September 20, 2021 | Volume 35, Issue 36

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In this issue

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COVID-19

Refusing care to the unvaccinated a potential legal and ethical pitfall

Recent reports of providers refusing to treat patients who are not vaccinated against COVID-19 raise the question: Can providers do that? While there are technical grounds that would arguably allow it, legal experts advise against it.

You may have seen reports about providers who opted not to see patients who remain unvaccinated against COVID-19. Miami family medicine doctor Linda Marraccini, M.D., "posted a note outside the office door and gave patients until Sept. 15 to get vaccinated against COVID-19 or else she will end the doctor-patient relationship," the Miami Herald reported Sept. 9.

Another family doctor, Jason Valentine, M.D. of Mobile, Ala., issued a similar ultimatum in a Facebook post, according to a report in the Washington Post on Aug. 18. "'If they asked why, I told them covid is a miserable way to die and I can't watch them die like that,' wrote Valentine," according to the report.

Akin to 'firing' a patient

Is a refusal to treat unvaccinated individuals allowed? In theory, yes, but the path is narrow and legal implications are thorny.

David Aylor, CEO of David Aylor Law Offices in Charleston, S.C., says that if the provider can show the patient is not being excluded for their status as a protected class under civil rights laws, she may have a case for excluding the patient on the grounds of vaccination status. Aylor notes the provider also cannot be the only medical practitioner available to treat the patient, e.g., during an emergency.

A near-analogy would be "firing" a patient who won't follow medical advice or who presents a threat to other patients. A vaccination-refusal policy would require a similar protocol (*PBN 7/24/17*).

Eyes on epidurals: Prep for changes

New utilization limits, new coding rules and new imaging guidelines are just three of the changes that Medicare Administrative Contractors (MAC) plan to implement for diagnostic and therapeutic epidural blocks. Attend the Oct. 21 webinar **Epidural Update: Prepare for the Uniform Policy for Translaminar, Transforaminal, and Caudal Epidurals** to get prepared for the big changes. Learn more: *https://codingbooks.com/ympda102121*.

"In the case of a non-emergency situation, though doctors are legally entitled to refuse service, they're obligated by the duty of care doctrine to explain why and offer to connect them to a doctor willing to treat them," Aylor says.

Urging caution

Even if you do all of that right, though, "it's a very slippery slope," says Mariel Smith, a labor and employment attorney at Hall Booth Smith P.C. in Columbus, Ga. That's because such a policy could lead to difficult situations that, if it came to cases, would not look good to a jury or judge, Smith notes.

"Think of someone at the door or in the waiting room, and you telling them, 'Sorry, we can't see you because you [aren't vaccinated],'" Smith says. "It could be seen as patient abandonment."

Faisal Khan, senior legal counsel at Nixon Gwilt Law in Cleveland, finds the whole fired-patient model sketchy.

"Intent is definitely a key factor in whether or not a provider is justified in terminating a provider-patient relationship," Khan says.

While a disruptive patient would be covered by that standard, "terminating the relationship based on a competent patient's informed decision to avoid vaccination does not represent any intentional risk to inflict physical harm to the provider, staff or patients," Khan explains. "In this case, the provider is terminating the relationship when the patient does not intentionally seek to harm anyone; the provider is essentially saying you pose a risk even when you don't intend to harm anyone."

Also, treating a patient differently because of their vaccination status invites anti-discrimination scrutiny under civil rights law.

Watch rights, ethics violations

Rich Cahill, Esq., vice president and associate general counsel for The Doctors Company in Napa, Calif., envisions "an investigation by the Office for Civil Rights (OCR) for violation of the Americans with Disabilities Act (ADA), and probably adverse blogging, negative posts on social media and other potential reputational harms." And the patient might also claim exemptions on religious or medical grounds and insist on being seen anyway.

Anna L. Schroeder, an associate with the Eastman & Smith Ltd. health care group in Toledo, Ohio, argues that "if your motivation is solely to incentivize vaccination, that may be [considered] unethical" because it "would damage trust in the medical profession, something essential between a physician and patient."

"People report physicians [to insurers or medical boards] all the time," Smith says. "Patients report if you open late or close early. Imagine the type of complaints this would raise."

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Depending on your motivation, you might be able to get the results you're hoping for from an exclusion policy through less extreme means. For example, if patient safety is your concern, you might be able to justify having separate waiting rooms for unvaccinated patients, Smith says. Although, she warns, you would still have to be careful.

"Suppose all of my elderly patients are saying that, for medical reasons, they're not getting the vaccine," Smith says. "Well, [if I separate them] it appears that I'm discriminating against my elderly patients."

You could also try harder to reach refusenik patients. "Refusing to treat unvaccinated individuals also removes the opportunity to educate them about the vaccine and address any concerns acting as a barrier to vaccination," Schroeder reasons.

"People need access to care and continuity of care more than ever given the pandemic," Khan says. Besides the risk it presents to the practice, excluding unvaccinated patients "certainly is not helping the cause of building the trust between individuals and local communities and their health care providers."
— *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- Miami Herald, "No vaccine, no service. Miami physician orders patients to get a shot or find another doctor," Sept. 9: www.miamiherald.com/news/coronavirus/article253973718.html
- Washington Post, "An Alabama doctor watched patients reject the coronavirus vaccine. Now he's refusing to treat them," Aug. 18: www.washingtonpost.com/health/2021/08/18/alabama-doctor-unvaccinated-patients-valentine/

COVID-19

Federal vaccine mandate could require shot or test for nearly all health care workers

The impact of the Biden administration's vaccine mandate will be more apparent when rulemaking and other sub-regulatory guidance emerges, but it appears that nearly all U.S. health care workers will be required to vaccinate against COVID-19 or take regular COVID tests as a condition of employment.

On Sept. 9, the White House released two Executive Orders (EO) — on Ensuring Adequate COVID Safety Protocols for Federal Contractors and on Ensuring Adequate COVID Safety Protocols for Federal Contractors — as well as a "Path Out of the Pandemic" plan outlining steps to increase the rate of vaccinations as a means to arrest the spread of COVID-19.

Health care facilities are directly targeted by the plan, which has CMS planning a rule mandating vaccination for facilities "including but not limited to hospitals, dialysis facilities, ambulatory surgical settings and home health agencies." The White House had already required vaccinations for staff of nursing homes in August.

The same day Biden released his directives, CMS announced it would issue an Interim Final Rule with Comment Period in October. The agency added: "Health care workers employed in these facilities who are not currently vaccinated are urged to begin the process immediately."

But non-facility practices stand to face similar requirements under two other aspects of the new federal actions:

- **Practices with 100 or more employees**. The plan calls for the Occupation Safety and Health Administration (OSHA) to issue a rule and a revision to its Emergency Temporary Standard (ETS) that has been in effect since the day Biden took office that would allow the executive branch of the federal government to "require all employers with 100 or more employees to ensure their workforce is fully vaccinated or require any workers who remain unvaccinated to produce a negative test result on at least a weekly basis before coming to work."
- **Practices taking federal dollars**. While it's less clear at this point, the Biden EO relating to federal contractors and sub-contractors would seem to apply to all parties that accept payment from the feds, including Medicare and other federal payers. The EO outlines a process by which the federal Workforce Task Force and the director of the Office of Management and Budget (OMB) will approve federal contract terms that subject individuals "working on or in connection with a federal government contract or contract-like instruments" to the same COVID safety guidelines required of federal employees; and the other Sept. 9 EO requires all federal employees to be vaccinated.

If that interpretation holds, when guidance is published nearly all health care workers would be covered by the vaccination-or-testing mandate; and, as the federal employee EO does not have a testing option, Medicare "contractors" may not either.

You can expect loopholes. Walter M. Foster of the Eckert Seamans law firm in Boston says that anti-discrimination laws can provide for a reasonable accommodation in certain circumstances, such as a religious objection or a medical condition. It's also likely that practice employees who are not directly involved with patient care, such as coders and billers working remotely, will be exempted, since the purpose of the executive orders is to prevent the spread of COVID-19, Foster says. And providers who don't take federal insurance, such as concierge practices, should be spared as well if they have fewer than 100 employees.

Since the joint announcements, several Republican office-holders have threatened to sue on constitutional grounds, which may delay if not prevent the mandates from taking effect. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- White House, "Path Out of the Pandemic," Sept. 9: *www.whitehouse.gov/covidplan*
- White House, "Executive Order on Ensuring Adequate COVID Safety Protocols for Federal Contractors," Sept. 9: *www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-ensuring-adequate-covid-safety-protocols-for-federal-contractors/*
- White House, "Executive Order on Requiring Coronavirus Disease 2019 Vaccination for Federal Employees," Sept. 9: *www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-federal-employees/*

Correct Coding Initiative

CCI version 27.3 edits reverse E/M bundles, lock in more code pairs

Mind the latest quarterly National Correct Coding Initiative (CCI) update, which includes a reversal of procedure-to-procedure (PTP) edits that involve E/M codes along with new medically unlikely edits (MUE) for a series of COVID-19 vaccination codes. The edits, released in early September, will go into effect Oct. 1.

Ablation codes bundled

The latest PTP update bundles 21 more Category I ablation codes into carrier-priced irreversible electroporation code **0601T** (Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open). The bundled procedures will be familiar to practices that perform **0600T** (… ; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous) and include cryosurgical ablation of fibroadenomas (**19105**) radiofrequency ablation (RFA) and cryoablation of bone tumors (**20982**, **20983**) and surgical ablation, RFA and cryosurgical ablation of renal cysts (**50541**), masses (**50542**) and tumors (**50592**-**50593**).

Coders may break these edits with a modifier when appropriate. Remind coders that they must code any services that meet the definition to 0601T, even when that has a negative impact on revenue.

Jawbone excision codes **21025**, **21044** and **21045** will be bundled into **41155** (Glossectomy; composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection [Commando type]), but the modifier indicator of 1 will allow the code pairs to be reported on the same date of service with the correct procedural modifier. However, **21198** (Osteotomy, mandible, segmental) is bundled into 41155 and cannot be unbundled.

COVID administration codes

The CCI update includes a small set of new, unbreakable edits for the COVID-19 vaccine and administration codes that went into effect May 4, including administration codes **0041A** (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; first dose); **0042A** (… ; second dose); and **91304** (Severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2[[coronavirus disease (COVID-19)] vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage, for intramuscular use).

The administration codes are bundled into vaccination codes **91300**-**91303**. Vaccine code 91304 will incorporate administration and vaccine codes **0001A**, **0002A**, **0011A**, **0012A**, **0021A**, **0022A**, **0031A**, 91300, 91301, 91302 and 91303.

(*continued on p. 6*)

Benchmark of the week

Use 2020 telehealth report as a baseline for internal review

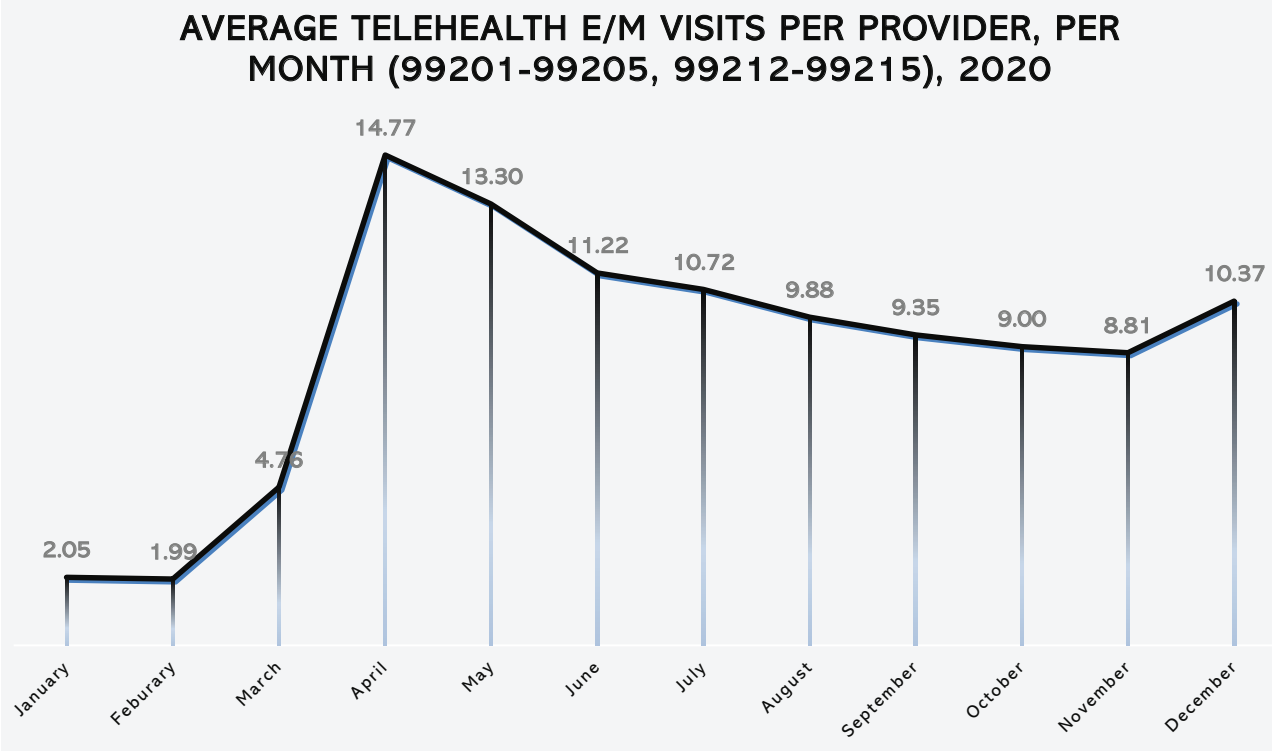
The number of office E/M visits performed via telehealth spiked in April 2020, a sign that medical practices around the country took advantage of the relaxed rules for telehealth services that went into effect March 1, 2020.

The latest Comparative Billing Report (CBR) analyzed claims for codes **99201-99205** and **99212-99215** that were reported from Jan. 1, 2020, to Dec. 31, 2020, with place of service code 11 (Office) and modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system), according to the webinar handout for CBR202108 – Impact of the public health emergency (PHE) on telehealth.

RELI Group, the contractor that produces CBRs, started with national Medicare Part B data for the year, drilled down to the top 25 specialties with providers whose claims met the CBR's criteria and sent reports to providers who were in the top 5% by claims volume, according to Annie Barnaby, CPC, CRC, CASCC, outreach and education specialist for RELI Group, during the Sept. 8 webinar, The CBR does not include telehealth visits reported with place of service code 02 (Telehealth), telehealth visits in other settings or telephone-only visits, Barnaby said in response to questions submitted during the webinar.

The chart below shows the national average for billing physicians and qualified health care professionals (QHP) on a month-by-month basis. Claims slid downward each month after the April high of 14.77 average visits, but never approached pre-PHE levels before another uptick to 10.37 average visits in December.

There's no way to get a CBR for providers who did not meet all of the criteria, Barnaby said. However, you can use the montly averages as a baseline when you conduct an internal review of telehealth claims during the ongoing PHE. Don't worry if your provider's claims are below or above average. Your claims are safe if providers and coders are following the rules for the services. Each provider's utilization will be based on a variety of factors, including their specialty, the patients they treat and their patients' ability to take part in a telehealth visit. You may find that providers are reporting more of the targeted codes by telehealth because the ability to see a provider without a trip to the practice means more patients are making, and keeping, appointments. – *Julia Kyles, CPC* (jkyles@decisionhealth.com)



Source: CBR202108 National and Specialty Statistics By Month (January 2020 - December 2020), https://cbr.cbrpepper.org/About-CBR/CBR-202108

(*continued from p. 4*)

Watch E/M updates

A Column 1 and Column 2 switch will reverse edits that bundle chronic care management (CCM) codes into end-stage renal disease (ESRD) codes.

Under the current PTP edits, if a practitioner provides an ESRD service (**90951-90961**) in conjunction with CCM performed by supervised clinical staff (**99490**), a physician or other qualified health care professional (QHP) (**99491**) or complex CCM (**99487**, **99489**), only the ESRD service will be paid. Under the new edits, effective Oct. 1, only the CCM code will be paid. The earlier edits will be deleted. However, one thing will stay the same: The edits cannot be broken with a modifier.

You also will find PTP edits for the new add-on code **99439**, which is reported with 99490. This bit of housekeeping makes it clear that edits that apply to the primary code also apply to the add-on code.

The final PTP update of 2021 also bundles E/M codes performed in other settings into complex CCM codes 99847 and 99489; however, those edits may be broken with a modifier when appropriate. Finally, a new edit will bundle prolonged office E/M service code **99415** into **99211**. Reporting the services together is considered improper coding. The prolonged service code can only be reported with time-based codes **99205** and **99215**. Practices that discover they were paid for the 99211-99415 code combination should take steps to return the revenue for the prolonged service code.

Medically unlikely edits

Remember to check the new and revised MUE updates for the final quarter of 2021. For example, the latest COVID-19 vaccine and administration codes (91304, 0041A and 0042A) will have MUEs of one, which means you can report the codes no more than once per patient per day. The codes have an MUE adjudication indicator (MAI) of 2, which means denials based on the edits can't be appealed.

Also taking an MUE cap of one unit are new codes for remote assessments (**G2250**) and virtual visits (**G2251**) performed by QHPs who can't bill E/M visits; 11-20 minute virtual visits by practitioners who can report E/M visits (**G2252**); collaborative psychiatric care management (**G2214**); and supply of take-home nasal naloxone (**G2215**) . Codes G2214 and G2250-G2252 will have an MAI of 2. The latest list of MUEs did not include MAI information for G2215.

Revised MUEs include the reduction of MUEs for reconstruction of the mandible or maxilla (**21246**) and repair of knee ligament or capsule codes (**27405-27407**). The MUEs will drop from two to one for each code. The MUEs will exchange the more liberal MAI of 3, which does allow appeals of denials based on the edit, for an MAI of 2.

CCI version 27.3 scorecard

Changes effective Oct. 1, 2021.
(*For more on CCI version 27.3 edits, see related story, p. 4.*)

Code range	CCI code pairs added	CCI code pairs deleted	MUEs added	MUEs deleted	MUEs revised
00000 – 09999	0	0	0	0	0
10000 – 19999	0	0	0	0	0
20000 – 29999	1	0	0	0	3
30000 – 39999	4	0	0	0	0
40000 – 49999	4	0	0	0	0
50000 – 59999	0	0	0	0	0
60000 – 69999	0	1	0	0	0
70000 – 79999	0	0	0	0	0
80000 – 89999	2	0	0	0	0
90000 – 99999	344	92	1	0	4
0001T – 0999T	28	0	0	0	0
A0000 – V9999	36	4	46	0	2
Totals	**419**	**97**	**47**	**0**	**9**

Note: Code range is based on the comprehensive code of the edit.
Source: Part B News *analysis of CCI version 27.3 changes,* www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes

Add-on codes for percutaneous transcatheter (**92929**) and percutaneous transluminal (**92934**, **92938** and **92944**) will receive two MUEs in place of six MUEs for codes 92929, 92934 and 92938 and three MUEs for 92944. However, all codes will receive an MAI of 3. Under the current MUE set, 92929 and 92934 have an MAI of 2.
— Julia Kyles, CPC (jkyles@decisionhealth.com)

RESOURCES

- Quarterly procedure-to-procedure edit update, practitioners, 27.3 (zip file): www.cms.gov/files/zip/quarterly-additions-deletions-and-modifier-indicator-changes-ncci-ptp-edits-physicians-practitioners.zip-5
- Quarterly medically unlikely edit update, practitioners, October 2021 (zip file): www.cms.gov/files/zip/practitioner-services-mue-table-effective-10-01-2021-posted-september-3-2021.zip
- Practitioner services MUE table, October 2021 (zip file): www.cms.gov/files/zip/practitioner-services-mue-table-effective-10-01-2021-posted-september-3-2021.zip

Coding

Is it an independent interpretation or review of test results? Here's how to tell

As practices adjust to the 2021 E/M office visit guidelines, one area of debate has continued to circulate around when it is appropriate to count an "independent interpretation" versus a review of "the result(s) of each unique test," as the guidelines define them.

The distinction is important; an independent interpretation counts as its own category in the data column of the medical decision-making (MDM) table.

"This element alone already puts the patient into a Level 4 code and only needs a prescription drug be ordered, for example, or a presenting problem that is moderate for the code to be assigned," observes Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O, director of HIM coding at HCPro.

When the doc ordered the test

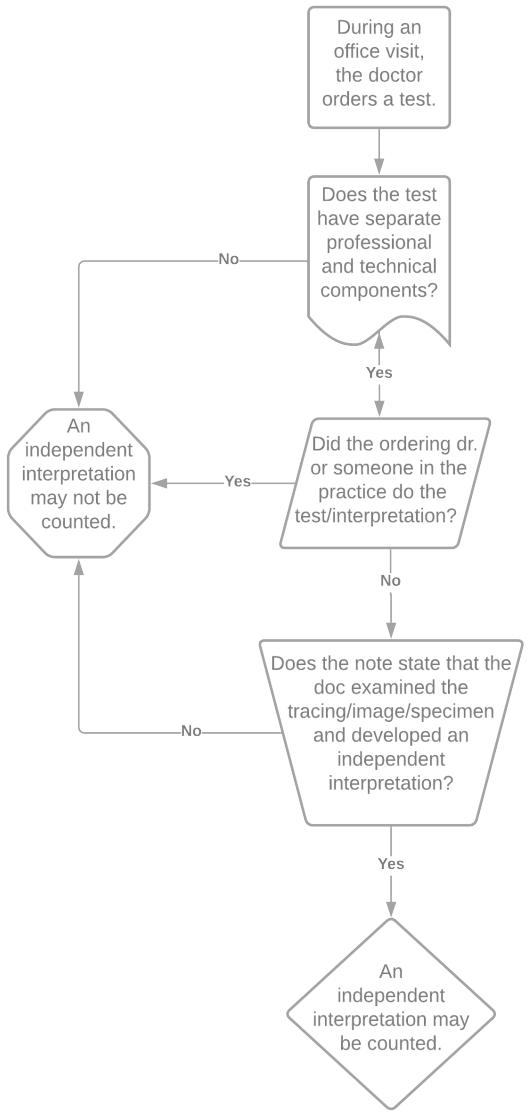
One key question on many coders' minds: Can a clinician count an independent interpretation when she ordered the test?

Answer: Yes, according to Peter Hollmann, M.D., and Barbara Levy, M.D., the AMA officials who headed the work group that wrote the guidelines.

During the November 2020 virtual AMA CPT Symposium, Hollmann and Levy described a scenario where a physician ordered a chest X-ray (CXR), which was performed and interpreted by a separate radiology clinic. The ordering physician then did his own interpretation of the results and developed the patient's plan of care based on that interpretation.

"Ordering the CXR and reading it are two distinct activities," they stated. "There was decision-making in deciding to order, i.e., that it might determine the course of treatment, including the decision to hospitalize. The independent interpretation was performed, which affected the decision to send [the] patient home with treatments for COPD exacerbation … Ordering and reviewing are mutually exclusive for data in MDM," the doctors concluded.

Decision tree: Know when to count an independent interpretation



But how does that square with new language added in the March 9 technical update to the guidelines? For example, it states: "Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter."

Must have separate tech, pro reports

The March 9 update applies to tests ordered with automated results such as blood tests, where the provider receives the results in a report format, explains Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, CPC emeritus, president of Enos Medical Coding.

"But independent interpretation is something else," Enos says. Many diagnostic procedures, such as imaging services, have both a technical and professional component. "The independent interpretation can be applied only to tests that require a professional component with a report" written by a different clinician, such as a radiologist.

When the ordering provider goes beyond simply reviewing the interpretation report to view and make a separate interpretation of the image, tracing or specimen, that would be considered an independent interpretation, Enos explains.

Here's how the guidelines define an independent interpretation: "The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician is reporting the service or has previously reported the service for the patient."

For example, you couldn't count an independent interpretation for X-rays you take in the office, Enos says. "Think of outside tests, such as X-rays taken at the hospital."

Doc should note own impression

Documentation "need not conform to the usual standards of a complete report for the test" to count as an independent interpretation, the E/M guidelines state.

Still, it should be more than simply cutting and pasting the radiologist's findings, McCall states. "The documentation has to at least support that they actually viewed the image themselves and did not just read the report from radiology," she says. "Otherwise, I don't see that it is any different than a lab test result."

Enos agrees: The office note should include "the impression of the independent physician viewing the image/tracing/specimen, she says. For example, the doctor might state, "to my view the X-ray did not show worsening of the pneumonia." — *Laura Evans, CPC* (levans@decisionhealth.com)

RESOURCE

- 2021 E/M office visit guidelines: www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Ask Part B News

Make sure practitioners get credit for requesting a virtual consult

***Question**: We are a busy family practice group and the physicians and nurse practitioners often contact specialists in our health system for treatment advice for some of our more complex patients. We know this is good patient care, but gathering records and talking to the specialists often takes a lot of time. When the practitioner sends a request on the same day as an office visit, we code the visit based on time and include that work. The problem comes when the request goes out on a different day. Is there a way to get credit for those requests?*

Answer: Yes. If the request and communication take place by phone, email or through the electronic health records (EHR) system, report **99452** (Interprofessional telephone/Internet/electronic health record referral service[s] provided by a treating/requesting physician or other qualified health care professional, 30 minutes).

The CPT manual's half-time rule applies to this code, which means you can report it when your treating practitioners spend at least 16 minutes "preparing for the referral and/or communicating with the consultant," the manual states.

You can break this service out of office visits when they're performed on the same day; just make sure you don't use it to select the code for the E/M visit and report it as a separate service. And keep an eye on the calendar when you bill this code. It should only be reported once in a 14-day period.

Prolonged service codes allowed

When you train your practitioners to report these codes, remind them to keep careful tabs on the time so they can report the consult code and prolonged service codes when the "time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed." You can report face-to-face codes (**99354-99357**) or non-face-to-face codes (**99358-99359**) depending on the circumstances of the consult. — *Julia Kyles, CPC* (jkyles@decisionhealth.com)