SARS-CoV-2 (COVID-19) CODING GUIDANCE

Temporary billing guidance due to the COVID-19 PHE (Public Health Emergency) has been changing rapidly as the response to identifying and treating patients with and without the illness has evolved. ***This document is therefore a living document and will be updated as changes are made to the laws and regulations guiding treatment, billing, and payment for services.***

TESTING

On May 24, 2020 the Department of Health and Human Services presented a COVID-19 Strategic Testing Plan to Congress which describes, among other things; detailed information on various testing methodologies; medical device and test availability; and, research and advice designed to inform the government as plans for re-opening the country are made and implemented. **Guidance to providers has remained fluid as more is learned about the virus and how best to test for active infection (COVID-19) and past infection.** The types of tests available, the settings in which they may be provided and/or processed, and the CMS coding, billing, and payment available for the various test-related scenarios is important for health centers to understand. **While CMS has provided definition and guidance in these areas, health centers need to check with their MACs and other payers in order to understand how best to bill and be reimbursed for the specific testing services that they provide.**

TEST TYPES RELATED TO SARS-COV-2

The FDA has been issuing Emergency Use Authorizations (EUA) to allow for the use of unapproved medical devices or unapproved medical products to be used for testing, treatment and prevention of the SARS-COV-2 infection during this COVID Public Health Emergency. There are currently several types of tests associated with the detection of the SARS-COV-2 virus and antibodies. Differences in tests include in how specimens are collected and processed as it relates to the sophistication of the approved laboratory instruments and testing kits. Health centers that hold a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation may perform tests that the FDA has authorized under a EUA.
CLIA guidance was issued by CMS outlining flexibilities offered to laboratories processing specimens during the COVID PHE that may be helpful for health centers to review to understand how they may impact patient testing. Testing may occur in laboratories, including those found in hospitals, and in provider offices.

Molecular Diagnostic Testing

A molecular test (i.e., PCR) tells if the patient currently has an infection. Direct collections samples include: Nasal, Throat, and/or Nasopharyngeal swabs. It cannot tell whether a resolved patient was previously infected by the virus. Molecular testing may be performed as a point of care (POC) test. A health center that holds a CLIA Waiver and EUA equipment (e.g., Abbott ID NOW) may perform molecular tests using EUA approved test kits.

Antigen Diagnostic Testing

Antigen tests look for part of the SARS-COV-2 viral protein. Like the molecular test, antigen tests are looking for a current infection and cannot tell if a resolved patient had been infected by the virus. Antigen tests are commonly used for point-of-care (POC) processing of specimens inside the health center. The advantage of antigen tests is the speed in which they produce results; however, they are considered less accurate than a PCR test. Companies are designing SARS-COV-2 antigen tests to be used with existing equipment. A CLIA-waived health center may have existing equipment that has been EUA-approved for running the tests using the company's cartridges. The current list of EUA approved devices and products can be found on the FDA's website.

NEW CPT TESTING CODES FOR COVID-19

CMS has created CPT code 87635 for providers to use to bill for testing performed using respiratory swabbing. It is the code health centers would use if they are performing the POC diagnostic viral test. This code became available for reporting on March 13, 2020 and will be part of the complete coding set in the 2021 data file set for release later this year. CPT 87471 is the parent code for 87635 and the full definition includes the language from the parent code:

- **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."

If testing requires two swabs from two different sources (e.g., nasopharyngeal swab and an oropharyngeal swab), the 87635 code would be used twice with the 59 modifier associated with the second assay, following the rules for microbiology coding of separate assays on multiple specimens. **Health centers who do not provide POC diagnostic testing would not bill using this code.**

Antibody (Serology) Testing

Antibody testing tells if a patient has already had the virus and built up the defenses in the blood. While they can detect if a person has been exposed to the virus, they cannot used to determine if a patient is infectious. Health centers can perform a blood draw and send the

specimen out to a laboratory for processing, but for POC testing approved (e.g., Chembio Diagnostics) through the EUA process, health centers can bill using the new antibody testing codes listed below.
The CPT codes 86328 and 86769 were created for COVID-19 antibody testing performed by providers to test patients for the novel coronavirus using blood, serum, or plasma. They became available for reporting on April 10, 2020 and will appear in the full CPT code set in the 2021 data file available later this year. The full code descriptions for the CPT codes are:

- **86328**: 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, single-step method.
- **86769**: 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, multi-step method.

CPT 86328 is used for a single-step reagent test, whereas CPT 86769 is used for a multi-step reagent test. CPT 86328 is the code that would be appropriate for a POC format. In order to bill a CPT 86328 the health center would have to use a EUA approved device and cartridge. Health centers not able to perform testing will perform a blood collection and send the specimen out to a laboratory for processing.

CODING TESTING SCENARIOS

For services provided on March 18, 2020 through to the end of the COVID PHE CMS will pay the reasonable costs for the specified Evaluation and Management E/M services that result in the "order for or administration of a COVID-19 test that relates to the furnishing or administration of such test or the evaluation of an individual for purposes of determine the need for such test." Telehealth services are included in this definition**. In order to qualify, health centers must waive the collection of the co-insurance from the patient.** The use of the "CS" modifier is required when health centers waive the co-insurance for COVID-19 testing related services. Claims will be automatically reprocessed July 1, 2020. These claims will be paid with the coinsurance applied.
The AMA provides excellent CPT reporting scenarios based upon where the patient is assessed and where the swab is collected. The AMA has also created an excellent guide regarding the various scenarios for both molecular and serologic testing for SARS-CoV-2. The guide can no longer be directly hyperlinked to so please find it by going to this AMA website, scroll to the bottom and click on "Coding scenarios and how to apply best coding practices (PDF"). Below is a chart to show how coding might look from the perspective of the testing process flow by location. It is important to note the CMS MLN SE20016 is clear that a Telephone (audio only) E/M service cannot be billed if it originates from a related E/M provided within the previous 7 days or leads to an E/M service or procedure within the next 2 hours or soonest available appointment.

Molecular and Antigen Diagnostic POC Test at the Health Center

LOCATION	IN OFFICE	E/M TELEHEALTH	Virtual Check-in or E-Visit	TELEPHONE
Assessment	New or Established E/M Visit code	New or Established E/M Visit code	99421-99423 G2010/G2012 (PPS G0071)	99441-99443 (G2025)
Swab Collection at the health center	Included	Included	Included	Included
POC Testing At Health Center	87635	87635	87635	87635

Serology Antibody POC Test at the Health Center

LOCATION	IN OFFICE	E/M TELEHEALTH	Virtual Check-in or E-Visit	TELEPHONE
Assessment	New or Established E/M Visit code	New or Established E/M Visit code	99421-99423 G2010/G2012 (PPS G0071)	99441-99443 (G2025)
Blood Collection at the health center	Included	Included	Included	Included
POC Testing At Health Center	86328 or 86769*	86328 or 86769*	86328 or 86769*	86328 or 86769*

* CPT 86328 is used for a single-step reagent test as would be typical with POC testing whereas CPT 86769 is used for a multi-step reagent test processed on more sophisticated laboratory instruments.

Serology Antibody Testing Not Performed at the Health Center

LOCATION	IN OFFICE	E/M TELEHEALTH	Virtual Check-in or E-Visit	TELEPHONE
Assessment	New or Established E/M Visit code	New or Established E/M Visit code	99421-99423 G2010/G2012 (PPS G0071)	99441-99443 (G2025)
Blood Collection at the health center	Included	99211*	99211*	99211*
Specimen Conveyance from health center to laboratory	99000**	99000**	99000**	99000**

** Check with Payer. CPT 99000 is not covered by Medicare

Depending upon the type of POC test performed at the health center CPT 87635 or 86328 or 86769 can be billed. If the health center is sending the specimen out to a laboratory, the laboratory would bill the applicable testing code.

DIAGNOSTIC CODING FOR COVID-19

On April 1, 2020, the CDC finalized guidelines for diagnostic coding for encounters for COVID-19 confirmed and suspected cases as well as those related to exposure, screening, and other respiratory illness associated with infection. A confirmed diagnosis will have the newly created U07.1, COVID-19 assigned to it. Patients who are asymptomatic and test positive for COVID-19 are assigned U07.1, COVID-19. A patient who is asymptomatic, exposure is not known, test is negative or unknown, code Z11.59. For someone who has been exposed to the virus and tests negative for infection Z20.828, "contact with and (suspected) exposure to other viral communicable disease". Where possible exposure is a concern but is ruled out after evaluation, assign code Z03.818 for "Encounter for observation for suspected exposure to other biological agents ruled out." Follow coding guidelines, also outlined in this same CDC document, for when to code symptoms.

TEST ORDER

This CMS guide explains that testing (and use of 99211) can be provided to both new and established patients and by whom specimens can be collected and locations where specimen collection and testing can occur. In addition, there are flexibilities for COVID-19 and RSV/Influenza tests for which Medicare does not require a practitioner order during the PHE. Local coverage determinations still apply, and health centers will need to check with other

payers to see if they have adopted this flexibility with regard to test ordering. If the code you intend to use is not on this list, then an order is still required.

SPECIMEN COLLECTION STAFF

Any clinical staff involved in specimen collection and testing must be properly trained and supervised in accordance with the health center's credentialing and privileging practices. Federal and state laws must also be adhered to as it relates to personnel and training requirements for laboratory testing and specimen collection. **States may be temporarily allowing health practitioners to provide these services outside their normal scope of practice; therefore, it is important for health centers to check with state laws for guidance.** In addition, temporary privileging can be used to expand the scope of services, as allowable under federal and state laws, and still fall under the FTCA.
In addition, while volunteer providers are not automatically covered by the FTCA, health centers can apply for protection.
FTCA coverage extends to providers of services to established patients and to those individual who are not patients of the health center.

PAYMENT

Payment for testing is set through the MACs (Medicare Administrative Contractor). This recently published payment guide will assist health centers in pricing tests and in determining payment. There is agreement across the country that CMS reimbursement will be:

CPT 87635	CPT 86328	CPT 86769
$51.31	$45.23	$42.13

QW MODIFIER

The QW Modifier is typically appended to CLIA waived tests requiring it. **Health centers are strongly urged to check with their MACs and other payers to determine if this modifier is required for the testing codes.**

TEMPORARY EXPANSION SITES

The government has created flexibilities to permit expansion of services within communities to allow for better access to care and testing. During the COVID PHE, CMS is removing the location restrictions to allow flexibility for existing health centers to expand services locations, which may be outside of the location requirements, to meet the needs of Medicare

beneficiaries. Where the provision of in-scope health center services is already within the health center's approved scope of project, HRSA approval is not required. Services that are not within the project scope can be submitted to the health center's Project Officer. It is important for health centers to check the criteria for better understanding of temporary expansion site provisions. As there are requirements for when health centers should apply for temporary site approval, centers should check the HRSA program requirements to make sure they are following the necessary steps for expansion. Health centers should also check with FTCA provisions or malpractice insurance carriers to make sure any questions have been addressed before temporary expansion sites become operational. Temporary locations that appear to be commonly used for assessment and testing are on current health center property in 'pop-up' tents, mobile units, and trailers. FTCA coverage also expands for health centers conducting testing on patients who are in their cars.

HOME VISIT TESTING FOR COVID-19

During the COVID PHE, health centers can make home visits in areas that are part of its service area plan, where there is a shortage of home visit agencies, and where no request for the determination is required. In addition, telehealth services (CPT 99342-99350) using audio and visual technology may be performed for homebound patients and health centers would bill the applicable HCPCS PPS G code for those services. **However, a health center nurse visit for the sole purpose of obtaining a swab is not considered a nursing visit as that service can be provided by a person of lesser training (e.g., lab technician). If a FQHC home visit nurse is already established then the nurse can take the swab and send it for testing.** This testing is permitted for homebound patients, which CMS defines as follows: "A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19. As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit."

Telehealth Services

It is important to understand that telehealth services and billing guidelines are dependent on payer specifics and state guidelines. The following information is applicable to Medicare.

Distant Site Designation

Even before the COVID PHE, an important consideration for billing for telehealth services was the location of the patient and the provider. The Originating Site was/is the location of the patient which before the COVID PHE had to be a medical practice or facility. The location of the rendering provider was/is the Distant Site. **Health centers have always been a Medicare-approved Originating Site but not historically permitted to be a Distant Site.** During the COVID-19 PHE CMS is allowing health centers to be Distant Sites and for health center providers working from home to bill under the health center as a Distant site. Patient homes are also now permitted to be an Originating site. Any health care providers working for a health center – and within the scope of their practice – may provide any approved Distant Site telehealth services. Health centers need to bill under their facility NPI as a Distant Site. **It is important to note that the changes in the eligible Originating Site locations – including the patient's home – are effective beginning March 6, 2020, and until the end of the COVID PHE.**
On April 17, 2020 CMS released the Medicare Learning Network Matter article (SE20016) as guidance for health centers regarding telehealth reimbursement during the COVID-19 and 1135 Waiver Public Health Emergency (hereafter "COVID PHE"). On April 30, 2020 the MLN SE20016 was updated to clarify areas of confusion and to add Telephone Evaluation and Management (E&M) visits as part of the list of covered telehealth services. On July 6, 2020 the document was updated for a third time to provide additional guidance on telehealth services that have cost-sharing waived and additional claim examples in addition to an added section on the RHC Productivity Standard.

Medicare telehealth services generally require real-time, interactive audio and visual communication between the patient and the provider. In earlier documents, we referred to these visits as Telemedicine E&M services, but the update on April 30, 2020 expanded the services to include a broader range of visit types. **Medicare is using the term "telehealth" to broadly define audio and/or visual and/or electronic interactions** in this way. During the COVID PHE telehealth may be used for providing E&M services to new or existing patients. In the MLN, Medicare provides a break-down of the services that may be provided under the telehealth definition.

Modifier CS

For services provided on March 18, 2020, through to the end of the COVID PHE CMS will pay the reasonable costs for the specified E&M services that result in the "order for or administration of a COVID-19 test that relates to the furnishing or administration of such test or the evaluation of an individual for purposes of determining the need for such test." Telehealth services are included in this definition**. In order to qualify, health centers must waive the collection of the co-insurance from the patient.** The use of the "CS" modifier is required when health centers waive the co-insurance for COVID-19 testing-related services or preventive and

preventive services that already have no cost share. Claims will be automatically reprocessed on July 1, 2020. These claims will be paid with the coinsurance applied.

Telehealth Covered Service Codes

CMS has provided a link to a zip file containing two Excel files that list the covered codes. The codes apply to services traditionally covered as part of telehealth, as well as the services added during the COVID PHE. The link to the resource is here. It is important to understand which services are codes that fall under a Medicare PPS Qualifying Visit definition, which do not, and which ones are permitted to be audio without the video. CMS makes the distinction between services that are a health center qualifying visit and those that are not as a way to stage the needed changes to the claims processing systems. For some services, that staging translates to delayed payment. Be sure to check back to their site frequently as updates may be added.

What are the telehealth services covered by Medicare as listed in the MLN SE20016?

- Telehealth Services (that are also PPS Qualifying Visits)
- Telehealth Services (that are NOT PPS Qualifying Visits)
- Virtual Communication Services
- Telephone E&M services

CMS has provided separate coding guidance within the MLN for covered telehealth services based on dates of service January 27, 2020, through June 30, 2020, and July 1, 2020 through the end of the PHE. The separate coding guidance was provided to accommodate for system updates and reprocessing of telehealth PPS claims for a new payment rate of $92.03.

TELEHEALTH SERVICES – PPS QUALIFYING VISITS

Please note that CMS has allowed some PPS Qualifying Visit services in this section to be audio-only as listed on the Telehealth Visit List. Those services that cannot be audio-only require both audio and visual components as part of the visit.

Telehealth services meeting Medicare's PPS G code Qualifying Visits rendered **for DOS January 27, 2020, through June 30, 2020**, health centers must submit the following ***three (3)*** HCPCS (e.g., CPT) codes for Distant Site telehealth services and **include modifier CS for services where cost-sharing should be waived** (e.g. care related to COVID testing or preventive services with no cost-share):

- Prospective Payment System (PPS) Code (i.e., G0466, G0467, G0468, G0469, G0470)
- A code from Telehealth Visit List that qualifies for a Medicare PPS G code with a modifier 95.
- The new G2025 code with modifier 95.

*Health centers will be paid PPS rate until June 30, 2020. Then claims will be reprocessed beginning July 1, 2020 at a rate of $92.03.

For **Telehealth services provided with a DOS of July 1, 2020 through the end of the COVID PHE**, health centers must submit only the new G2025 code (95 Modifier is optional) per CMS guidance.

TELEHEALTH SERVICES THAT ARE NOT PPS QUALIFYING VISITS

There are a number of CMS-approved telehealth services that do not correspond to specific health center PPS codes. They include services such as TCM, psychotherapy, tobacco-use counseling, to name a few. These codes are provided as part of the CMS Telehealth Services Code list, and some of the services may be offered without video as indicated on the list.

For **Telehealth services with DOS January 27, 2020 until the end of the COVID 19 PHE**, that are **not** also PPS G Code Qualifying Visits, health centers must **hold the claims until July 1, 2020**. Claims can then be submitted with the new G2025 code and the 95 Modifier is optional.

VIRTUAL COMMUNICATION SERVICES

Virtual Communication Services (HCPCS G2012 and G2010) are brief (5-10 minute) check-in services with a provider using a telephone or other telecommunication device to decide whether an office visit is needed. VCS may also be a remote evaluation of recorded video or images submitted by a patient. VCS is an option for new and established patients during the COVID PHE. VCS are initiated by the patient most typically via phone call or through a patient portal. Patient consent is required, but during the COVID PHE may be obtained during the time of service. This consent may be obtained by auxiliary staff under the general supervision of the billing provider. Auxiliary staff may be an employee, independent contractor, or leased employee.

For **March 1, 2020, through to the end of the COVID PHE** health centers offering VCS will need to submit:

- G0071 code
- G2010 or G2012; See coding definitions for specifics.

E-Visits

On-line digital E&M services, also known as E-Visits (99421-99423 or G2061-G2063) are used for established patients during the COVID PHE. They are patient-initiated most typically through the patient portal affording 24/7/365 access. Patient consent is required and, so far as we can currently find, still requires it to be obtained in advance of the time of service. Consent may be obtained by auxiliary staff under the general supervision of the billing provider. Auxiliary staff may be an employee, independent contractor, or leased employee.
Billing for E-Visits with DOS **March 1, 2020, through to the end of the COVID PHE** require**:**

- G0071 code
- 99421-99423 or G2061-G2063; See the coding definitions for specifics.

TELEPHONE E&M SERVICES

Prior to the April 30th MLN update, Telephonic E&M visits (99441-99443) were not approved as part of the CMS COVID PHE Telehealth Services list nor were they reimbursable to health centers under Medicare PPS G codes. The codes in this range are, by definition, telephonic services requiring at least 5 minutes of E&M service time by a physician or other qualified health professional. Telephone E&M services may be offered to an established patient and/or a patient's parent or guardian. They cannot be billed if they are rendered as follow up to an E&M visit provided during a preceding 7-day visit. It also may not be billed if the service leads to a procedure or E&M visit within 24 hours or next available appointment.
For **Telephone E&M services provided with a DOS March 1, 2020, and until the end of the COVID PHE**, health centers must submit just the new G2025 code. The 95 Modifier is optional.
Telehealth Technology and HIPAA guidance can be found through the Office for Civil Rights FAQs**.** While there is flexibility during the COVID PHE exception, HIPAA-secure technology is strongly recommended. Latitude exists for providers using non-HIPAA-secure technology (e.g., FaceTime or Zoom). When used in good faith the OCR will "exercise enforcement discretion and waive penalties for HIPAA violations" around non-HIPAA compliant technology. In short, use HIPAA secure systems as able. When unable, document notification of patients of such and exercise caution around securing PHI.

Coding Examples

**Remember to append modifier CS for services requiring cost- share waiver as stated above.*

Telehealth- PPS Qualifying Visits (DOS 1/27/2020 through 6/30/2020)

Revenue Code	health center Code	Modifiers	Payments
052X	G0466 – G0470	N/A	Health centers will be paid the PPS rate until June 30, 2020, and then claims will be automatically reprocessed beginning July 1, 2020 at the $92.03 rate.
052X	PPS Qualifying Payment Code (e.g., 99214 or 90845)	95	
052X	G2025	95	

Telehealth- PPS Qualifying Visits (DOS 7/1/20 through the end of COVID-19 PHE)

Revenue Code	health center Code	Modifiers	Payments
052X	G2025	95 (optional)	$92.03

Telehealth- Non PPS Qualifying Visits (DOS 1/27/20 through the end of COVID-19 PHE)

**billable beginning July 1, 2020 per CMS*

Revenue Code	health center Code	Modifiers	Payments
052X	G2025	95 (optional)	$92.03

Virtual Communication Services (DOS 3/1/20 through the end of the COVID-19 PHE)

Revenue Code	health center Code	Modifiers	Payments
052X	G0071	N/A	$24.76 for DOS March 1, 2020 until the end of the COVID PHE $13.53 for DOS January 1 until March 1, 2020 MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1, 2020 that were paid before the claims processing system was updated.
052X	G2010 or G2012	N/A	

E-Visits (DOS 3/1/20 through the end of the COVID-19 PHE)

Revenue Code	health center Code	Modifiers	Payments
052X	G0071	N/A	$24.76 for DOS March 1, 2020 until the end of the COVID PHE $13.53 for DOS January 1 until March 1, 2020 MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1, 2020 that were paid before the claims processing system was updated.
052X	99421-99423 G2061 - G2063	N/A	

Telephone E&M (DOS 3/1/20 through the end of the COVID-19 PHE)

Revenue Code	health center Code	Modifiers	Payments
052X	G2025	N/A	$92.03