administered in July (*PBN 12/21/20*).

A return to normal has not come quickly. A survey conducted in December 2020 by the Society for Cardiovascular Angiography and Interventions found that 40% of Americans "still do not feel safe going to the doctor's office" due to the virus.

Treat furloughs differently

More than one-third, or 37%, of practices that responded to the DecisionHealth survey reported that they have furloughed staff, or let them go for a duration of time with the promise or prospect of taking them back on once things get better (PBN 11/5/20).

Brian M. Casaceli, an associate at Mirick O'Connell in Westborough, Mass., explains how this type of leave differs from a layoff: "When an individual is laid off, the employment relationship ends, the employee's eligibility for benefits ceases — except as required by law — and there is no expectation that the employee will return to his/her employment at a later time."

Under a furlough, however, "the employee is placed on a temporary leave of absence with the expectation that the employee will be recalled to perform his or her duties in the foreseeable future," Casaceli explains.

Furloughing employees may cost you more than firing them in the short term, particularly if you continue to fund the furloughed employees' benefits. But, Ashish Mahendru, founder of Mahendru P.C., a commercial litigation law firm in Houston, notes that "keeping the same headcount with reduced hours will provide some cost savings in the immediate terms without incurring the tangible and intangible costs of recruiting and training new hires once economic conditions improve."

Mind the law

Before approaching staff about a furlough, you and counsel should discuss the legal situation. In many cases, at-will employment gives you the right to terminate employment with or without cause.

But be careful, cautions Brett Holubeck, a labor and employment lawyer with Liskow & Lewis in Houston, Texas, and proprietor of the Texas Labor Law Blog (*texaslaborlawblog.com*). Contracted employees may have safeguards you'll need to address, and you definitely cannot choose who gets furloughed based on standards that would run afoul of protected categories under civil rights law (*PBN 9/26/19*).

For example, if you choose to furlough your oldest employees first, you may be vulnerable to challenge on the basis of the Age Discrimination in Employment Act (ADEA). And this may be the case even if those employees are chosen on another basis. For example, Holubeck says, "laying off or choosing not to recall the most expensive employees can cause the most senior and oldest employees to be terminated, which could form the basis of an age discrimination claim."

The cutoff thresholds for such laws vary. The ADEA, for example, applies to employers with 20 or more employees, Holubeck says, while the Uniformed Services Employment and Reemployment Rights Act (USERRA), which protects employees with U.S. military service obligations, applies to all employers regardless of the number of employees. Also in play are "state discrimination laws which often have a threshold of one or more employees," Holubeck adds.

If your business has 100 employees or more, Holubeck advises that you heed the U.S. Worker Adjustment and Retraining Notification (WARN) Act.

Note: Some states have their own versions of the WARN Act and it may differ in some respects, including the cutoff number of employees.

According to the U.S. Department of Labor, the WARN Act requires "at least 60 calendar days advance written notice of a plant closing and mass layoff affecting 50 or more employees at a single site of employment." There are exceptions for "a faltering company, unforeseeable business circumstances, or natural disaster." It's up to you whether you would prefer to give the required notice or try that defense in court should an employee sue.

6 tips when considering furloughs

- **Maintain a protocol.** As with most business practices, it helps to have written protocols that you can point to when investigators ask questions about your process. "Having a legitimate, business reason for choosing certain employees for the furlough over others puts an employer in a much better position to defend itself against potential disparate treatment/impact claims by aggrieved employees on the basis of their membership in a protected class," Casaceli says.

"If companies plan to retain some employees, then the company should develop objective criteria to determine which employees should be kept and which should be let go," Holubeck says. "The criteria could be seniority, job performance, skills/jobs that are needed or some combination." Similarly, Holubeck says, you'll need objective criteria "to determine which employees you will recall if you do not recall everyone."

- **Find out how benefits vendors work with furloughs**. Your employee health insurance, 401k, and other benefits rely on employment status and contributions, but they probably have workarounds for furloughed employees such as allowing them to contribute outside of payroll. You may choose not to continue your company contributions to these programs, but then it's not really a furlough anymore.

A recent International Federation of Employee Health Plans survey found that 39% of employers who furlough employees "are continuing health care for furloughed employees for the entire period as if the employee was actively employed with the usual cost-sharing between worker and employer." Additionally, that survey found, "23% are continuing health care for the entire period as if the employee was actively employed with the employer paying full costs." Only 8% took it as a termination and set up the employees' post-employment Consolidated Omnibus Budget Reconciliation Act (COBRA) package.

Also, check your state law to determine whether a furlough triggers the need to pay the furloughed employee out their accrued and unused vacation time at the time of the furlough, Casaceli advises.

- **Explain the situation thoroughly**. "Your employees likely understand that the pandemic is having a financial impact on the business," says Chris Von Wilpert, founder of marketing company Content Mavericks in Crestview, Fla. "What they probably don't know is what specifically that impact is," Von Wilpert says. "Be transparent about cash flow issues and predictions. Give folks a sense of how exactly the furlough will help your company weather the storm."
- **Stay in touch**. You want these people to come back, so act like it. "Keep the lines of communication open by providing regular updates on the business," Casaceli says. "Doing so will allow the furloughed employees to feel connected to the company and help morale during their leave of absence."
- **Prepare for unemployment claims**. According to the U.S. Department of Labor, while furloughed employees are not generally eligible for company benefits such as family leave, state law may allow them to claim unemployment insurance. If this is the case in your state, Holubeck suggests you assist your employees to help retain their good will for when they return to work. "Businesses can also file a mass claim for unemployment if permitted by their state, which should help workers get unemployment checks faster," Holubeck says. You might even offer a severance payment and — if you aren't sure you'll be able to take them back — a letter of recommendation.
- **Try something besides furloughing**. "As an alternative to furloughing employees, medical practices should instead work to develop optimized, quick ways to upskill and retrain existing employees to support priority initiatives such as post-acute care follow ups, clinical quality measures and population health management," says Krithika Srivats, vice president of the Clinical Center of Excellence at HGS Healthcare in Lisle, Ill. "For example, many employees who are subject to furloughs may work in clinical roles, so an alternative could be reskilling them to place a greater focus on clinical documentation deficiencies, which can ultimately result in millions of dollars in accounts receivables." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- WARN Act: https://webapps.dol.gov/elaws/elg/layoffs.htm
- International Foundation of Employee Benefit Plans, "Are Laid Off or Furloughed Employees Eligible for Health Care Benefits?" May 12, 2020: https://blog.ifebp.org/index.php/laid-off-furloughed-employees-health-care-benefits
- Society for Cardiovascular Angiography and Interventions, "New Data Confirms Alarming Trend: Covid-19 Fears Are Causing Americans to Avoid the Doctor's Office and Delay Routine Care": https://scai.org/new-data-confirms-alarming-trend-covid-19-fears-are-causing-americans-avoid-doctors-office-and

Coding

AMA announces new CPT code for Johnson & Johnson's COVID-19 vaccine

In preparation of a pending vaccine approval, the AMA recently added a new CPT code that will be used to report a COVID-19 vaccine candidate under development by Janssen Pharmaceuticals, a division of Johnson & Johnson.

The new CPT code is:

- **91303** (Severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [COVID-19] vaccine, DNA, spike protein, adenovirus type 26 [Ad26] vector, preservative free, 5x1010 viral particles/0.5 mL dosage, for intramuscular use).

The AMA also created a new HCPCS Level II code for the vaccine's administration:

- **0031A** (Immunization administration by intramuscular injection of SARS-CoV-2 [COVID-19] vaccine, DNA, spike protein, Ad26 vector, preservative free, 5x1010 viral particles/0.5 mL dosage, single dose).

The two codes will take effect when the Food and Drug Administration approves the vaccine candidate or grants it emergency use authorization, according to the AMA.

You can find a complete list of CPT and HCPCS codes for COVID-19 vaccines and associated payment allowances online: www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies. — *Sarah Gould* (pbnfeedback@decisionhealth.com) ■