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In this issue

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Coding

4 tips to help coders determine the MDM level for E/M services

In 2021, the elements used to determine E/M leveling for office or outpatient visits changed to primarily focus on medical decision-making (MDM) and time. Effective Jan. 1, 2023, the same formula applies to facility-based E/M services: history and exam will no longer be used to select the level of code for hospital inpatients, observation care visits, consultations, ED visits, and nursing facility services along with home, rest home and domiciliary services (*PBN 7/11/22*).

No longer using the documentation elements of history and physical exam leaves the burden on the coder to determine the level of MDM. Coders must assess the knowledge and research that the physician needed to determine next steps, such as diagnostic testing, diagnosis confirmation, and establishment of an effective and efficient treatment plan.

Many coders find this task overwhelming. After all, how can the coder possibly know what was going on in the physician's head? For this, you need some quantitative building blocks to fulfill your quest. To follow are some critical resources and tips your coding staff can use to help with determine the correct MDM level for E/M services.

- **Gather possible diagnoses indicated by signs and symptoms.** There are times when a patient's signs and symptoms lead clearly to a definite diagnosis. For example, a patient walks in with a bone sticking out of his upper arm. The physician can easily diagnose this as a fractured humerus and determine the treatment plan to follow.

Then, another patient walks in and complains about occasional confusion, unsteady walking and urgency to urinate.

This could be a generalized infection, brain injury or many other conditions. Diagnostic tests and further information will be needed to determine possible diagnoses.

- **Identify if and how the patient's comorbidities relate to the current condition or treatment.** Coders are aware of underlying conditions and the necessity to report them in addition to the condition for which the patient is being seen. Comorbidities can influence or be influenced by this additional concern and alter the testing performed or the treatment plan.

For example, if the patient with the fractured humerus is pregnant, this would affect the decision for an X-ray, as well as medication management. Other elements, such as extreme age (younger than 1 year or older than 70 years), known allergies, personal or family histories, or other issues may complicate treatment.

- **Seek evidence-based research that may reveal new treatments**. Health care researchers worldwide are continually identifying new ways to care for the human body. Every day, new surgical procedures, diagnostic tests, therapeutic services, devices, tools and medications are approved and made available.

Non-specializing physicians will need to do research to ensure that they are offering their patients the newest, most-effective treatments possible. With Clinical Decision Support Systems (CDSS) embedded into EHRs, finding up-to-date research is much quicker than having to go to a medical library in person, but still takes time.

Resources to help you calculate the level of medical MDM begin with the physician. Virtually every physician's office, particularly if he or she is a specialist, will have a percentage of individuals with the same or similar condition.

For example, research from the American Diabetes Association shows that approximately 46% of all patients in the average endocrinologist practice in the U.S. have been diagnosed with diabetes mellitus. Therefore, almost half of E/M visits in this office will involve the physician's attention to this condition.

When an endocrinologist is caring for a patient with diabetes mellitus, the majority of outcomes will be familiar. This specialist will be knowledgeable with the condition, its effect on the human body and medical innovations.

In contrast, professionals who work with a family practice or an internal medicine office face greater challenges. These physicians see a much greater range of maladies, covering everything from preventive care to hypertension and potential heart disease and stroke concerns. It is with these primary care providers that a greater range of symptoms may be documented.

Many encounters in a family practice or internal medicine office require more investigation to confirm a specific diagnosis. For example, the patient comes in with complaints of a fever, headache and stomach cramps.

Certainly, the headache can be caused by a sinus infection, meningitis or stress, while the fever might also indicate meningitis, the stomach flu (gastroenteritis), or ear infection (labyrinthitis). The stomach cramps may point toward a diagnosis of gastroenteritis (stomach flu),

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constipation (a blocked bowel) or a long list of other concerns. Additional testing and research will be necessary to provide important information to confirm a diagnosis and find out how to help this patient.

- **Turn to trusted tools to aid coding efforts**. The internet provides some credible, valid information that can help you figure some of the physician's mental calculations. You may find these websites can also support your diagnostic and procedural coding.

Here are some websites to bookmark:

- BioMed Central.
- JAMAnetwork.com (Journal of the American Medical Association).
- Medscape.com.
- MedlinePlus.gov.
- NEJM.org (New England Journal of Medicine).
- PubMed.ncbi.nlm.nih.gov (National Institute of Health's National Library of Medicine and National Center for Biotechnology Information).

Coding professionals must work with the physicians for whom they code, especially when new challenges arise, to ensure documentation and coding accuracy. — *Shelley C. Safian, PhD, RHIA, CCS-P, CPC-H, CPC-I* (*pbnfeedback@decisionhealth.com*) ■

Editor's note: *Shelley C. Safian, PhD, RHIA, CCS-P, CPC-H, CPC-I, of Safian Communications Services Inc. in Longwood, Fla., is an AHIMA-approved ICD-10-CM/PCS trainer who has been teaching for over a decade. Opinions expressed do not necessarily reflect those of HCPro, Decisionhealth or any of its subsidiaries.*

Telehealth

Implement 6 tips to manage telehealth compliance risks

Your practice should check its telehealth claims against the information in the recent data brief on telehealth services, health care attorneys advise. The Sept. 2 report from the HHS Office of Inspector General (OIG), "Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks," contains findings and program integrity measures for telehealth services (*PBN 9/26/22*).

What if your practice discovers a mistake? Health care attorneys say it isn't the end of the world if you take the right steps in response.

You shouldn't be surprised if you do find errors. It's difficult to implement new coding and billing rules under ideal conditions, and most practices in 2020 had to get up to speed on telehealth services during a public health emergency and keep track of a steady stream of new and revised coding and billing rules.

Here are six steps to take when you review your practice's telehealth claims:

1. **Read the data brief.** "The OIG data brief is a useful compliance roadmap for providers, and one that should inspire both providers and telemedicine companies to take a closer look at internal coding, billing, auditing and monitoring practices, which serve as important checks and balances in any health care organization," says Amy Lerman, member of the firm with Epstein Becker Green in Washington, D.C. For example, the brief includes seven program integrity measures that the OIG created for telehealth services (*PBN 9/26/22*).
2. **Increase your red flag knowledge base.** You should also use the Department of Health and Human Services' (HHS) list of common telehealth billing mistakes when you review claims. Mistakes include using or reporting:
   - **The wrong codes**. The wrong code can delay payments or cause improper payments. For example, confusion about when to report a telephone code versus an office/outpatient visit code may have caused improper coding. Another error could occur if a practice reported a store-and-forward visit (**G2010**) with a code for a real-time visit.
   - **The wrong documentation**. In addition to meeting the documentation requirements for the service, your practice must document "whether the patient gave you verbal or written consent to conduct a virtual appointment," according to the HHS. In addition, the provider must clearly document whether the connection was audio and visual or audio-only.
   - **The wrong time**. "A common mistake made by health care providers is billing time a patient spent with clinical staff," the HHS report says. "Providers should only bill for the time that they spent with the patient."
3. **Probe if you find a problem.** You don't need to drop everything and start a full-scale review of every claim if you find one error, but ignoring

the error is not an option. You should find out what caused the mistake, figure out its scope and act on your findings, such as returning an overpayment.

4. **Conduct a thorough analysis into what caused the error**. "Secondarily, the organization should conduct a root cause analysis to determine whether any bigger picture solutions … need to be implemented," Lerman says. Those solutions could include better training, improving the practice's coding and billing resources, and correcting behavior that could be fraudulent.
5. **Bring in outside help**. If you discover a serious issue such as dozens of incorrect claims or signs that point to fraud, don't try to tackle the problem on your own. "This is one of those instances in which we recommend practices work with their counsel," says Sara Shanti, partner with Sheppard Mullin in Chicago. Fraud, waste or abuse "may not be the only issue, so it is important to investigate," Shanti says. A health care attorney can help with full-scale audits, self-reporting to the government, training staff and creating compliance plans. It is natural for practices to balk at the expense of hiring an attorney or other outside help, but don't assume your practice can't afford it, Shanti says. At the very least, attorneys and consultants will provide an estimate of the cost at no charge. If a practice finds that it can't afford outside help, they should make a note of that along with the quotes they received and add it to the file on their internal investigation, Shanti advises.
6. **Document everything you do**. The enduring maxim, "If it isn't documented, it isn't done," applies to compliance efforts as well as providers' work. A written record of the steps the practice took will help build up the practice's compliance plan, prevent mistakes in the future and, if the worst happens and the practice is investigated, it will show the government that you tried to do the right thing. "I think intention is important," Shanti says. But good intentions are easier to prove with records the practice made at the time it discovered the problem, rather than waiting until an auditor or investigator discovers the problem to say they worked on it. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCES

- Medicare telehealth services during the first year of the pandemic: Program integrity risks: https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf
- Common telehealth billing mistakes: https://telehealth.hhs.gov/providers/billing-and-reimbursement/billing-and-coding-medicare-fee-for-service-claims/#common-telehealth-billing-mistakes

Coding

2023 ICD-10-CM refresh: Review new codes for musculoskeletal, genitourinary conditions

Effective Oct. 1, CMS updated the ICD-10-CM code set to include over 1,100 new codes, before counting revisions and deletions. The codes will further define and give specificity to newly categorized diseases and disorders. Ensure you are up to speed on new codes for musculoskeletal and genitourinary conditions, including muscle wasting, fractures, drug-induced neuropathy and endometriosis.

Musculoskeletal system

Thirty-five new codes will be added to this section of the ICD-10-CM manual. The topics are listed below according to ICD-10-CM chronology:

- Intravertebral annulus fibrosis defect.
- Muscle wasting and atrophy.
- Slipped upper femoral epiphysis.
- Fractures from cardiopulmonary resuscitation (CPR).

Intravertebral annulus fibrosis defect (M51.A0–M51.A5)

New codes in category **M51** (Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders) describe intravertebral annulus fibrosis defects. Vertebrae contain rings of cartilage, called annulus fibrosus, and jelly-like vertebral disks, called nucleus pulposus. With age or injury, the disks can deteriorate and cause stress on the surrounding vertebrae and muscles.

These new diagnosis codes specify the size of the defect and region of the spine affected. As an example, **M51.A2** (Intravertebral annulus fibrosis defect, large, lumbar region) would be reported for a large defect located in one of the lumbar vertebrae.

(continued on p. 6)

Benchmark of the week

Gastro codes do well with modifier 53, but 52 has some denial traps

The modifiers **52** (Reduced services) and **53** (Discontinued procedure) often confuse providers (*PBN 4/5/21*). While total utilization remains low – 184,489 claims with 52 in 2021 and 30,850 for 53 the same year – your personal patterns may warrant another look, particularly if your practice performs a lot of the tests and exams that make up the bulk of services tied to these claims.

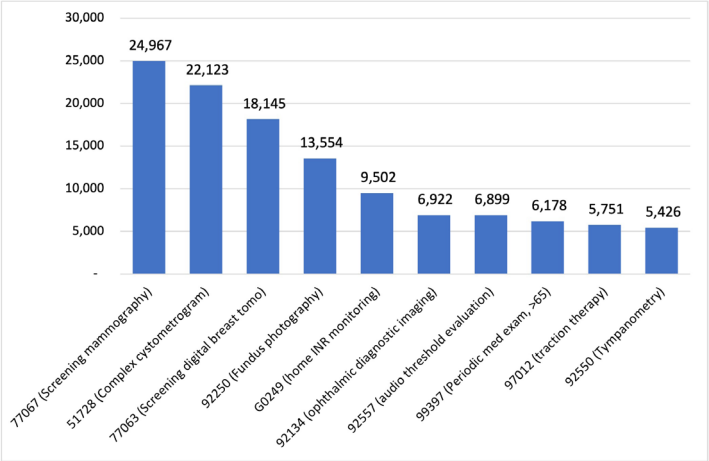
The codes most often used with 53 mostly involve tests and exams in which either patient or equipment issues might necessitate a stoppage, such as probes of the esophagus, uterus and colon. This may explain the low denial rates for some of the services: for example, **G0105** (Colorectal cancer screen, high risk), has a 1% denial rate on 5,928 discontinued claims, and **45378** (Colonoscopy) shows a 7% denial rate on 15,241 claims with 53.

Claim acceptance was more problematic for practices claiming **94618** (Pulmonary stress test) with 53, however. The test, which includes a six-minute treadmill walk during which multiple vitals are measured, received a 17% denial rate.

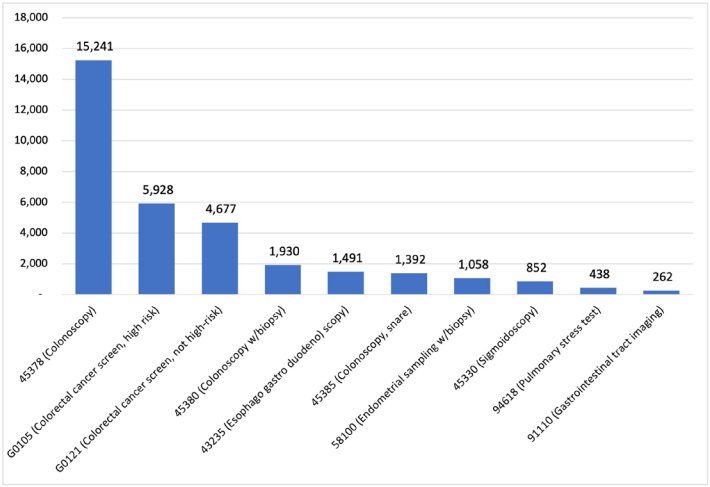
You'll find more variation among the top codes claimed with 52. These include two hearing tests, **92557** (Audio threshold evaluation) and **92550** (Tympanometry), as well as the eye imaging codes **92134** (Ophthalmic diagnostic imaging) and **92250** (Fundus photography). The latter draws a 24% denial rate with 52, though overall the code, which was claimed 3.6 million times in 2021, has only a 7% denial rate. Claims for **G0249** (Provision of test materials and equipment for home INR [prothrombin] monitoring) with 52 did even worse: Overall, it has a 4% denial rate, but draws a 77% rate with 52.

The specialties claiming 52 the most in 2021 were diagnostic radiology (25%), chiropractic (15%) and urology (13%). (Note: Chiropractic returned a 100% denial rate on its 52-appended claims.) Gastroenterology filed an overwhelming 98% of 53 claims, or 30,192 out of 30,850, with a collective 5% denial rate. – *Roy Edroso* (*redroso@decisionhealth.com*)

Most-used codes with modifier 52 (Reduced services), 2021



Most-used codes with modifier 53 (Discontined procedure), 2021



Source: Part B News *analysis of 2021 Medicare claims data*

(continued from p. 4)

Tabular notes specify that coders should first code, if applicable, disc herniation. For example, if coders assign code **M51.A2**, then lumbar disc herniation (**M51.06**, **M51.16**, or **M51.26**) should be coded with it.

Muscle wasting and atrophy NEC (M62.5A0-M62.5A9)

New codes will be added to this section for muscle wasting and atrophy not elsewhere classified in the ICD-10-CM manual.

Muscle wasting and atrophy describe the loss of muscle mass. Lack of mobility, psychological problems or infection can cause muscle atrophy. While some conditions have muscle wasting as symptoms, such as those in category **G12** (Spinal muscular atrophy and related syndromes), these new codes report the symptom itself, with an unlisted or unknown cause.

Additionally, the codes specify the location of the muscular atrophy. For example, code **M62.5A0** (Muscle wasting and atrophy, not elsewhere classified, back, cervical) would be reported specifically for atrophy of the cervical spine.

Codes in this range have Excludes1 notes to not report with **G54.5** (Neuralgic amyotrophy), **G12.21** (Progressive muscular atrophy) or **M62.84** (Sarcopenia).

Slipped upper femoral epiphysis (M93.004–M93.074)

Many codes for slipped upper femoral epiphysis, otherwise known as slipped capital femoral epiphysis (SCFE), have been revised for 2023. SCFE is a condition in which the femoral head slides off the femoral shaft, leading to instability, pain, and stiffness. Risk factors include obesity, family history and endocrine disorders.

"SCFE usually develops during periods of rapid growth, shortly after the onset of puberty," the American Academy of Orthopedic Surgeons (AAOS) states.

The condition's stability is characterized by its weight-bearing ability. Patients with stable SCFE can put weight on the affected hip with or without the assistance of crutches. Hips with unstable SCFE cannot bear weight, according to the AAOS.

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 you. 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.

This section of codes has an Excludes2 note of osteochondrosis of spine (**M42.-**) and an instructional note directs coders to "use additional code for associated chondrolysis (**M94.3**)."

Fractures from CPR (M96.A1–M96.A9)

These codes describe the presence of sternal or rib fractures resulting from CPR. To correctly conduct CPR, the resuscitator must compress the chest by two inches. This pressure can cause fractures for some people.

"About 30% of those who survive CPR wake up with a cracked sternum or a broken rib," says Kimberly Cunningham, CCS, CPC, a coding instructor for HCPro from Dillsburg, Pa.

ICD-10-CM code **M96.A4** (Flail chest associated with chest compression and CPR) includes the occurrence of flail chest. Flail chest is described as "two or more contiguous rib fractures with two or more breaks per rib," according to Mayo Clinic. It is the most serious of these injuries and often leads to mortality.

Genitourinary system

There are 139 new codes for the genitourinary system. These diagnoses are listed below according to ICD-10-CM chronology:

- Drug-induced nephropathy.
- Fournier disease of vagina and vulva.
- Endometriosis.
- Isthmocele.

Drug-induced nephropathy (N14.11, N14.19)

Nephropathy describes decreased kidney function due to disease or trauma. There are four stages of nephropathy, but the last is known as end-stage renal disease and requires intermittent dialysis or transplant. The new codes in this section pertain to nephropathy resulting from contrast, medicaments, biological substances, and other drugs.

Code **N14.1** (Nephropathy induced by other drugs, medicaments and biological substances) will be deleted and replaced with codes **N14.11** (Contrast-induced nephropathy [CIN]), which is reported for kidney damage sustained from adverse reactions to iodinated contrast, and **N14.19** (Nephropathy induced by other drugs, medicaments and biological substances).

ICD-10-CM code N14.11 has an Excludes2 note of **N17.-** (Acute kidney failure). These two codes also have directions to first code poisoning due to drug or toxin,

if applicable (**T36-T65** with fifth or sixth character 1-4 or 6), and to use an additional code to identify the drug from range **T36-T50**.

Fournier disease of vagina and vulva (N76.82)

The update includes new code **N76.82** (Fournier disease of vagina and vulva). Fournier disease, or Fournier's gangrene, is a type of acute necrotizing fasciitis infection that affects the perineal, genital and perianal areas. The disease is often seen with comorbidities such as diabetes, chronic alcoholism and HIV-positivity. It is treated with antibiotics and surgical debridement, but if it is not caught early enough, it can lead to mortality.

This code has notes to also code, if applicable, diabetes mellitus (**E08-E13**) and has an Excludes1 note of gangrene in diabetes mellitus (E08-E13).

Endometriosis (N80.00–N80.D9)

Endometriosis is a condition in which tissue that normally forms the uterine lining grows outside of the uterus and on surrounding organs. This abnormality causes pain, menorrhagia and infertility. The 2023 update will add 135 new endometriosis codes and delete the following codes:

- **N80.0** (Endometriosis of uterus).
- **N80.1** (Endometriosis of ovary).
- **N80.2** (Endometriosis of fallopian tube).
- **N80.3** (Endometriosis of pelvic peritoneum).
- **N80.4** (Endometriosis of rectovaginal septum and vagina).
- **N80.5** (Endometriosis of intestine).

The expanded list of endometriosis codes arises from the inclusion of specifics in laterality and depth. Specificity to laterality allows a decreased need for modifiers such as **LT** (Left side), **RT** (Right side) and **50** (Bilateral). Codes now have the precision of superficial endometriosis, deep endometriosis or endometriosis of unspecified depth.

This innate laterality and specificity of depth are seen in the example code **N80.122** (Deep endometriosis of left ovary).

Isthmocele (N85.A)

A uterine isthmocele, or uterine niche, is a 1-to-2-mm "pouch-like diverticulum that forms because of myometrial thinning or defect at the site of cesarean scar in the anterior wall of the lower uterine segment," an NIH article explains.

The condition can cause chronic pelvic pain, menorrhagia and infertility. Magnetic resonance imaging scans usually confirm the diagnosis, and it is repaired laparoscopically.

This code has an Excludes1 note to not report with **O34.22** (Maternal care for caesarean scar defect) and has a note to also report associated conditions, such as:

- Abnormal uterine and vaginal bleeding, unspecified (**N93.9**).
- Female infertility of uterine origin (**N97.2**).
- Pelvic and perineal pain (**R10.2**). — *Sarah Gould, CPC* (*sgould@hcpro.com*) ■

Editor's note: *This article is based on information from the HCPro webinar,* ***2023 ICD-10-CM Code Updates****. Learn more: https://codingbooks.com/yhha082422.*

Ask Part B News

When the patient brings a drug and you inject? Largely OK; charge a penny

Question: *We have a patient whose testosterone therapy is ordered elsewhere and will be sent to us for injection. I've had it drilled into me that we never leave off the drug code when we bill administration, but we clearly can't charge for the drug. How do we bill?*

Answer: This is not uncommon. Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, CPC emeritus, of Enos Medical Coding in Ft. Myers, Fla., says she sees it in family medicine when a vaccine is state-supplied. "Most payer systems are set up to look for a code pair, administration code and drug code," she says. "For the state-supplied vaccines, many payer instructions are to report the vaccine code with a $0.01 fee and modifier **SL** that indicates state supplied. For drugs purchased through a patient's drug coverage, the same is required so the payer knows what was injected."

Even if it's not a state-supplied medicine, if you're billing Medicare they'll still want to know what the drug is, so put the HCPCS code on the claim line and charge a penny ($0.01) for it. CMS explains the claim line procedure in its A55044 "Billing and Coding: Patients Supplied Donated or Free-of-Charge Drug" publication (*see resource, below*). You'll also bill **96372** (Injection of drug/substance under skin or into muscle) or whatever is the appropriate injection code variant.

If the drug is a "self-injectable," such as certain arthritis drugs, but the patient brings it in and wants your help injecting due to tremor or disability or other reasons — what then?

"There is no code for such an injection," Enos explains. "But if a nurse has to assist the patient, they could charge **99211** for a 'nurse visit' because these injections are only subcutaneous and wouldn't meet the description of most injection codes."

But over time this may raise medical necessity flags, says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati. You'd have to explain in the notes why the patient needed assistance — "wrist in cast, recent problem, poor eyesight," for example. "In other words, there must be an explanation for the 99211 other than giving a shot," Lewis says.

If this is unsustainable over the long run (as it would be for, say, daily insulin shots), seek out alternatives. "A patient's caregiver or family member could be trained to give the injection," Enos says. If the patient is really incapable of doing their own medically-necessary shots, maybe it's time to think about a home health aide. — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCE

- CMS, "Billing and Coding: Patients Supplied Donated or Free-of-Charge Drug": www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=55044&Cntrctr=364

Coding

AMA releases CPT codes for COVID-19 bivalent booster vaccines

On Aug. 31, the AMA announced eight new CPT codes for bivalent COVID-19 vaccine booster doses. The vaccine boosters are designed to combat both the original COVID-19 strain and omicron subvariants BA.4 and BA.5. Of the eight new CPT codes, four are to be used for Moderna booster vaccines and four are to be used for Pfizer-BioNTech boosters.

The bivalent booster vaccine and administration codes for Moderna's shot for individuals 18 years and older are:

- **91313** (Severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [COVID-19] vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use).
- **0134A** (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [COVID-19] vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, booster dose).

Bivalent booster vaccine and administration codes for Moderna's shot for children between 6 and 11 years old are:

- **91314** (Severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use).
- **0144A** (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, mRN-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, booster dose).

Codes for Pfizer-BioNTech's bivalent booster vaccine and its administration for individuals 12 years and older are:

- **91312** (Severe acute respiratory syndrome coronavirus 2 ([SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use).
- **0124A** (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, booster dose).

For children from 5 through 11 years old, Pfizer-BioNTech's bivalent booster vaccine and its administration are reported with:

- **91315** (Severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use).
- **0154A** (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, booster dose).

The FDA approved four of the eight new codes (91312, 91313, 0124A and 0134A) for immediate use, while the remaining four (91314, 91315, 0144A and 0154A) will be effective upon FDA authorization. For more information, coders can reference AMA's website. — *Sarah Gould, CPC* (sgould@hcpro.com) ■