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Telehealth Learning Collaborative Group Session 3: Coding and Billing Telemedicine Visits in Reproductive Health Care

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shaping the future of sexual + reproductive health care™

Disclosure of Commercial Interests

Michael Policar, MD, MPH has nothing to disclose

Evolution of Telemedicine Policies

Policies evolve frequently References are at the end of this presentation
-- All have links to source policy

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Telehealth Service Provision

- All states define, regulate and reimburse differently
- Clinicians must be licensed in states where they offer services
- Most states require a patient-provider relationship be established before e-prescribing of medications
- All states have laws determining which telemedicine services their Medicaid programs will cover and their payment rates
  - All cover videoconferencing
  - Some cover store and forward, but may be specialty-limited

Payment for Telehealth Visits

- Service parity
  - In ½ of states, if telehealth services are *medically necessary and meet the same standards of care as in-person services*, private insurance plans *must* cover telemedicine services if they would normally cover the service in-person
- Payment parity
  - 10 states require TH services to be reimbursed at the same rate as equivalent in-person services,
  - In the remaining states, TH is typically reimbursed at lower rates than equivalent in-person care

Telemedicine Visit Types

1. Telemedicine (E/M) Visit
2. Virtual Check-in Visit
3. Virtual Check-in Store and Forward
4. Audio Only Visit
5. Digital E-visit

1. Telemedicine Visit

- No restrictions on provider location or patient location
- Use any phone, tablet, laptop or desktop computer that allows audio and video communication
- Telemedicine E/M visits are based on MDM or total time
  - Compute MDM level (problems, data, risk)
  - Compute Total Time (before, during, after visit)
  - Select the higher of MDM or Total Time
  - Reimbursed at the same rate as in-person visits

Telemedicine Visit: Modifiers

- Modifier **-95** is for synchronous telemedicine service rendered via a real-time interactive audio *and* video telecommunications
- Modifier **-93** is for synchronous telemedicine service rendered via a real-time interactive audio-only telecommunications
- It is not necessary to use Modifiers -93 or -95 for
  - Telephone calls (99441-99443)
  - Virtual check-in visits (G2010, G2012, G2252)
  - Digital e-visits (99421-99423)

Telemedicine Visit: Place of Service (POS)

- -10: Patient at home
- -02: Patient at another location
- -11: Office visit

- Codes differ for FQHCs

2. Virtual Check-In Visit

- Synchronous discussion over a telephone or A/V to decide whether an office visit or other service is needed
  - Clinician may respond by telephone, A/V, secure text messaging, email, or a patient portal
- Initiated by the patient
- Established relationship with practice
- Not related to a medical visit within < 7 days and does not lead to a visit in < 24 hours (or soonest appointment)
- Patient verbally consents to receive virtual check-in
- HCPCS codes
  - G 2012 (5-10 minutes)
  - G 2252* (11-20 minutes)

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** Not Family PACT or Medi-Cal benefits*

3. Virtual Check-In: Store & Forward

- Remote evaluation of video or images submitted by an established patient
  - Example: Client has a genital skin lesion that s/he is willing to self-photograph and submit for evaluation
- Interpretation with follow-up in < 24 business hours
- Not originating from related E/M service provided < 7 days or leads to E/M visit < 24 hours (or asap)
- HCPCS Code **G2010**

4. Audio only - Telephone E/M Services

- Telephone E/M services for an established patient, not from a related E/M service provided < 7 days, nor leading to an E/M in next 24 hours or soonest appointment
- May (or may not) be covered by commercial insurance
  - 99441 5-10 minutes
  - 99442 11-20 minutes
  - 99443 21-30 minutes
- Will be ended by Medicare 151 days after the end of PHE and replaced with E/M plus -95 modifier

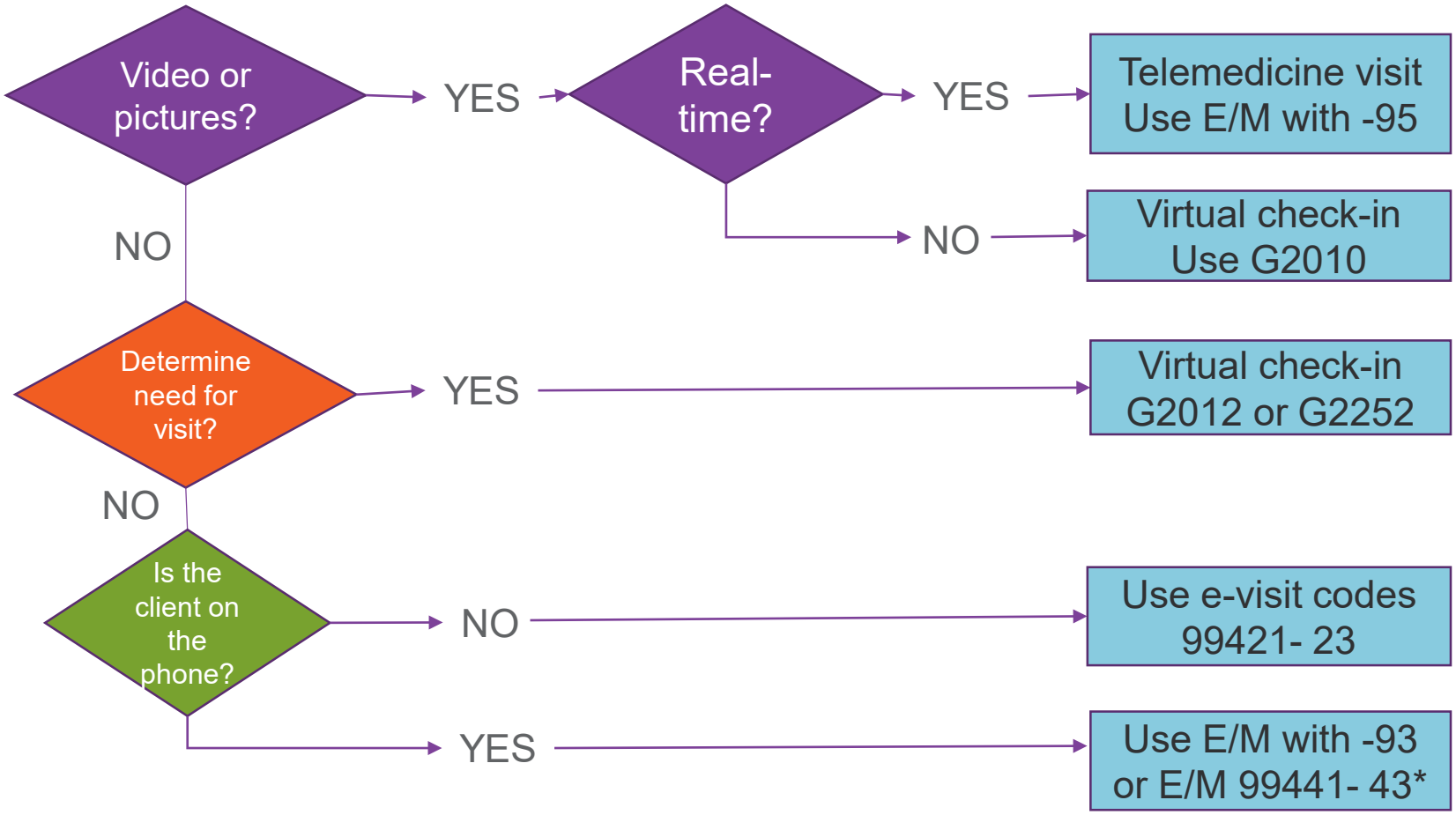
** All of these codes are not used Family PACT or Medi-Cal*

5. Digital E-Visits

- Patient must generate initial inquiry (patient portal, e-mail)
- Online digital E/M service for an established patient, MD or QHP, for up to 7 days, cumulative time
  - 99421 5–10 minutes
  - 99422 11– 20 minutes
  - 99423 21 or more minutes

** All of these codes are not used Family PACT or Medi-Cal*

AAFP Visit Algorithm



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* Will be ended by Medicare 151 days after end of PHE

Family PACT Telehealth Policy

Telehealth Policy

- Billing codes for covered Family PACT services, refer to
  - Part 2 Medi-Cal Manual: *Medicine:Telehealth* (Jan 2023)
  - https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf
  - https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
  - https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-Telehealth-Policy-Exec-Summary.pdf
- Family PACT services by telehealth
  - PPBI, section: *Benefits: Clinical Services Overview*

Telehealth Policy

- Services may be provided via a telehealth ***if all*** are satisfied
  1. The treating HCP at the distant site believes services provided are clinically appropriate for telehealth
  2. The benefits/services delivered via telehealth meet the procedural definition of the CPT or HCPCS code(s) covered under Family PACT
  3. Services provided via telehealth meet all laws regarding confidentiality of health care information and the right to his/her medical information

Can Telehealth Visits Ever Be Telephone-Only?

- May be necessary if
  - A clinic does not have an A/V platform
  - The client doesn't have access to a computer or a smartphone
  - Internet access is unavailable or slow
- During the public health emergency
  - Covered by Medicare and some commercial plans
  - Considered to be "an encounter" in Title X
  - Covered by Medi-Cal, Medi-Cal Managed Care and FPACT

Telehealth: New Patients

- May establish a relationship with new patients via *A/V visit*
- May establish a relationship with new patients via an *audio visit only* if one or more of the following applies
    - The visit is related to *sensitive services*: mental or behavioral health, SRH, STIs, substance use disorder, gender-affirming care, and IPV. At or above the minimum age specified for consenting to the service
    - The patient requests an audio-only modality
    - The patient attests they do not have access to video

E-Consults

- Description
  - Interprofessional telephone/Internet/electronic health record E/M service provided by a consultative physician/QHP, including a *written report* to the requesting physician/QHP
- CPT Code
  - *99451-GQ*: ≥ 5 minutes of medical consultative time
  - Different from CPT codes 99446* -99449*, which require both verbal *and* a written report to the requestor

QHP: qualified health professional

* Not Family PACT or Medi-Cal benefits

Summary: Family PACT Telemedicine Visit Coverage

Code	Description	Modality
99202-4 - 95 modifier - 93 modifier	Telehealth visit (new client)	 Audio-visual Telephonic only
99211-4 -95 modifier - 93 modifier	Telehealth visit (established)	 Audio-visual Telephonic only
G2010	VCI: Store and forward	E-mail photo
G 2012	Virtual check-in visit	Telephone
99451	E-consult	E-mail

Not covered: Digital e-visits, telephone E/M codes (99441-3)

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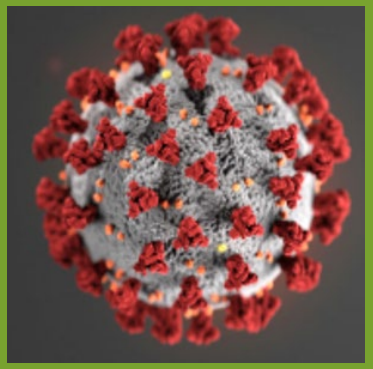
Documentation

- Start note with: “Telemedicine Visit”
  - Note whether A/V or telephonic-only
- Patient consent for video visit
- Patient location at the time of visit
- Provider location at the time of visit
- Who’s present and their role (family members, etc.)
- Use of interpreter: language, identity
- All other usual components of in-person visit

Telehealth Consent

- Obtain verbal consent and document in medical record
  - Share a digital copy with client, if possible
  - Obtain written consent when client returns to clinic
- Include language that explains what a telehealth or phone consult is, expected benefits and possible risks, and security
- Example of documentation
  - Verbal consent to treat obtained via phone, and written consent will be obtained when client comes to clinic
  - Consent reviewed in detail with client, digital copy shared, and client verbalized understanding

Telemedicine in Family Planning Clinics **Since the PHE**



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Family Planning Clinic Changes Since 3/2020

- Rapid adoption of telehealth capability
- Prioritization templates
- Office procedure protections
- Curbside pick-up: methods, lab tests, injections
- Clinic and pharmacy dispensed medications
  - Mailing and curbside
- Adaptations of clinical practices
  - BP determination
  - DMPA-SQ
  - Syndromic management

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Alice: Contraceptive Initiation by Telemedicine

- Alice, a new client, calls to request a visit to initiate contraception
- Informed that the clinic is open in limited circumstances and that most visits now are done by telemedicine
- A/V telehealth visit (patient at home)
  - Discussed all available methods
  - Total time: 27 minutes
- Copper IUD chosen
  - After discussion, verbally consented to placement
  - Scheduled for in-person visit for placement in 3 days

E/M Code: Total Time

January 1, 2021

- Changes time intervals associated with each code
- Removes “50% threshold” for counseling time
- Time redefined *from* face-to-face time *to* total time spent on the day of the encounter
  - Specific criteria for total time
  - Guideline added to clarify when > 1 provider is involved

E/M Codes: Time Defined

January 1, 2021

Before the visit
• Prepare to see the patient (e.g., review test results)
• Obtain and/or review separately obtained history
During the visit
• Perform medically appropriate exam and/or evaluation
• Counsel and educate the patient/family/caregiver
After the visit
• Document clinical information in the health record
• Independently interpret results (not separately reported) and communicate results to the patient/family/caregiver
• Care coordination (not separately reported)

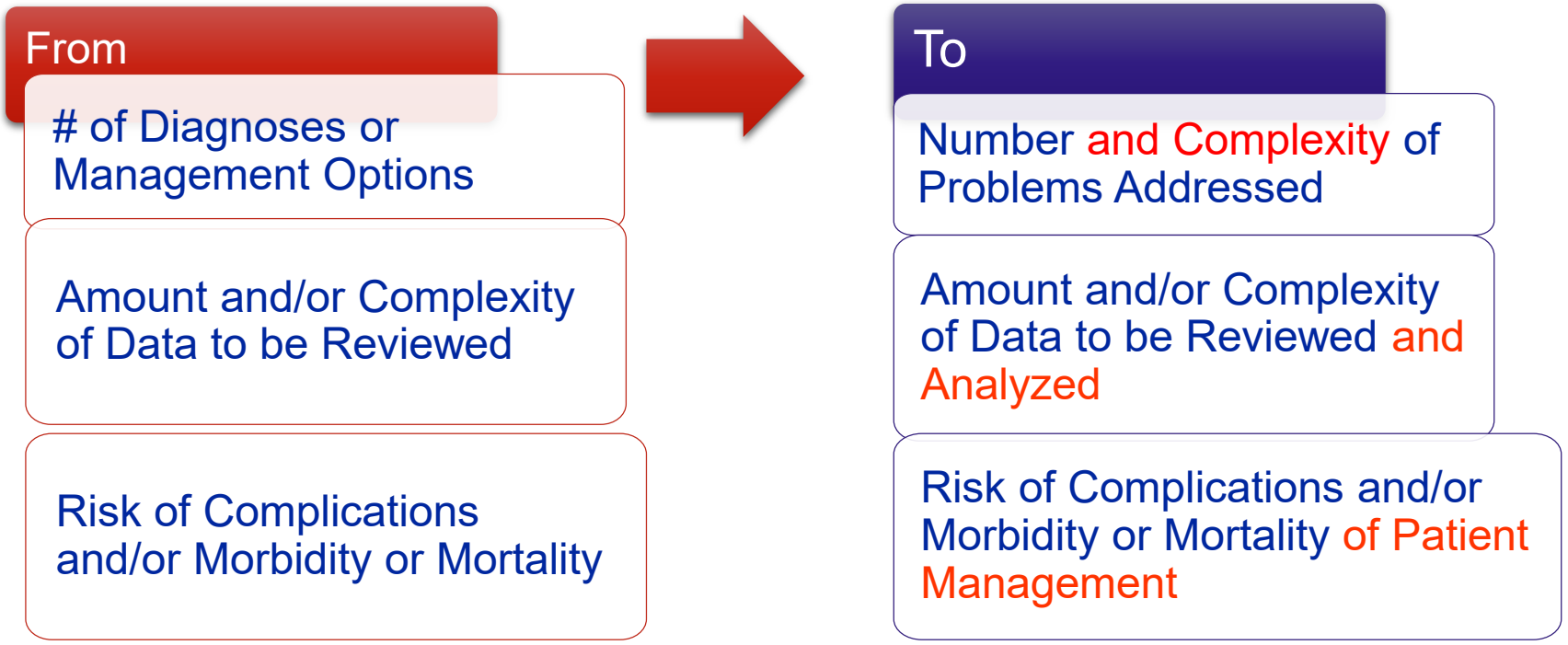
Alice: Coding by Total Time

- New client, total time 27 minutes

New	Time
deleted	
99202	15-29
99203	30-44
99204	45-59
99205	60-74

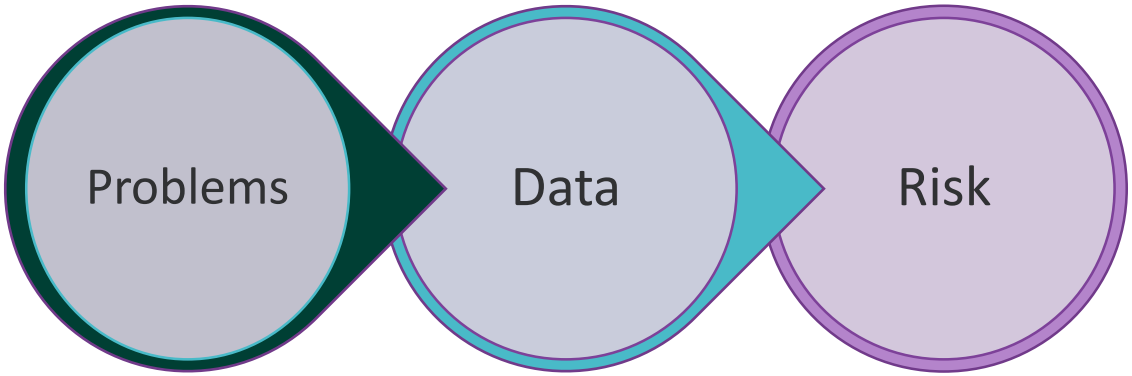
Established	Time
99211	N/A
99212	10-19
99213	20-29
99214	30-39
99215	40-54

Level of MDM



Red: Modifications beginning 1.1.2021

Level of MDM



MDM: *Number of Problems*

Level	Number, complexity of problems
Minimal	• *1 self-limited or minor problem*
Low	• 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • *1 acute, uncomplicated illness or injury*
Moderate	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • *1 undiagnosed new problem with uncertain prognosis; or* • 1 acute illness with systemic symptoms; or • 1 acute complicated injury
High	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or function

MDM: *Number of Problems*

Level	Number and complexity of problems addressed	*SRH Example*
Minimal	1 self-limited or minor problem	• Follow-up, straightforward • Refill of a contraceptive prescription (Rx) • Pre-pregnancy visit • STI counseling visit

Level	Number/complexity of problems	*SRH Example*
Low	≥2 self-limited or minor problems	• ≥ 2 of above problems on same date of service
	1 stable chronic illness	• Follow-up after genital wart treatment
	1 acute, uncomplicated illness or injury (~1 single uncomplicated problem)	• Healthy patient presenting for contraception • New complaint of (c/o) vaginal discharge • IUD, implant, other hormonal contraceptive user with a c/o unscheduled vaginal bleeding

MDM: *Data Element*

Level	Amount and/or Complexity of Data to be Reviewed and Analyzed
Minimal	Minimal or none
Limited	Any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test
Moderate (Must meet requirements of at least 1 out of 3 categories)	Category 1: any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s), or Cat 2: Independent interpretation of tests by another MD, QHP, or Cat 3: Discussion of management or test result with external physician or QHP
Extensive	Must meet requirements of at least 2/3 categories above

MDM: *Data Element*

Level	*SRH Examples*
Minimal	• No tests ordered or results reviewed • No review of external records
Limited	Any combination of 2 from the following: • Review of note(s) from provider in a distinct group or different specialty • Review of each unique test result ordered by an external provider • Each unique test ordered today, not including billed point-of-care tests (Examples: GC, CT, CBC, Hgb A1c) • Additional history required from a partner, parent, guardian, caregiver
Moderate (1/3 categories)	• Category 1: any combination of 3 of the above items • Category 2: Review of pelvic sonogram or CT images • Category 3: - Discussion with pathologist about biopsy result - Discussion with radiologist about mammogram result
Extensive (2/3 categories)	• 2 out of 3 from above

In the Weeds: *MDM Data Element*

- If you code and bill for a (point-of-care) test, you CAN now count it as "data"
- If you *order* a test, it includes *review* of the result as 1 point, whether you review the result today or next week
- “Review of test results” *can* be counted only for tests that you didn't order
- Each unique “test” has a CPT code; a “panel” counts as 1 unique test

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MDM: *Risk of Complications*

Level	Risk of Complications and/or Morbidity or Mortality of Patient Management
Minimal	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate risk of morbidity from testing or treatment. Examples • Prescription drug management • Decision re: minor surgery with patient or procedure risk factors • Decision re: major surgery without patient or procedure risk factors • Diagnosis or treatment limited by social determinants of health
High	• Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

MDM: *Complications*

Level	Risk of complications	Examples in SRH
Minimal	Minimal risk of morbidity from additional diagnostic testing or treatment	• No diagnostic studies or treatment

Level	Risk of complications	Examples in SRH
Low	Low risk of morbidity from additional diagnostic testing or treatment	• Point-of-care tests done • Venous blood drawn for a serologic test • Condoms, spermicides dispensed • Treatment with an over-the-counter (OTC) NSAID (e.g., ibuprofen, naproxen sodium)

MDM: *Complications*

Level	Risk of complications	Examples in SRH
Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Rx drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	• Rx of any contraceptive or antibiotic • Discussion and consent for IUD or implant placement, endometrial biopsy, or colposcopy • Discussion and consent for laparoscopic tubal occlusion or extract translocated IUD • Individual experiencing homelessness that may experience challenges with maintaining treatment recommendation(s) [social determinant must be addressed at visit and increases risk of complication]

MDM: Risk of *Complications*

Level	Risk of complications	Examples in SRH
High	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Decision regarding emergency major surgery • Decision regarding hospitalization	• Discussion and consent for laparoscopy for ruptured ectopic pregnancy • Discussion regarding hospitalization for treatment of a patient with a tubo-ovarian abscess

Alice: MDM *(based on highest 2 of 3)*

Problems	Data	Risk	E/M Code
Minimal	Minimal or none ✓	Minimal risk of morbidity ✓	99202 99212
Low ✓	Limited	Low risk	99203 99213
Moderate	Moderate	Moderate	99204 99214
High	Extensive	High risk	99205 99215

- Alice is a new client
- MDM level is straightforward

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Alice Visit #1: Coding Framework

	CPT Code	ICD-10-CM Code
Procedure	none	
Drug/supply	none	
POC lab	none	
E/M code	99202-95	Z30.09 (Encounter for other general counseling and advice on contraception)
Modifier	-95 A/V telemedicine visit	
Location	-10 (patient at home)	

- Total time: 99202 (new patient, 15-29 minutes)
- MDM: 99202 (new patient; straightforward)

Alice: Explanation

- CMS-defined “telemedicine visit”, since both audio and video were used
- -95 modifier indicates that this was an **A/V** telemedicine visit
- ICD-10 Z30.09 was chosen because an IUD was not yet her method of contraception

Alice: Continued

- Seen in-person for the procedure 3 days later
- UPT done because of confusing menstrual history: neg
- Copper IUD was placed without difficulty

- *Total time*: 15 minutes

Alice Visit #2: Coding Framework

	CPT code	ICD-10 Code
Procedure	53800 (insertion of IUD)	Z30.430 (Insertion of IUD)
Drug/supply	J7300 (Copper IUD)	Z30.430 (Insertion of IUD)
POC lab	81025 (pregnancy test, urine)	Z32.02 (Pregnancy exam or test, negative)
E/M	None	
Modifier	None	
Location	-11 (office visit)	

Alice (continued)

- This is a "**hybrid visit**", as it is starts with a telemedicine visit and is completed in-person services
- An E/M code is not billed on this date, since there was no "separately identifiable service" performed while in clinic
  - Method choice, counseling and consent were done at the prior telemedicine visit

Patricia: Telemedicine Visit for Vaginal Discharge

- Patricia (she/her), a 24-year-old established patient, called from school to c/o recurrent vaginal discharge
- Oral contraceptive user; no problems
- A/V telemedicine visit; *total time:* 22 minutes
- Diagnosis: vaginal candidiasis
- Prescription for oral fluconazole transmitted to pharmacy

Patricia: Coding by Total Time

Established patient; Total time 22 minutes

New	Time
deleted	
99202	15-29
99203	30-44
99204	45-59
99205	60-74

Established	Time
99211	N/A
99212	10-19
99213	20-29
99214	30-39
99215	40-54

Patricia: Coding by MDM *(based on highest 2 of 3)*

Problems	Data	Risk	E/M Code
Minimal	Minimal or none ✓	Minimal risk of morbidity	99202 99212
Low ✓	Limited	Low risk	99203 99213
Moderate	Moderate	Moderate ✓	99204 99214
High	Extensive	High risk	99205 99215

- Established patient
- MDM level is Low

Patricia: Coding Framework

	CPT Code	ICD-10-CM Code
Procedure	None	
Drug/supply	None*	
POC lab	None	
E/M code	99213-95	B37.3 (Vaginal candidiasis) Z30.41 (Surveillance of OC)
Modifier	-95 A/V telemedicine visit	
Location	-02 (patient at another location)	

- Don't charge for fluconazole, since pharmacy will bill payer
- E/M: 99213, based on both total time and MDM

Alexa: Hybrid Visit

- Alexa is a new Family PACT client who calls from home and wants to initiate contraception
- A/V telehealth visit; discussed all available methods
  - Time with clinician: 27 minutes
- Copper IUD chosen
  - After discussion, verbally consented to placement
- Seen in-person for the procedure *3 days later*
  - UPT done because of confusing menstrual history: negative
  - Cooper IUD was placed without difficulty

Alexa: Coding Framework

Visit	POS	CPT code	ICD-10 code	Supplies
#1	-10	99203-95	Z30.09 Encounter for other general counseling and advice on contraception	None
#2	-11	58300 Insertion of IUD	Z30.430 Insertion of IUD	• J7300 (Copper IUD) • 58300UA (supplies for IUD insertion)
	-11	81025 Urine preg test	Z32.02 Preg exam or test, negative	none

- POS (Place of Service) -10 (at home) -11 (office visit)
- Clinics and FQHCs have other numbers

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Comment: Alexa

- Visit #1
  - CMS-defined “telehealth visit”, which should be coded on the basis of video time with the clinician
- Visit #2
  - ICD-10 code is different than for visit #1
  - E/M code is not billed on this date of service, since there was no “separately identifiable service” performed while in clinic

Rosie: Replace Expired IUD

- Rosie calls from work to request replacement of expired IUD
- Telephone-only visit; discussed all available methods
- LNg 52 mg IUD chosen (Mirena®, Liletta®)
  - After discussion, verbally consented to placement
- Seen in-person for the procedure *3 days later*
  - UPT because of confusing menstrual history: negative
  - Cooper IUD was placed without difficulty

Duration of Use For LARC

	FDA-Approved	Evidence-Based
Implant (Nexplanon)	3 years	5 years
LNG 52 (Mirena)	8 years	8 years
LNG 52 (Liletta)	8 years	8 years
LNG 19.5 (Kyleena)	5 years	5 years
LNG 13.5 (Skyla)	3 years	3 years
Copper IUD (Paragard)	10 years	12 years
DMPA-IM	13 weeks	15 weeks
DMPA-SQ	13 weeks	15 weeks

Level II HCPCS: Contraceptive J-Codes

HCPCS	Description
J1050	Injection, DMPA, 1 mg
J7294	EE/SGA contraceptive vaginal ring (Annovera) **new!**
J7295	EE/ETG contraceptive vaginal ring (NuvaRing) **new!**
J7296	LN-releasing IUS, 19.5 mg (Kyleena)
J7297	LN-releasing IUS 52 mg (Liletta)
J7298	LN-releasing IUS, 52 mg (Mirena)
J7300	Intrauterine copper contraceptive (ParaGard)
J7301	LN-releasing IUS, 13.5 mg (Skyla)
J7303	Contraceptive supply, vaginal ring, each **(retired)**
J7304	Contraceptive supply, hormone containing patch, each
J7307	Etonogestrel implant (insertion kit and supplies)

Follow-Up After IUD Placement

- In-person follow-up (string check) visits were optional even before PHE
  - No routine follow-up visit is required
  - More frequent follow-up visits: adolescents, persons with certain (or multiple) medical conditions
- Check-in can be done by telemedicine, as needed
  - To discuss side effects or other problems
  - If she wants to change the method being used
  - When it is time to remove or replace the IUD

Rosie: Coding Framework

Visit	Loc'n	CPT code	ICD-10 code	Supplies
#1	-02	99203-93	Z30.09 Encounter for other general counseling and advice on contraception	None
#2	-11	58300 IUD Insertion	Z30.430 Insertion of IUD	J7300 (Copper IUD)
	-11	81025 Urine preg test	Z32.02 Preg exam or test, negative	none

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Comment: Hybrid Visits

- Visit #1
  - CMS-defined “telehealth visit”, which should be coded on the basis of video time with the clinician
- Visit #2
  - ICD-10 code is different than for visit #1
  - E/M code is not billed on this date of service, since there was no “separately identifiable service” performed while in clinic

Bella: DMPA SQ by Telemedicine

- Bella is a 30-year-old established client who has been using DMPA every 13 weeks for the past 2 years
- She called from home for an appointment 2 weeks before her next injection was due, but was hesitant to come in
- Telephonic visit:
  - 15-minute discussion with a clinician about her alternatives
  - Decided to try self-injection of DMPA-SQ
- One unit delivered curbside to Bella by a local retail pharmacy

Bella: Coding Framework

	CPT code	ICD-10-CM code
Procedure	None	
Drug	None (pharmacy will claim)	
POC lab	None	
E/M	99213 (established, 20-29m)	Z30.42 Surveillance of injectable contraceptive
Modifier: -93 (Telephone-only telehealth visit)		
Location code: -10 (patient at home)		

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Bella (continued)

- 12 weeks later, Bella called the clinic and stated that she wanted to switch back to DMPA-IM at the clinic
- When seen, she complained that she has had continuous light spotting over the last 4 weeks
  - Discussed with clinician; wants to continue
- Office pregnancy test negative
- DMPA-IM injection given by MA
- Total time of visit: 24 minutes

3 Ways to Bill for a DMPA Injection

1. IM injection by MA at a follow-up visit
   - 96372, no E/M
2. IM injection by RN (or clinician) after short history update
   - 99211 *or* 96732 (not both)...whichever pays better
3. Clinician visit for DMPA-related (or other) problem
   - 96372 *and* E/M (99212-5) with -25 modifier
   - This requires two (or more) ICD-10 codes
     - Z30.42 (surveillance of DMPA)
     - 2nd diagnosis code for the problem (e.g. N92.1, excessive and frequent menstruation)

Bella (continued): Coding Framework

	CPT code	ICD-10-CM code
Procedure	96372 (office IM injection, therapeutic)	Z30.42 Surveillance of injectable contraceptive
Drug	J 1050 DMPA injection, 1 mg x 149 units	Z30.42
POC lab	81025 (urine preg test)	Z32.02 Preg test; negative
E/M	99213 (established patient; 20-29 minutes)	N92.1 Excessive and frequent menstruation, irregular cycle
Modifier	99213-25	" "

- Unit is calculated by mg. The first unit is included in the HCPCS code and remaining mg units are added separately. NDC #: 0009-4709-13

Bella: Family PACT Coding

	CPT code	ICD-10-CM code
Procedure	None	
Drug	J3490 U8: DMPA 150 mg, for contraception	Z30.42 Surveillance of injectable contraceptive
POC lab	81025 (urine preg test)	Z32.02 Preg test; negative
E/M	99213 (established patient; 20-29 minutes)	N92.1 Excessive and frequent menstruation, irregular cycle
Modifier	99213	“ “

Note: Family PACT and Medi-Cal do not accept CPT 96372

Thank you!

AMA Documents

- E/M Services Guidelines
  https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

- E/M MDM Chart
  https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Other AMA Resources

E/M

- https://www.ama-assn.org/practice-management/cpt/10-tips-prepare-your-practice-em-office-visit-changes
- https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

AMA Online Modules

- Office Evaluation and Management (E/M) CPT Code Revisions:
  - https://edhub.ama-assn.org/cpt-education/interactive/18057429
- Revisions to the CPT E/M Office Visits: New Ways to Report Using Medical Decision Making (MDM)
  - https://edhub.ama-assn.org/cpt-education/interactive/18461932
- Revisions to CPT E/M Office Visits: New Ways to Report Using Time
  - https://edhub.ama-assn.org/cpt-education/interactive/18461930

Other Resources

Auditing

- https://oig.hhs.gov/authorities/docs/physician.pdf
- https://www.beckershospitalreview.com/healthcare-information-technology/identify-e-m-compliance-risks-before-auditors-do.html
- https://www.acponline.org/practice-resources/business-resources/coding/how-to-complete-a-coding-audit-internal-medicine