



## **Coding During the COVID-19 Public Health Emergency (PHE)**

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## ICD-10-CM Coding Guidance

The introduction of 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) in the United States has produced an influx of patients into the health care system. While knowing how to diagnose and treat these patients is vital, being able to appropriately capture this information for data tracking and payment also is important. The National Center for Healthcare Statistics has developed a resource for International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding that already is in effect.

COVID-19 attacks the respiratory system; therefore, suspicion of the disease typically will accompany respiratory conditions. A confirmation of COVID-19 will therefore be linked to a specific respiratory condition.

**Administration of COVID-19 vaccine:** Report **Z23, encounter for immunization**. This is a generic immunization code; there is no specific COVID-19 counterpart. The ICD-10-CM code indicates that a vaccination was given; the CPT code(s) will indicate which vaccine it was.

### ICD-10-CM Guidance for use *on or after April 1, 2022*

New subcategory: Z28.31 Underimmunization for COVID-19 status

NOTE: These codes should *not* be used for individuals who are not eligible for the COVID-19 vaccines, as determined by the health care provider.

New code: Z28.310 Unvaccinated for COVID-19

New code: Z28.311 Partially vaccinated for COVID-19

New code: Z28.39 Other underimmunization status

Delinquent immunization status

Lapsed immunization schedule status

### ICD-10-CM Guidance for use *on or after October 1, 2021*

- **Post COVID-19 condition:** Report code **U09.9** to establish a link with a previous COVID-19 infection and a post-COVID-19 condition. This code is not to be used in cases that are still presenting with active COVID-19. However, an exception is made in cases of re-infection with COVID-19, occurring with a condition related to prior COVID-19 infection. Report **U09.9** first followed by the specific condition such as:
  - chronic respiratory failure (J96.1-)
  - loss of smell (R43.8)
  - loss of taste (R43.8)
  - multisystem inflammatory syndrome (M35.81)

\*No other guidelines have changed from January 1, 2021\*

### ICD-10-CM Guidance for use *on or after January 1, 2021*

A few new codes were added for COVID conditions. These new codes will supersede previous guidance when noted. If the condition is not listed here, refer to the guidance below, as that guidance has not changed.

- **“Suspected” COVID-19:** If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code **U07.1**. Assign a code(s) explaining the reason for encounter (such as fever) and/or **Z20.822**, Contact with and (suspected) exposure to COVID-19
- **Pneumonia/+COVID-19:** For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes **U07.1** and **J12.82**, Pneumonia due to coronavirus disease 2019
- **Multisystem Inflammatory Syndrome in Children (MIS-C): Report M35.81 for** Multisystem inflammatory syndrome (MIS) or MISC. See below for update Q & As.
- **Exposure to COVID-19:** For cases where there is a concern about a *possible exposure* to COVID-19, but this is ruled out after evaluation, assign code **Z03.818**, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code **Z20.822, Contact with and (suspected) exposure to COVID-19**.
- **Personal history of COVID-19:** When a patient has a history of COVID-19 report **Z86.16**.
- **Screening for COVID-19:** During the COVID-19 pandemic, a screening code is generally not appropriate. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19. See guideline for

*Exposure* in this document. For asymptomatic individuals who test positive for COVID-19, assign code **U07.1**. A new code was added for “screening.” However, as stated it will not be appropriate until the public health emergency is over. When that happens, report **Z11.52, Encounter for screening for COVID-19**.

#### ICD-10-CM Guidance for use *on or after April 1, 2020*

##### **U07.1** COVID-19

Use this code as primary and also report manifestations such as pneumonia or bronchitis.

Note that you may not report codes B34.2, B97.2- or J12.81 in addition to the **U07.1**.

The WHO also released another code that has not been approved for use in the US at this time (U07.2); therefore, do not report code U07.2 until directed by the National Center for Healthcare Statistics.

- **Positive COVID-19:** Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. For a confirmed diagnosis, assign code **U07.1**, COVID-19. “Confirmation” does not require documentation of the type of test performed; the provider’s documentation that the individual has COVID-19 is sufficient.
  - **“Suspected” COVID-19:** If the provider documents “suspected,” “possible,” “probable,” or “inconclusive” COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) and/or **Z20.828**, Contact with and (suspected) exposure to other viral communicable diseases. (Updated January 1, 2021)
  - **Pneumonia/+COVID-19:** For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes **U07.1** and **J12.89**, Other viral pneumonia. (Updated January 1, 2021)
  - **Acute bronchitis/+ COVID-19:** For a patient with acute bronchitis confirmed as due to COVID-19, assign codes **U07.1** and **J20.8**, Acute bronchitis due to other specified organisms. If the bronchitis is not specified as acute, due to COVID-19, report code **U07.1** and **J40**, **Bronchitis, not specified as acute or chronic**.
  - **Lower respiratory infection/+COVID-19:** If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, report with codes **U07.1** and **J22**, Unspecified acute lower respiratory infection. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be appropriate to assign codes **U07.1** and **J98.8**, Other specified respiratory disorders.
  - **Acute respiratory distress syndrome (ARDS)/+COVID-19:** ARDS may develop in conjunction with COVID-19. Cases with ARDS due to COVID-19 should be assigned the codes **U07.1** and **J80**, Acute respiratory distress syndrome.
  - **Exposure to COVID-19:** For cases where there is a concern about possible exposure to COVID-19, but this is ruled out after evaluation, assign code **Z03.818**, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code **Z20.828**, Contact with and (suspected) exposure to other viral communicable diseases. (Updated January 1, 2021)
  - **Fetal Exposure to COVID-19:** For cases where a newborn is known to be born to a mother who is COVID + but the status of the baby is unknown, report code **P00.2**, Newborn affected by maternal infectious and parasitic diseases. If during the hospital stay, the baby is tested and COVID infection is ruled-out, report **Z05.1**, Observation, and evaluation of newborn for suspected infectious condition ruled out instead. If, however, the baby is positive for COVID, you will report **P00.2** and **U07.1** to indicate the infection in the newborn.
  - **Signs and symptoms:** For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
    - **R05** Cough
    - **R06.02** Shortness of breath
    - **R50.9** Fever, unspecified
- If a patient with signs/symptoms associated with COVID-19 *also has an actual or suspected contact* with or exposure to someone who has COVID-19, assign **Z20.828**.
- **Screening for COVID:** During the COVID-19 pandemic, a screening code is generally not appropriate. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19. See guideline for *Exposure* in this document. For asymptomatic individuals who test positive for COVID-19, assign code **U07.1**. (Updated January 1, 2021)
  - **Multisystem Inflammatory Syndrome in Children (MIS-C):** Official guidance was just released. Please see the scenarios below for coding guidance. (Updated January 1, 2021)

Question: What is the ICD-10-CM diagnosis code(s) for a child admitted due to documented multisystem inflammatory syndrome in children (MIS-C) due to COVID-19?

Answer: For MIS-C due to COVID-19:

**U07.1**, COVID-19, (principal diagnosis)

**M35.8**, Other specified systemic involvement of connective tissue, (secondary diagnosis)

**After January 1, 2021, report M35.81 instead of M35.8.**

The MIS-C is a manifestation of the COVID-19 infection. Per the instructional note under code **U07.1**, COVID-19, should be sequenced as the principal diagnosis and additional codes should be assigned for the manifestations. However, if the documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection vs. a residual effect from a previous COVID-19 infection, ask the provider for clarification. (Updated January 1, 2021)

Question: A child diagnosed with COVID-19 several weeks ago is now admitted with multisystem inflammatory syndrome in children (MIS-C) due to COVID-19. The patient no longer has COVID-19. How should this be coded?

Answer:

**M35.8**, Other specified systemic involvement of connective tissue, (principal diagnosis) for the MIS-C

**After January 1, 2021 report M35.81 instead of M35.8**

**B94.8**, Sequelae of other specified infectious and parasitic diseases, (secondary diagnosis) for the sequelae of a COVID 19 infection (Updated January 1, 2021)

## CPT Laboratory Testing Services

There is no unique CPT code for evaluating and managing COVID-19; however, be sure to document additional time spent with the family or time spent coordinating care that is not provided in person with the patient and/or family.

There is no unique CPT code for specimen collection for COVID-19, much like there is no such code for specimen collection for influenza. However, effective March 1, 2020, Medicare allows reporting of code 99211 (appended with modifier CS to waive cost-sharing) when clinical staff collects COVID-19 specimens for new or established patients. Please check with your payers to determine if they may allow this, as well.

If the specimen is prepared by your office and sent to an outside lab, report the specimen collection code **99000**.

The CPT Editorial Panel has developed several CPT codes for COVID-19 infectious agent detection, antibody, and antigen testing.

The following infectious agent **detection testing** code is effective March 13, 2020:

**87635** *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique*

The following **infectious agent detection testing** codes are effective October 6, 2020:

**87636** *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique*

**87637** *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique*

(For nucleic acid detection of multiple respiratory infectious agents, including severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] in conjunction with additional target[s] beyond influenza virus types A and B and respiratory syncytial virus, see 87631, 87632, 87633)

The following **antigen testing** code is effective June 26, 2020:

**87426** Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])

**87428** severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B

**87811** Infectious agent antigen detection by immunoassay with **direct optical (ie, visual) observation**; severe acute respiratory syndrome coronavirus (eg, [SARS-CoV] SARS-CoV-2)

The following **Proprietary Laboratory Analyses (PLA)** codes are effective October 6, 2020:

**0240U** Infectious disease (viral respiratory tract infection), pathogen-specific RNA, **3 targets** (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected

Xpert® Xpress SARS-CoV-2/ Flu/RSV (SARS-CoV-2 & Flu targets only), Cepheid

**0241U** Infectious disease (viral respiratory tract infection), pathogen-specific RNA, **4 targets** (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected

Xpert® Xpress SARS-CoV-2/ Flu/RSV (all targets), Cepheid

**Note:** These PLA codes were established to report proprietary POC testing for simultaneous qualitative detection and differentiation of SARS-CoV-2, influenza A, influenza B, and RSV viral RNA that are performed in the office by a physician or other qualified health care professional (QHP). It is important to note that the tests represented by these two PLA codes employ the same cartridge and the assay is performed with or without RSV, and the code selection is differentiated by the number of targets tested.

### Common COVID-19 Test CPT Codes

Test name	Test method	Only COVID-19 or multiple antigens?	CPT
<a href="#">Abbott ID Now COVID-19</a>	molecular	COVID-19	87635
<a href="#">Abbott BinaxNOW Rapid</a>	Rapid	COVID-19	87811
<a href="#">Quidel Sofia 2 SARS Antigen</a>	antigen	COVID-19	87426
<a href="#">Quidel Sofia Flu &amp; SARS</a>	antigen	COVID-19 + Flu A + Flu B	87428
<a href="#">BD Veritor SARS-COV2 Rapid Detect</a>	antigen	COVID-19	87426
<a href="#">Cepheid Xpress SARS-COV-2/FLU/RSV</a>	PCR	COVID-19 + Flu A + Flu B + RSV	0241U
<a href="#">CareStart COVID-19 Antigen Test</a>	antigen	COVID-19	87426
<a href="#">Roche cobas SARS-COV FLU A/B Assay</a>	PCR	COVID-19 + Flu A + Flu B	87636
<a href="#">QuickVue SARS Rapid Antigen Test</a>	Rapid	COVID-19	87811

\*Tests listed for coding examples only, the AAP does not endorse any product.

**CLIA-Waived Status:** The Food & Drug Administration (FDA) has authorized Emergency Use Authorization (EUA) for SARS-CoV-2 point of care test systems. Therefore, these tests are deemed to be Clinical Laboratory Improvement Amendments (CLIA)-waived tests. Accordingly, for the duration of the PHE, such tests can be performed in a patient care setting that is qualified to have the test performed there as a result of operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation.

The Centers for Medicare & Medicaid Services (CMS) developed two lab testing codes:

- **U0001** will be reported for coronavirus testing using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel
- **U0002** will be reported for validated non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

If your office is not running the test for COVID-19 or incurring the expense, you will not report U0001 or U0002.

The following **antibody testing** codes are effective April 10, 2020:

**86328** Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

(For severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] antibody testing using multiple step method, use **86769**)

**86769** Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

The following **antibody testing** code is effective September 8, 2020:

**86413** Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative

**NOTE:** Codes **86328** and **86769** are both reported as qualitative or semiquantitative assays, while code **86413** is reported as a quantitative assay

## **Vaccines and Immunization Administration CPT Codes for COVID-19**

The CPT Editorial Panel has developed several new SARS-CoV-2 vaccine product and immunization administration codes. This will be an ongoing process as new vaccines are approved and released on the market. The new CPT codes clinically distinguish each coronavirus vaccine product for better tracking, reporting, and analysis that supports data-driven planning and allocation. Importantly, these CPT codes are available before the public availability of the vaccines to facilitate updating of health care electronic systems across the US. The new immunization administration codes are both distinct to each coronavirus vaccine and the specific dose in the required schedule. This level of specificity is a first for vaccine CPT codes, but offers the ability to track each vaccine dose, even when the vaccine product is not reported (eg, when the vaccine may be given to the patient for free). These CPT codes report the actual work of administering the vaccine, in addition to all necessary counseling provided to patients or caregivers and updating the electronic record. Note you will not report the immunization administration codes in the current CPT codebook (90460-90461, 90471-90474) when administering a COVID vaccine.

**Note:** All new vaccine-specific CPT codes will be available for use and effective upon each new coronavirus vaccine receiving Emergency Use Authorization or approval from the Food and Drug Administration.

### **[AAP COVID-19 Vaccine Coding Chart](#)**

The AAP (via COCN) has led the development of RUC recommendations for thirty-seven (37) new COVID-19 Immunization Administration CPT codes and successfully advocated for their appropriate valuation (\$40 per dose) by the Centers for Medicare and Medicaid Services (CMS).

CMS, however, is not adding RVUs for the COVID-19 IA codes to the [RVU files](#).

HCPCS	MOD	DESCRIPTION	STATUS	PAYMENT	RVU	PE RVU	NON-FAC	NA	FACILITY	NA	MP	NON-FACILITY	FACILITY	PCTC	GLOB	PRE
5089	V5336	Repair communication device	N		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5090	V5362	Speech screening	N		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5091	V5363	Language screening	N		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5092	V5364	Dysphagia screening	N		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5093	0001A	Adm sarscov2 30mcg/0.3ml 1st	X		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5094	0001F	Heart failure composite	I		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5095	0002A	Adm sarscov2 30mcg/0.3ml 2nd	X		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5096	0003A	Adm sarscov2 30mcg/0.3ml 3rd	X		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5097	0005F	Osteoarthritis composite	I		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00
5098	00100	Anaesth salivary gland	I		0.00	0.00			0.00		0.00	0.00	0.00	9	XXX	0.00

Additionally, the COVID-19 IA codes will remain status “X” (ie, X = Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of “physician services” for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule.)

This is due to the fact that [payment for the COVID-19 IA codes](#) was determined by CMS ‘backing into’ the payment amount it wanted to pay (ie, \$40 per dose) rather than the RUC-recommended values (eg, RUC recommended 0.20 wRVUs for the COVID-19 IA codes).

The \$40 figure is based on the fact that CMS thinks 90460 (the base code for all COVID-19 IA codes) is worth ~\$30 and the PPE required for COVID-19 IA (99072) is worth ~\$10.

Our extrapolation leads to \$40 per dose by using the following RVUs:

- 0.40 wRVUs
- 0.73 PE RVUs
- 0.02 PLI RVUs
- 1.15 Total RVUs

This is an approximation using the 2022 Medicare CF (\$34.6062). The Medicare Geographic Practice Cost Indices (GPCIs) (along with the aforementioned RVUs) can be found by scrolling down to the very last document under “Additional Resources” on [this page](#).

### Immunizing Patients with No Health Insurance or Cost Sharing

If a patient does not have health insurance coverage or they have cost-sharing related to the COVID-19 vaccine administration, visit the [COVID-19 vaccine payment resource](#) for more information. However, it is important to remember that there cannot be any out-of-pocket expense at this time for patients.

### Immunizing Medicare Patients

If you are asked to immunize a Medicare Beneficiary, and you are not currently a Medicare provider, please follow the necessary steps outlined by Medicare. You must become a Medicare provider through your local [Medicare Administrative Contractor](#). Here is a helpful link: <https://www.cms.gov/covidvax-provider>

## COVID-19 Antibody Infusion Services

On November 9, 2020, the US Food and Drug Administration issued an emergency use authorization (EUA) for the investigational monoclonal antibody therapy, bamlanivimab, for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients (12 years of age and older) with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. Bamlanivimab may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the emergency medical system (EMS), as necessary. For more information on the use of this infusion, please see <http://pi.lilly.com/eua/bamlanivimab-eua-factsheet-hcp.pdf>.

Product	EUA Effective Date(s)	Specific Product Code	Administration Code
<a href="#"><u>Eli Lilly and Company's Antibody Bamlanivimab</u></a>	November 10, 2020 - April 16, 2021*	<b>Q0239</b> Injection, bamlanivimab-xxxx, 700 mg	<b>Mo239</b> Bamlanivimab-xxxx infusion
<a href="#"><u>Regeneron's Antibody casirivimab and imdevimab</u></a>	November 21, 2020 - TBD	<b>Q0240</b> Injection, Casirivi and imdevi 600 mg	<b>Mo240</b> Casirivi and imdevi repeat
<a href="#"><u>Regeneron's Antibody casirivimab and imdevimab</u></a>	November 21, 2020 - TBD	<b>Q0240</b> Injection, Casirivi and imdevi 600 mg	<b>Mo241</b> Casirivi and imdevi subsequent repeat doses
<a href="#"><u>Regeneron's Antibody casirivimab and imdevimab</u></a>	November 21, 2020 - TBD	<b>Q0243</b> Injection, casirivimab and imdevimab, 2400 mg <b>Q0244</b> Casirivi and imdevimab 1200 mg	<b>Mo243</b> IV or Subcu injection, casirivimab and imdevimab includes post admin monitoring



<a href="#"><u>Regeneron's Antibody casirivimab and imdevimab</u></a>	November 21, 2020 – TBD	<b>Q0243</b> Injection, casirivimab and imdevimab, 2400 mg <b>Q0244</b> Injection, casirivimab and imdevimab, 1200 mg	<b>Mo244</b> IV or subcu injection, casirivimab and imdevimab includes post admin monitoring in the home or residence
<a href="#"><u>Eli Lilly and Company's Antibody Bamlanivimab and Etesevimab</u></a>	February 9, 2021 - TBD	<b>Q0245</b> Injection, bamlanivimab and etesevimab, 2100 mg	<b>Mo245</b> IV infusion, bamlanivimab and etesevimab, includes infusion and post admin monitoring
<a href="#"><u>Eli Lilly and Company's Antibody Bamlanivimab and Etesevimab</u></a>	February 25, 2021	<b>Q0245</b> Injection, bamlanivimab and etesevimab, 2100 mg	<b>Mo246</b> Bamlan and etesev infusion home
<a href="#"><u>GlaxoSmithKline's Antibody Sotrovimab</u></a>	May 26, 2021 - TBD	<b>Q0247</b> Injection, sotrovimab, 500 mg	<b>Mo247</b> IV infusion, sotrovimab, includes post administration monitoring
<a href="#"><u>GlaxoSmithKline's Antibody Sotrovimab</u></a>	May 26, 2021 - TBD	<b>Q0247</b> Injection, sotrovimab, 500 mg	<b>Mo248</b> Sotrovimab infusion, home admin
<a href="#"><u>Genentech's Antibody Tocilizumab</u></a>	June 24, 2021 – TBD	<b>Q0249<sup>1</sup></b> Injection, Tocilizumab for COVID-19, 1 mg	<b>Mo249</b> IV infusion, Adm Tocilizu COVID-19 1st dose
<a href="#"><u>Genentech's Antibody Tocilizumab</u></a>	June 24, 2021 – TBD	<b>Q0249<sup>1</sup></b> Injection, Tocilizumab for COVID-19, 1 mg	<b>Mo250</b> IV infusion, tocilizumab, includes post admin monitoring, 2 <sup>nd</sup>

\* Note: On April 16, 2021, the FDA revoked the EUA for bamlanivimab when administered alone.

<sup>1</sup>Given the limited clinical situations allowed under the EUA, you should only bill for tocilizumab on a 12x type of bill (TOB).

For complete details, go to <https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion>

## Personal Protective Equipment

Effective September 8, 2020, there is a new CPT code to report additional supplies, materials, and clinical staff time required for patient symptom checks over the phone and upon arrival, donning and removing personal protective equipment (PPE), and increased sanitation measures to prevent the spread of communicable disease. This new code was established in response to the significant additional practice expenses related to activities required to safely provide medical services to patients in person during a public health emergency (PHE) **over and above those included in an office visit or other non-facility service.**

99072 *Additional supplies, materials, and preparation time required and provided by the physician or other qualified health care professional and/or clinical staff over and above those usually included in an office visit or other service(s), when performed during a nationally declared public health emergency due to respiratory transmitted infectious disease*

Code 99072 is part of the HIPAA procedural code set effective 9/8/20.

For those familiar with the CPT code set, the following outlines the differences between this new code and existing code 99070 (*Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)*):

	99072	99070
When is the code reported?	<ul style="list-style-type: none"> <li>•Only during a PHE</li> <li>•Only for additional items required to support a safe in-person provision of evaluation, treatment, or procedural</li> </ul>	<ul style="list-style-type: none"> <li>•For additional supplies provided over and above those usually included with a specific service, such as drugs, intravenous (IV) catheters, or trays –</li> </ul>

	service(s) •Can be reported with 99070	when a more specific supply code (eg, HCPCS Level II) is not available •Can be reported with 99072
Are there limits to the number of times this code can be reported?	Yes -- reported only once per in-person patient encounter per provider identification number, regardless of the number of services rendered at that encounter.	No
Are there Place of Service (POS) restrictions?	Yes – this code can only be reported when the service is rendered in a <b>non-facility</b> POS setting, and in an area where it is required to mitigate the transmission of the respiratory disease for which the PHE was declared.	No
Is clinical staff time included?	Yes – this code accounts for the additional time required by clinical staff to provide the service safely.	No
What does this code cover?	•Time over what is included in the primary service of clinical staff time to conduct a pre-visit phone call to screen the patient, provide instructions on social distancing during the visit, check patients for symptoms upon arrival, apply and remove PPE, and perform additional cleaning of the room, equipment, and supplies •Three surgical masks •Cleaning supplies, including additional quantities of hand sanitizer and disinfecting wipes, sprays, and cleansers	Additional supplies provided over and above those usually included with a specific service, such as drugs, intravenous (IV) catheters, or trays.
Is this an add-on code?	No -- it does <b>not</b> have to be reported with an Evaluation and Management (E/M) service. If it is reported with an E/M service, 99072 is a separately payable code and <b>not</b> bundled with the E/M code. It is appropriately reported with an in-person patient encounter for an office visit or other non-facility service (eg, immunization administration) during a PHE to prevent the spread of the disease.	No
Is the appropriate reporting of this code diagnosis-specific?	No -- appropriate reporting of code 99072 is not dependent on a specific patient diagnosis (eg, COVID-19).	No

While valuation recommendations were forwarded to CMS on 9/8/20, there are not yet values published on the Medicare Physician Fee Schedule. In the interim, the AAP is advocating with payers to:

- Pay at 100% of billed charges until CMS values the code
- Avoid cost shifting expenses to patient responsibility
- Automatically re-adjudicate unpaid or denied claims for payment retroactive to 9/8/20 once values are published

## Telemedicine & Telehealth

As concerns arise over the easy spread of COVID-19, there has been increasing use of telemedicine and telehealth.

Telemedicine is *very specific* and only applies to codes typically performed in-person but rendered via a real-time (synchronous) interactive audio and video telecommunications system. Telemedicine requires use of modifier 95 and is limited to codes listed in Appendix P of the CPT manual (eg, 99213-95). Telemedicine is only *one type* of telehealth.

Telehealth refers broadly to electronic and telecommunications technologies and services used to provide care and services at-a-distance. Therefore, it includes services such as Telephone Care and eVisits.

Please note that CMS and other payers may use the terms interchangeably.

Knowing your state laws and payer rules is important. (Please see 'Resources' section below for AAP Telemedicine Coding Fact Sheet and help in navigating your state laws on telehealth services). If a payer wants you to report a code outside of its intention, make sure to get it in WRITING!

## **Medicare COVID-19 Telehealth Expansion**

On March 17, 2020, the Trump Administration announced expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of health care services from their doctors without having to travel to a health care facility. Beginning on March 6, 2020, Medicare will temporarily pay clinicians to provide telehealth services for beneficiaries residing across the entire country (see resources). Prior to this announcement, Medicare was only allowed to pay clinicians for telehealth services such as routine visits in certain circumstances. For example, the beneficiary receiving the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. In addition, the beneficiary would generally not be allowed to receive telehealth services in their home. A range of health care providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to Medicare beneficiaries. Beneficiaries will be able to receive telehealth services in any health care facility including a physician's office, hospital, nursing home or rural health clinic, as well as from their homes. Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home. As part of this announcement, patients will now be able to access their doctors using a wider range of communication tools including telephones that have audio and video capabilities, making it easier for beneficiaries and doctors to connect. Clinicians can bill immediately for dates of service starting March 6, 2020. Telehealth services are paid under the Medicare Physician Fee Schedule at the same amount as in-person services. Medicare coinsurance and deductible still apply for these services.

Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits a) that are furnished between March 18, 2020 and the end of the PHE; b) that result in an order for or administration of a COVID-19 test; c) are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and d) are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other

providers and suppliers that bill Medicare for Part B services under these payment systems should use the **CS modifier** on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

### **Medicare COVID-19 Telehealth Expansion: UPDATE 4/11/20**

In March 2020, representatives of major health insurance companies met with President Trump, where they voluntarily committed to covering COVID-19 testing without cost sharing such as copays and coinsurance. Building on this commitment, this guidance implements the recently enacted Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act, which require that private health issuers and employer group health plans cover COVID-19 testing and certain related items and services furnished during the COVID-19 pandemic, with no out-of-pocket expenses.

Specifically, this announcement implements the requirement for group health plans and group and individual health insurance to cover both diagnostic testing and certain related items and services provided during a medical visit with no cost sharing. This includes urgent care visits, emergency room visits, and in-person or telehealth visits to the doctor's office that result in an order for or administration of a COVID-19 test.

Covered COVID-19 tests include all FDA-authorized COVID-19 diagnostic tests, COVID-19 diagnostic tests that developers request authorization for on an emergency basis, and COVID-19 diagnostic tests developed in and authorized by states. It also ensures that COVID-19 antibody testing will also be covered.

Medicaid already provides a great deal of flexibility to states that wish to use telehealth services in their programs. States can cover telehealth using various methods of communication such as telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for in-person services.

This guidance follows on President Trump's call for all insurance companies to expand and clarify their policies around telehealth.

### **OCR COVID-19 HIPAA Enforcement Discretion**

In light of the COVID-19 nationwide public health emergency, the HHS Office for Civil Rights (OCR) is exercising its enforcement discretion and, effective immediately, will not impose penalties on physicians using telehealth in the event of noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA).

Physicians may seek to communicate with patients and provide telehealth services through remote communications technologies. Some of these technologies, and their use, may not fully comply with the requirements of the HIPAA Rules (see resources).

However, this means that physicians who want to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing service that is available to communicate with patients. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

For example, a physician using their professional judgement may request to examine a patient exhibiting COVID-19 symptoms, using a video chat application connecting the physician's or patient's phone or desktop computer in order to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a physician may provide similar telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, dental consultation or psychological evaluation, or other conditions.

Under this Notice, physicians may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules. Physicians should not use Facebook Live, Twitch, TikTok or other public facing communication services. Physicians are encouraged, but not required, to notify patients of the potential security risks of using these services and to seek additional privacy protections by entering into HIPAA business associate agreements (BAA). HHS also noted that while it hasn't confirmed such statements, Skype for Business, Updox, VSee, Zoom for Healthcare, Doxy.me, and Google G Suite Hangouts have said that their products will help physicians comply with HIPAA and that they will enter into a HIPAA BAA.

**Medicare COVID-19 Telehealth Expansion: UPDATE 4/30/20**

For audio-only encounters (ie, telephone calls), CMS will still require the reporting of the Telephone Care codes (99441-99443) – but Medicare physicians will be paid commensurate with Office Visit telemedicine services. As such, the Telephone Care codes have been added to the CMS Telehealth List for the remainder of the PHE.

Telephone Care CPT Codes	2020 Medicare Allowable	Increase Allowable During Public Health Emergency	Office Visit CPT Codes (2020 Medicare Allowable)
99441 (5-10 min)	\$14	\$14 + \$32 = \$46	99212 (10 min; \$46)
99442 (11-20 min)	\$28	\$28 + \$48 = \$76	99213 (15 min; \$76)
99443 (21-30 min)	\$41	\$41 + \$69 = \$110	99214 (25 min; \$110)

**Other Non-Direct E/M Services Reportable During the PHE**

In the wake of the PHE, pediatric practices are looking for alternatives to risking unnecessary exposure via in-person visits. Some alternative services being offered are listed here with their codes. Be sure to look into these services more carefully. Refer to your CPT resources or see [AAP Coding for Care Management & Other Non-Direct Services](#).

**Digital Online Evaluation and Management**

For physicians and advanced practitioners (NP or PA):

**99421** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

**99422** 11-20 minutes

**99423** 21 or more minutes

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless allowed by your payer:

**98970** Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

**98971** 11-20 minutes

**98972** 21 or more minutes

**Telephone Care**

For physicians and advanced practitioners (NP or PA):

**99441** Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**99442** 11-20 minutes of medical discussion

**99443** 21-30 minutes of medical discussion

For care continuity, patient safety, and medical liability purposes, the AAP recommends at minimum the following documentation for a physician telephone care with patient/caregiver:

*Date and time of call, patient's name, date of birth, reason for call, relevant history and evaluation, vaccine status, assessment, plan,*

*disposition, symptoms/signs for patient/caregiver to call back or go to emergency department, total encounter time*

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless allowed by your payer:

**98966** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**98967** 11-20 minutes of medical discussion

**98968** 21-20 minutes of medical discussion

## Special Modifier

### CR Catastrophe/Disaster-Related

This modifier is currently being used for Medicare payment and tracking; therefore, consider reporting it with any service during this PHE. It should be reported as a secondary modifier to payment modifiers (eg, 25).

## Advocacy & Payment

During the COVID-19 PHE, payers are waiving member cost sharing for COVID-19 diagnostic testing and vaccination. The AAP is monitoring Medicaid and health plan carrier telemedicine/telehealth coverage changes.

For additional information please see:

- [State Notices on Telehealth Policy in Response to COVID-19](#)
- [Telehealth Payer Policy in Response to COVID-19](#)

Some payers have already updated their telemedicine/telehealth policies. Please check for updates on health plan carrier websites, including information on telemedicine/telehealth coverage policies and billing guidance.

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## Providing Preventive Medicine Services During the PHE

### Purpose

To create clear direction for reporting and paying for Preventive Medicine Service (PMS) visits via telemedicine during the COVID-19 PHE.

- 1) To recognize PMS visits an essential component of pediatric primary care
- 2) To establish a coding and payment mechanism to ensure services are provided timely and all components of a PMS visit are performed with a combination of a telemedicine and in-person visits

### Why?

During a PHE, there may be significant obstacles which prevent the medical home from providing safe care inside the medical home in many places in this country. PMS visits are the cornerstone of pediatric care and promoting health is key during and after the PHE.

When the PHE persists for more than a few weeks, delaying all PMS visits has the following implications:

- In the absence of telemedicine, PMS visits for infants spaced 2-3 months apart must be subsumed by future visits, diluting their efficacy
- Families may go months without education, reassurance, screening, anticipatory guidance from their pediatrician (downstream impacts of this unknowable)
- During this time of crisis, some of our most vulnerable patients may be in crisis or have increased need of services such as safe housing, adequate food, or community resources, which a PMS visit would identify. In addition, patients may be experiencing worsening of their chronic conditions or a new acute condition for which they felt they could not safely seek access to care.

- Not every patient has an identified problem or condition which qualifies as a payable eVisit, telephone call/virtual check-in, or telemedicine visit which would lend itself to the current guidelines for providing non-PMS via telemedicine during a PHE
- Traditionally, summers are already overburdened with PMS visits and there will likely not be enough scale to accommodate the increased demand as a result of the PHE, thereby putting the medical home at risk of fragmentation as families search for alternatives for back-to-school/sports clearance visits
- Without PMS visits, a practice's viability is threatened, resulting in patients losing access to care in the medical home during both the PHE and in the recovery phase

### Proposed Solution

During a PHE, all payers must recognize Preventive Medicine Services CPT codes (99381-99385, 99391-99395) as eligible for telemedicine and pay with parity to in-person visits with no cost-sharing to families in keeping with current PMS payment policies.

As all children should ideally receive all comprehensive components of the PMS visit, the American Academy of Pediatrics strongly recommends a second (in-person) visit, wherever and whenever feasible, to complete components that were not able to be accomplished during the telemedicine PMS visit. Payment for this second visit will be included (bundled) in the initial full PMS payment. While guidance for the reporting of CPT and ICD-10-CM codes is included below, we defer to individual payer policy with regard to Place of Service (POS) codes and telemedicine modifier application.

### Initial Encounter

#### Reporting Preventive Medicine Services via Telemedicine

ICD-10-CM Code(s)	CPT Code(s)
Z00.110	99381-99385 or 99391-99395
Z00.111	plus
Z00.121	screening(s)/assessment(s) performed
Z00.129	via telemedicine (eg, 96110, 96127, 96160, 96161)
Z00.00	
Z00.01	

Report the Place of Service (POS) Code (eg, 02, 11) and append the Telemedicine Modifier (eg, 95, GT) as required by the payer, which should be consistent with current policies required by the payer for Office or Other Outpatient Services (99201-99215) telemedicine visits.

### Second Encounter

#### Reporting an In-Person Visit to Complete Preventive Medicine Service Performed via Telemedicine

ICD-10-CM	CPT Code
Z00.110	99024
Z00.111	plus each screening/vaccine service(s)
Z00.121	performed on the same date of service (eg, 99177)
Z00.129	
Z00.00	
Z00.01	

Or an alternate:

Z00.8

Report the CR (*Catastrophe/Disaster-Related*) modifier for the second encounter.

CPT	CPT DESCRIPTION
99381	E/M PREVENT MED SERV NEW PT <1YR
99382	E/M PREVENT MED SERV NEW PT 1-4YRS

99383	E/M PREVENT MED SERV NEW PT 5-11 YRS
99384	E/M PREVENT MED SVC/NEW PATIENT 12-17YRS
99385	E/M PREVENT MED SVC/NEW PATIENT 18-39YRS
99391	E/M PREVENT MED SERV EST PT < 1 YR
99392	E/M PREVENT MED SERV EST PT 1- 4 YRS
99393	E/M PREVENT MED SERV EST PT 5-11 YRS
99394	E/M PREVENT MED SVC EST PATIENT 12-17YR
99395	E/M PREVENT MED SERV EST PATIENT 18-39YR
99024	POSTOP F/U VISIT E/M RELATED TO ORIGINAL PROC

ICD-10-CM	ICD-10-CM DESCRIPTION
Z00.110	Health examination for newborn under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.8	Encounter for other general examination
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings

The second encounter will fulfill the exam elements that the physician was unable to obtain during the PMS telemedicine visit. To aid the second encounter, the physician should note areas that need to be examined or issues on which to follow up during the initial PMS telemedicine visit. Ideally screenings, testing, and vaccines should be ordered during the initial PMS telemedicine visit but may have changed during the interval period. Care gaps should be identified and closed during the second encounter designed to provide the remainder of the services for a comprehensive PMS visit. The second encounter should not be repetitive, but close gaps not able to be performed via telemedicine.

To report the second encounter, the Academy recommends CPT code 99024, which does not have assigned RVUs but is typically used for tracking visits, albeit in post-operative periods. While the PMS codes do not have “post-operative periods,” the underlying premise applies. Code 99024 is subsumed in payment for the initial code and is for tracking of services that are inherently expected to be completed at a date after the original procedure. In addition, code 99024 is a recognized CPT code available in electronic systems designed for claims processing. We are recommending that our members charge \$0.01 for code 99024 to ensure the claims are not scrubbed by claims adjudication systems.

### **Standardized Screenings & Assessments via Telemedicine**

In addition to the telemedicine PMS visit, separate standardized screening/assessment instruments may be administered via telemedicine through a mechanism that is most appropriate to the practice’s communication methods, staffing model, and patient population.

Therefore, the following CPT codes may be reported via telemedicine:

**96110** Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

**96127** Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

**96160** Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument

**96161** Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the



benefit of the patient, with scoring and documentation, per standardized instrument

Other screenings/assessments may be administered via telemedicine based on the requirements of a particular patient.

Methods to complete standardized instruments will vary by practice. For example, some practices may email a standardized tool to the caregiver in advance of the PMS telemedicine visit and request the caregiver upload a photo of the screener to a patient portal, while other practices may have clinical staff administer the standardized tool with the caregiver at the start of the PMS telemedicine visit. The latter approach is preferred for a family to complete a standardized tool verbally with a medically qualified interpreter, when a family has Limited English Proficiency.

In addition, we are recommending the use of **CR** (*Catastrophe/Disaster-Related*) modifier for the 99024 follow up service. This will allow services to be identified as a follow-up from a previous service completed during the PHE and may explain any delays. For the initial telemedicine visit, use of the **CR** modifier should be consistent with payer guidance for all other non-preventive services performed via telemedicine.

The Academy recommends that an appointment for the second encounter is scheduled prior to completion of the initial PMS telemedicine visit. This will ensure that there is a continuity of care and these patients do return to the office for essential Preventive Medicine Services.

Services provided during the second encounter must be paid in parity to how they would have been paid if performed at the time of an in-person comprehensive PMS visit. Similarly, they should be provided according to the same rules for patient responsibility as if the services have been provided contemporaneously.

If a separately identifiable problem is identified at the second encounter that requires management or intervention, an Office Visit E/M service should be reported in the same way that would have been used to document sick + preventive services occurring on the same date of service. These services should also be paid according to the same policy rules as if all services had been provided on the same day.

When the age-appropriate telemedicine PMS visit takes place, the physician will need to complete all elements he/she is able to do and document what requires follow-up (eg, elements of the exam that could not be completed). Documentation should include age and gender appropriate history, developmental surveillance, anticipatory guidance and preventive counseling, and the ordering of labs and age appropriate screens (to be completed at a later date if need be).

While *nearly* all of the elements of a PMS visit can be completed through current telemedicine technology (at least during this unprecedented crisis), we recognize there are some limitations to a telemedicine PMS visit (such as the inability to directly measure growth and collect vital signs, the ability to complete a full exam). However, given the resourcefulness of pediatricians and families, especially those with a long-standing relationship with the patient and family, a well-rounded PMS visit is possible. Any vital signs obtained by the family will be noted as such. As mentioned above, the “exam” portion may not be as comprehensive as it would have been had it been conducted in-person; therefore, another encounter at a later date may be necessary. The second encounter should be provided in-person, and its completion is implied in the initial PMS payment at parity. The second encounter is expected to be completed as soon as can be reasonably completed in a safe environment to fulfill the remainder of the comprehensive PMS visit. This service will be in-person and required to be completed at a time when it is safe in order to fulfill the remainder of the comprehensive PMS visit.

### **Implications for Pediatricians**

Pediatricians should continue to see infants and young children and provide PMS visits in-person as long as it is safe to do so in their physical environment (safe for both families and patient care teams), while prioritizing infant visits that are associated with immunizations.

If practices can safely see older patients, they should continue to provide PMS visits in-person as long as they can provide a safe environment for families and patient care teams.

Whenever and wherever it is not possible to provide safe PMS visits in the office, telemedicine PMS visits should be performed on the same schedule as in-person care as outlined in [Bright Futures](#).

All telemedicine PMS visits should include language acknowledging that the service is being performed via telemedicine during the PHE, as well as the limitations of the virtual visit (which include inability to perform a complete exam, collect growth and vital sign measurements, provide any necessary screenings which require office equipment and administer vaccines.) And that every effort will be made to collect key supplementary information and provide appropriate follow-up care as soon as safely possible during the recovery from the PHE.

### **Other Important Considerations**

To align with AAP recommendations, practices are encouraged to review their payer policies regarding the following:

- For children aged 3 and older, removal of the required 365-day interval or any other arbitrary interval between annual PMS visits. Instead, payers should revise the requirement to one PMS visit per calendar year. This is critical because if pediatricians substantially increase PMS visits in the recovery period, yet payers continue to insist on an arbitrary interval, the recommended schedule of PMS visits will be askew, creating a perpetual problem for years to come that is not sustainable.
- Any pay for performance (P4P) or value-based payment incentives based on PMS visits or immunizations must be adjusted for 2020. If a practice improves its performance over 2019, it should be rewarded. However, if a practice is lower than 2019 performance due to the COVID-19 PHE, it should be paid at 2019 performance rates for an additional year as it recovers as these payments have become part of necessary cash flow and support for any quality transformation efforts.

### **Providing Post-COVID-19 Sports Clearance Exam**

Children who have tested positive for COVID-19 within the past 6 months should visit their pediatrician for a post-illness encounter prior to return to physical activity per the AAP [COVID-19 Interim Guidance: Return to Sports and Physical Activity](#). This examination is also required prior to return to participation in physical activities by many school districts.

Although the patient's request for post-COVID-19 examination may be for clearance to return to a physical activity, this encounter has a clinical indication to evaluate for any concerning pulmonary and/or cardiac signs and symptoms that could be due to postinfectious myocarditis. This is follow-up care and should be reported with the appropriate level of office or other outpatient E/M service. Diagnosis codes for this encounter may include Z09 (encounter for follow-up examination after completed treatment for conditions other than neoplasm), Z86.16 (personal history of COVID-19), and Z02.5.

Post-COVID-19 examination could also be provided as part of an annual preventive E/M service when the child has not had a preventive E/M as recommended by Bright Futures periodicity schedule. If a full preventive E/M service is provided and no significant work is necessary to address abnormal findings, the preventive E/M service would be reported in conjunction with codes Z00.129, Z09, and Z86.16. If during the preventive E/M service, an abnormal finding requires significant E/M, both the preventive E/M and a separate office E/M service with modifier 25 may be reported with a diagnosis code for the problem addressed linked to the separate office E/M service.

## FAQs

Q. Can we report **Preventive Medicine Services** (eg, 99393) via telemedicine (ie, real-time synchronous audio + video service)?

A. At this time, neither CPT nor CMS have made allowances to add Preventive Medicine Services codes to their telemedicine lists.

However, some payers are allowing Preventive Medicine Services to be provided via telemedicine; therefore, check with your specific payers.

Q. We “see” patients for telemedicine services after our usual office hours and on Saturdays. Is it appropriate to additionally report a **Special Service codes** 99050 (*Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service*) or 99051 (*Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service*) – *Special Services – can you add 99050/99051* with the telemedicine service?

A. CPT has not yet addressed this issue. While the Special Services code descriptors do state “in the office,” payers may start to allow their use during this unprecedented time. The AAP does not believe that given the current environment their use is entirely inappropriate. However, please check with your payers since it is not entirely consistent with the current CPT code descriptors.

Q. We are implementing **telemedicine**. The physician is using a HIPAA-compliant platform to communicate with our patients who are usually at home. The physician is sometimes at home when these services take place. Can you please clarify what the **place of service** (POS) code should be reported?

A. Before the COVID-19 public health emergency (PHE) declaration, all telemedicine services were reported with POS code **02**. And some payers are continuing to follow that guidance.

However, in the [CMS Interim Final Rule With Comment Period \(IFC\)](#), CMS has waived that requirement to allow physicians to report the POS code that would have been reported had the service been furnished in person (eg, POS 11 for office). This allows for Medicare payment at the same rate as would have been paid if the services were furnished in person. Service reported with POS 02 are paid assuming lower practice expense (PE), such as at the Facility rate. Facility rates are lower than Non-Facility rates due to the fact that there are fewer PE resources (ie, clinical staff time, medical supplies, medical equipment) expended by the physician in provision of the service.

Q. We see a patient via **telemedicine**. The patient comes to the **office** later that same day to be swabbed so that a strep test can be run. How do we handle coding for this, including the **POS**?

A. Please see answer above. Pre-PHE, the POS would have been 02 for the telemedicine service. And some payers are continuing to follow that guidance. However, CMS guidance is that during the COVID-19 PHE, the POS will be **11** (office) for the telemedicine service. The strep service will also be reported with POS 11 (office).

Q. We are using our digital online portal to communicate with patients. When the physician starts a communication with a patient about an issue (such as an ongoing chronic issue) and it meets the requirements for reporting a **digital online E/M service** (eg, 99442) what are the constraints? Meaning if we end up seeing the patient, can we report both the online and the office-based E/M services?

A. It depends. The digital online E/M service is a “7-day cumulative service.” Determine the day the digital online E/M service begins, which is the date of the initial communication from the patient. Let’s say the initial communication begins on March 10 and there is digital online communication through March 13, when the condition is “resolved.” If you end up seeing the patient in your office for a related condition after March 13, but on or before March 17 (ie, 7 days after the initial date of service of March 10), you cannot separately report the digital online E/M service. It would all be

“bundled” into the office visit code (even if provided via telemedicine).

If, however, the patient experiences a flare up on March 22 and you see her, you may report both the digital online E/M service (making sure dates of service line up with when the service took place) and the office visit (eg, 99213) – even if provided via telemedicine.

Q. We are now moving away from using nebulizers in the office to using **metered dose inhalers** to administer medication. What codes are reported for the administration, supplies and if we have to teach the patient how to use at home?

A. The administration code will not change from the nebulizer and neither will the teaching service.

#### Administration of the MDI

94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device

#### Teaching/Demonstration for Home Use

94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device

If reporting both the 94640 and 94664, append modifier 25 to the E/M service (eg, 99214) and modifier 59 to the 94664.

#### Medication

J3535 Drug administered through a metered dose inhaler

Report appropriate NDC code

Unit of measure is GR (Gram)

#### Spacer

A4627 Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler

S8100 Holding chamber or spacer for use with an Inhaler or nebulizer; without mask

S8101 Holding chamber or spacer for use with an inhaler or nebulizer; with mask

Q. What **documentation** is required for reporting a telemedicine service, such as a 99213?

A. The documentation requirements for the service reported via telemedicine will not change. You will still have to meet the requirements of a given code level.

For example, if you report a 99213, you will still be required to document at least 2 of the following 3:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

or

If you are documenting that you are coding based on time (>50% counseling or coordination of care), you must document both total time and total time spent in counseling and/or care coordination.

Please note that the AAP is aware that CMS is making allowances for using the 2021 Office Visit requirements. What that means is that if your payer is following CMS, you may report the Office Visit codes (99201-99215) based on time (regardless of how it is spent) or MDM only (do not use history or exam).

Q. If we have to bill a telemedicine service (using modifier 95) and another service that requires modifier 25 to be used in addition, which modifier should be listed first?

A. In general, the rule is to report the “payment” modifier before any other descriptive modifier. Since both modifier 25 and 95 can impact payment, list modifier 25 first.

Q. Can we report “**telemedicine**” using **audio only** – like a telephone call?

A. It can vary by payer. However, CPT and is making allowances during this COVID-19 outbreak to allow telemedicine services to no longer require the “video” portion if it is not available -- yet still report the service as a telemedicine service with modifier 95. Please refer to the [AMA COVID-19 Coding Guidance](#) for more details.

Additionally, while CMS requires that audio-only visits be reported with the Telephone Care codes (99441-99443), Medicare payment for those codes has been made equivalent to the Office Visit codes (99201-99215). In addition, the HHS Office for Civil Rights (OCR) is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients *in good faith* through everyday communications technologies, such as FaceTime or Skype, during the PHE.

As always, please check with your payers before implementing any new coding guidance -- and make sure to get any policy declarations in writing.

Q. CMS requires that audio-only encounters (ie, telephone calls) be reported with Telephone Care codes (99441-99443), even though Medicare physicians will be paid commensurate with Office Visit telemedicine services. What are the **documentation** requirements for providing such a service?

A. While CMS does not offer documentation guidance for these services, the AAP offers the following guidance for patient safety, care continuity, and medical liability purposes: document audio-only encounters thoroughly as one would document an encounter provided via a real-time (synchronous) interactive audio + video telecommunications system.

Q. Is it true that I can report a **telehealth transmission fee**?

A. At the present time, no, you cannot. Where the patient receives services is known as the originating (or hosting) site. The patient’s home is generally not an eligible originating site, but the 1135 waiver now allows this exception. Only the originating/hosting site is allowed to report Q3014 (ie, telehealth originating site facility fee). Where the physician is located is the distant site. Distant sites are not eligible to report Q3014 – even within the exceptions provided by the 1135 waiver.

However, physicians should see if their payers might allow payment for the incremental expense associated with developing and sustaining a telemedicine program. For example, a payer can allow a physician to additionally report HCPCS Level II code T1014 (*telehealth transmission, per minute, professional services bill separately*) or pay the physician a small telemedicine capitation fee.

Q. We have residents in our clinic. We still want our **trainees** to see patients; however, most of our services are conducted through telemedicine. How will that work for our **teaching physicians**? In addition, we are a primary care teaching site, what Office Visit codes can we report?

A. From the [CMS Interim Final Rule With Comment Period \(IFC\)](#): The requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology. Use of real-time, audio and video telecommunications technology allows for the teaching physician to interact with the trainee through virtual means, thereby allowing them to furnish assistance and direction without requiring the teaching physician’s physical presence for the key portion of the service.

Additionally, for the duration of the PHE, CMS is allowing all levels of Office Visit services (ie, levels 1-5) under the PCER.

Q. How do I report disposable **personal protective equipment (PPE)**?

A. Starting 9/8/20, you may report CPT code **99072**:

*99072 Additional supplies, materials, and preparation time required and provided by the physician or other qualified health care professional and/or clinical staff over and above those usually included in an office visit or other service(s), when performed during a nationally declared public health emergency due to respiratory transmitted infectious disease*

You are limited to reporting 99072 once per patient encounter, regardless of the number of services performed at that encounter. It is a practice expense only code; therefore, it is not reportable in the Facility setting. On 9/8/20, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) sent CMS its valuation recommendations for inclusion on the Medicare Physician Fee Schedule.

Q. Each of my staff members wear surgical masks for the entirety of their shifts. Can I report code **99072** for each patient encounter?

A. No. Medical supplies are by (CMS and RUC) definition – **disposable**. Therefore, if staff members each wear a single “disposable” mask during the course of entire day, code 99072 can only be appropriately reported/attributed to one patient encounter. By reporting one unit of 99072, you are (theoretically) receiving credit for three disposable surgical masks.

Q. When providing **PMS via telemedicine**, can clinical staff (eg, RN) perform the second encounter and the physician still report code 99024?

A. It is a clinical decision but from a coding perspective, yes -- as long as:

- There is nothing to indicate from the notes of the initial encounter that physician follow up is required and
- The clinical staff is following the physician’s orders

Q. Can codes from the **90460-90461** family be reported in the situation where the physician provides vaccine counseling during the initial telemedicine encounter, but the vaccine is not actually administered until the second in-person encounter?

A. No. CPT guidelines specifically state that codes 90460-90461 are reported when the physician or other qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. Instead, you should instead report codes 90471-90474 during the second in-person encounter (ie, when the vaccine is administered).

Q. Which **date of service** should I report for Telephone Care (99441-99443) and eVisits (99421-99423)?

A. The date of service will vary depending on the service that you provide. For Telephone Care, the date of service is the date you speak to the patient/parent. The clock will then “re-set” the next calendar day. Therefore, if you speak with the family again the next day (eg, dad calls to clarify something), you will report another Telephone Care service based on time spent. However, remember that no Telephone Care service is separately reportable 7 days prior to or within 24 hours/soonest available appointment from a related E/M service.

The date of service for the eVisit will be the initiation of the service. If the eVisit begins on 5/15 and there is communication through the 19<sup>th</sup> – your date of service will either be the range of dates (5/15-5/19) or the date the service began, which is 5/15.

This service is “cumulative” time over 7 days, which differs from the telephone care code, which is a per day service. However, like the telephone care, if you see the patient in the office or via telemedicine within the 7 days from the eVisit initiation, you will not separate report the eVisit code.

For example, the eVisit is initiated on 5/15. On 5/20 the patient must be seen in the office in relation to the same issue. All the cumulative time is not report under the eVisit code but subsumed under the E/M service (eg, 99214).

Q. Is there a **CPT code for a “screening” instrument** for patients to determine exposure to COVID-19?

A. We are not aware of any standardized, scorable screening instruments currently available for COVID-19. CPT requires screening tools to be standardized and scorable in order to report code 96160 (health risk assessment). If your public health department has developed a standardized/scorable health risk assessment for COVID-19, then you may report code 96160 -- otherwise it is subsumed by the reported E/M service.

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## Resources

- [CMS Medicare Coverage and Payment Related to COVID-19](#)
- [CMS MAC COVID-19 Test Pricing](#)
- [Medicare Telemedicine Health Care Provider Fact Sheet](#)
- [Notification of Enforcement Discretion for Telehealth](#)
- [AAP Telemedicine Coding Fact Sheet](#)
- [AMA Telehealth Quick Guide](#)
- [AMA CPT Reporting for COVID-19 Testing](#)
- [AMA CPT Assistant August 2020 Update: Laboratory COVID-19 Testing](#)
- [CCHP Telehealth State Laws](#)
- [AAP Care Management and Other Non-Direct Services Coding Fact Sheet](#)
- [AAP News Coverage of COVID-19](#)
- [AAP News Coding Corner Columns](#)