MGMA COVID-19 Coding Cheat Sheet (*Updated Dec. 23, 2020*)

ICD-10-CM CODES		
CONFIRMED COVID-19 DIAGNOSIS		**Code only confirmed cases**
COVID-19	**U07.1**	***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. This is an exception to the hospital inpatient guideline Section II, H. In this context, "confirmation" does not require documentation of the type of test performed; the provider's documentation that the individual has COVID-19 is sufficient. ICD-10-CM code U07.1, COVID-19, may be used for discharges/date of service **on or after April 1, 2020**. For guidance prior to April 1, 2020, please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak. **Sequencing of codes:** When COVID-19 meets the definition of principal or first-listed diagnosis, code U07.1, COVID-19, should be sequenced first, and followed by the appropriate codes for associated manifestations, *except in the case of obstetrics patients*. Use O98.5- as principal diagnosis followed by U07.1.
PNEUMONIA		Code first COVID-19 (U07.1)
Pneumonia due to coronavirus disease 2019	J12.82	
BRONCHITIS		For a patient with acute bronchitis confirmed as due to COVID-19, assign code J20.8. Bronchitis not otherwise specified (NOS) due to the COVID-19 should be coded using code J40, Bronchitis, not specified as acute or chronic.
Acute bronchitis due to other specified organism	J20.8	
Bronchitis, not specified as acute or chronic	J40	
LOWER RESPIRATORY INFECTION		If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, this should be assigned with code J22, Unspecified acute lower respiratory infection. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be
Unspecified acute lower respiratory infection	J22	
Other specified respiratory disorders	J98.8	

		appropriate to assign code J98.8, Other specified respiratory disorders.
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)		Acute respiratory distress syndrome (ARDS) may develop in with the COVID-19, according to the Interim Clinical Guidance for Management of Patients with Confirmed 2019 Novel Coronavirus (COVID-19) Infection. Cases with ARDS due to COVID-19 should be assigned the codes J80, Acute respiratory distress syndrome.
Acute respiratory distress syndrome	J80	
SIGNS AND SYMPTOMS		For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms.
Cough	R05	
Shortness of breath	R06.02	
Fever, unspecified	R50.9	
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, it would be appropriate to assign the code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.822, Contact with and (suspected) exposure to COVID-19.
Encounter for observation for suspected exposure to other biological agents ruled out	Z03.818	
Contact with and (suspected) exposure to COVID-19	Z20.822	
Encounter for screening for COVID-19 (for **asymptomatic individuals** being screened for COVID-19, have *no known exposure* to the virus, and test results are either unknown or negative)	Z11.52	

IMPORTANT NOTES
Sequencing: U07.1 should be the primary diagnosis in confirmed COVID-19 diagnosis, followed by appropriate codes for associated manifestations: • **J12.82** (other viral pneumonia) • **J20.8** (acute bronchitis due to other specified organisms) • **J22** (unspecified acute lower respiratory infection NOS) • **J40** (bronchitis, not specified as acute or chronic) • **J80** (acute respiratory distress syndrome) • **J98.8** (other specified respiratory disorders)
Diagnosis code B34.2, Coronavirus infection, unspecified, would in generally **not be appropriate** for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified."
If the provider documents "suspected", "possible" or "probable" COVID-19, **do not assign** code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).
For more detailed guidance regarding diagnosis coding for COVID-19 and guidelines for pregnant patients, see this CDC guideline.

CPT CODES

TESTING		
Immunoassay for infectious agent antibody, quantitative, not otherwise specified	86317	These codes are used to report a qualitative or semi-quantitative immunoassay to identify infectious agent antibodies (DNA or RNA); SARS-CoV-2. Specimen is serum which a reagent strip is used for the specific antibody.
Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip)	86318	
Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); **screen**	86408	The CPT® Editorial Panel published the following two codes, *effective August 10, 2020*, for reporting lab tests that determine if the antibodies present can block COVID-19 viral infection.
Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID19]); **titer**	86409	
Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	86328	**ANTIBODY TESTING**: These two new codes are effective immediately, according to the AMA. The new codes are intended for use as the industry standard for accurate reporting and tracking of blood tests performed to specifically detect antibodies associated with the SARS-CoV-2 virus," according to the AMA release. CPT® 86328 is for antibody tests using a single-step method immunoassay. This often includes a strip with all the critical components for the assay, and is appropriate for a point of care platform, according to an AMA press release. CPT® 86769 is for antibody tests employing a multiple-step method.
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative	86413	
Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	86769	
Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; adenovirus enteric types 40/41	87301	*Effective June 25, 2020*, code 87426 is used to report infectious agent antigen detection of SARS-CoV and SARS-CoV-2 by immunoassay technique. It is a waived test under CLIA. https://www.cms.gov/files/document/MM11815.pdf
■ severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])	87426	

■ severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	87428	
Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets.	87631	*Effective October 6, 2020*, code 87631 is revised to reflect a test panel of multiple viruses. The revision captures 3-5 targets by DNA or RNA agent detection resulting in viral panel to distinguish: • Influenza A • Influenza B • RSV • SARS-CoV-2 AMA provided this guidance in a CPT Assistant Special Edition: October Update https://www.ama-assn.org/system/files/2020-10/cpt-assistant-guide-coronavirus-october-2020.pdf
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.	87635	The AMA has published guidance in CPT Assistant stating to use 87635. All healthcare entities must manually load it into their EHRs. An excerpt from CPT Assistant is as follows: *These codes are effective immediately for use in reporting this testing service. Note that code 87635 is not in the CPT 2020 publication; however, it will be included in the CPT 2021 code set in the Microbiology subsection of the Pathology and Laboratory section.* Accepted addition of code 87636 for reporting combined respiratory virus multiplex testing for either SARS-CoV-2 with Influenza A&B, code 87637 for combined respiratory virus multiplex testing for either SARS-CoV-2 with Influenza A&B and RSV and 87811 for antigen detection of SARS-CoV-2 by direct optical (i.e., visual) observation.
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	87636	
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	87637	
Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	87811	
Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source.	G2023	Two new Level 2 HCPCS codes have been established to identify specimen collection for COVID-19 testing. Independent laboratories must use one of these two HCPCS codes when billing Medicare for the nominal specimen collection fee for COVID-19 testing, for the duration of the PHE for the COVID-19 pandemic.
Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-	G2024	

CoV-2) (Coronavirus disease [COVID-19]), from an individual in an SNF or by a laboratory on behalf of an HHA, any specimen source.		The second Level 2 HCPCS code, G2024, was created to address the higher fee associated with collecting a specimen from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency. As time goes on, there will be further guidance provided when these codes are no longer valid, and therefore terminated from the HCPCS file and the clinical lab fee schedule.
Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually travelled.	P9603	Independent laboratories can bill for travel allowance when there is inclusion of a pickup service. Code P9603 and the flat-rate travel allowance is addressed and described by HCPCS code P9604. There will be no requirement of paper documentation of miles traveled; however, laboratories must maintain electronic logs with the necessary information in a method that can be shared with Medicare Administrative Contractors (MACs).
Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge.	P9604	
Coronavirus testing using the CD 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel.	U0001	If your office is not running the test for COVID-19 or incurring the cost, you will **not report these codes**.
Report this code for validated non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).	U0002	
Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected.	0202U	The listed new codes will be manually added to the national HCPCS files by the MACs. Also, these new codes are contractor-priced (where applicable) until they are nationally priced and undergo the CLFS annual payment determination process in accordance with the Social Security Act § 1833(h)(8), § 1834A(c) and § 1834(A)(f). **MACs shall only price PLA codes for laboratories within their jurisdiction.** https://www.cms.gov/files/document/MM11815.pdf
Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected.	0223U	
Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	0224U	

(Coronavirus disease [COVID-19]), includes titer(s), when performed.		
Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	0225U	**Proprietary Laboratory Analyses (PLA)** Two PLA codes were established to report proprietary 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.
Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum	0226U	
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	0240U	
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	0241U	
VACCINES/TOXOIDS		Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine other than when performed for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccines. For immunization administration of any vaccine, other than SARS-CoV-2 (coronavirus disease [COVID-19]) vaccines, that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family/guardian or for administration of vaccines to patients over 18 years of age
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	90460	
+ each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)	+90461	

		(Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines], report 90460 in conjunction with 90461 for each additional component in a given vaccine)
Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	90471	Do not report 90471 in conjunction with 90473
+ each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	+90472	Do not report 90471, 90472 in conjunction with 91300, 91301, 91302 unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter
Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	90473	Do not report 90473 in conjunction with 90471
+ each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	+90474	Use 90474 in conjunction with 90460, 90471, 90473 Do not report 90473, 90474 in conjunction with 91300, 91301, 91302 unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter
Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	0001A	Report 0001A, 0002A for the administration of vaccine 91300 Report 0011A, 0012A for the administration of vaccine 91301 Effective upon receiving Emergency Use Authorization or approval from the Food and Drug Administration Report 0021A, 0022A for the administration of vaccine 91302 0001A 1st dose, 0002A 2nd dose – Pfizer-BioNTech (21 days dosing interval) 0011A 1st dose, 0012A 2nd dose – Moderna (28 days dosing interval) 0021A 1st dose, 0022A 2nd dose – AstraZenaca (28 days dosing interval)
■ second dose	0002A	
Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	0011A	
■ second dose	0012A	
Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose	0021A	
■ second dose	0022A	
Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative	91300	Report 91300 with administration codes 0001A, 0002A Report 91302 with administration codes 0021A, 0022A

free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use		91300, 91301, 91302) should be reported with the corresponding immunization administration code (0001A, 0002A, 0011A, 0012A, 0021A, 0022A *Do not report 90476-90749 in conjunction with the SARSCoV-2 (coronavirus disease [COVID-19]) immunization administration codes 0001A, 0002A, 0011A, 0012A, 0021A, 0022A unless both a SARS-CoV-2 (coronavirus disease [COVID-19]) vaccine/toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter.* >Modifier 51 should not be reported with vaccine/toxoid codes 90476-90749, 91300, 91301, 91302, when reported in conjunction with administration codes 90460, 90461, 90471, 90472, 90473, 90474, 0001A, 0002A, 0011A, 0012A, 0021A, 0022A.<
Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use	91301	
Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use	91302	
Adenovirus vaccine, type 4, live, for oral use	90476	For administration of vaccines/toxoids, see 90460, 90461, 90471, 90472, 0001A, 0002A, 0011A, 0012A, 0021A, 0022A
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	96372	
ONLINE DIGITAL E&M		These services are not for the non-evaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the clinician, the patient must be an established patient. • **Can be done synchronously and asynchronously and audio/video phone can be used (but not a traditional telephone).** • ***Must be patient initiated*.** The patient can initiate a virtual check-in, the practice can let the patient know about their options. If the patient calls back within 7 days, then the time from the virtual check-in can be added to the digital E/M code and only the digital E/M code is billed. Cost sharing applies to the E/M service; copays are waived for COVID-19 testing, but deductibles still apply. • Use only once per 7-day period. • Clinical staff time is not calculated as part of cumulative time • Service time must be more than 5 minutes • Do not count time otherwise reported with other services
Patient-initiated digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; **5-10 minutes**	99421	
11-20 minutes	99422	
21 minutes or more	99423	

		• Do not report on a day when the physician or other qualified health care professional reports E/M services • Do not report when billing remote monitoring, CCM, TCM, care plan oversight, and codes for supervision of patient in home, domiciliary or rest home etc. for the same communication[s]) • Do not report for home and outpatient INR monitoring when reporting 93792, 93793) • If the patient presents a new, unrelated problem during the 7-day period of an online digital E/M service, then the time is added to the cumulative service time for that 7-day period. • **No modifier needed as these are technology-based codes.** If the patient initiates a call to the physician office this would qualify for the remote check-in code (G2012), the time for the remote (virtual) check-in can be counted toward 99421-3 only if and when the patient calls back, so it is important to document the time. The CPT book denotes details regarding when the 7 days begins, how to count time, which "qualified non-physician health professionals" it applies to, and other documentation requirements.
REMOTE MONITORING		**Use of codes:** • Established patients only. • Follow-up can be by phone, audio/video, secure text messaging, email or patient portal communication. • Involves "asynchronous transmission of healthcare information" from the patient. If the images are not enough to perform the evaluation, then *do not bill for the service.* • If an E&M service is provided within the defined time frames, then the telehealth visit is bundled in that E&M service. It would be considered pre- or post-visit time of the associated E&M service and thus not separately billable. • Should be initiated by the patient since a copay is required. Verbal consent to bill and documentation is required.
Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	99453	
Remote monitoring of physiologic parameter(s) (eg, weight, BP, pulse oximetry, respiratory flow rate) initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	99454	
Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff, physician, or other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month	99457	

MGMA COVID-19 Coding Cheat Sheet (*Updated Dec. 23, 2020*)

TELEPHONE *ONLY* (AUDIO ONLY)		
Telephone E/M service provided by a physician to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hrs or soonest available appointment, **5-10** medical discussion	99441	Telephone only (no video) are reimbursable by Medicare as well as many private payers during this public health emergency, and in California, all payers at the same rates and cost sharing as in-person services. • No modifier is needed for these codes because they are not telehealth – they are audio only telephone. • Use your normal Place of Service. For instance, POS=11 (private practice). • Can be used for new or established patients. CMS new policy based on the Interim Final Rule from 3/31 states that these codes are covered and can be billed retroactively from March 1, 2020. If the patient initiates a call to the physician office this would qualify for the remote check-in code (G2012), the time for the remote (virtual) check-in can be counted toward 99421-3 only if and when the patient calls back, so it is important to document the time. The CPT book denotes details regarding when the 7 days begins, how to count time, which "qualified non-physician health professionals" it applies to, and other documentation requirements.
11-20 minutes of medical discussion	99442	
21-30 minutes of medical discussion	99443	

SUPPLIES		
Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease.	99072	Code 99072 is **reported only during a PHE** and only for additional items required to support a safe in-person provision of evaluation, treatment, or procedural service(s). ➢ Time over what is included in the primary service of clinical staff time ➢ Cleaning supplies, including additional quantities of hand sanitizer and disinfecting wipes, sprays, and cleansers ➢ Use of multiple PPE to treat patient during encounter on same day (ie. 3 surgical masks, 5 pairs of gloves) *Effective September 8, 2020* There is no set value for this code and is reimbursed by payer's discretion. https://www.ama-assn.org/system/files/2020-09/cpt-assistant-guide-coronavirus-september-2020.pdf

MGMA COVID-19 Coding Cheat Sheet (*Updated Dec. 23, 2020*)

<table>
<tr><th colspan="3">HCPCS CODES</th></tr>
<tr><td colspan="2">VIRTUAL CHECK-IN</td><td rowspan="3">Consider the following when billing these codes:
Can be any real-time audio (telephone), or "2-way audio interactions that are enhanced with video or other kinds of data transmission."
Communication can use non-HIPAA compliant technology during the COVID-19 public health emergency.
New or established patients.
Any chronic patient who needs to be assessed as to whether an office visit is needed.
Patients being treated for opioid and other substance-use disorders.
Nurse or other staff member cannot provide this service. It must be a clinician who can bill E&M services.
If an E&M service is provided within the defined time frames, then the telehealth visit is bundled in that E&M service. It would be considered pre- or post-visit time of the associated E&M service and thus not separately billable.
No geographic restrictions for patient location.
Should be initiated by the patient since a copay is required. Verbal consent to bill and documentation is required.
No modifier needed as these are technology-based codes.</td></tr>
<tr><td>Remote evaluation of recorded video and/or images submitted by an established patient (e.g. store and forward), including interpretation with 13.35followup with the patient within 24 business hours, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.</td><td>G2010</td></tr>
<tr><td>Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report E&M services, provided to an established patient, not originating from a related E&M service provided 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.</td><td>G2012</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">ONLINE ASSESSMENT</td><td rowspan="4">There are no new rules specific to the COVID-19 public health emergency.</td></tr>
<tr><td>Qualified non-physician professional online assessment (such as using the patient portal), for up to 7 days,
5-10 minutes cumulative time during the 7 days</td><td>G2061</td></tr>
<tr><td>11-20 minutes</td><td>G2062</td></tr>
<tr><td>21 minutes or more</td><td>G2063</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">RHC or FQHC VIRTUAL COMMUNICATION</td><td rowspan="2">RHCs and FQHCs must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with</td></tr>
<tr><td>Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication</td><td>G0071</td></tr>
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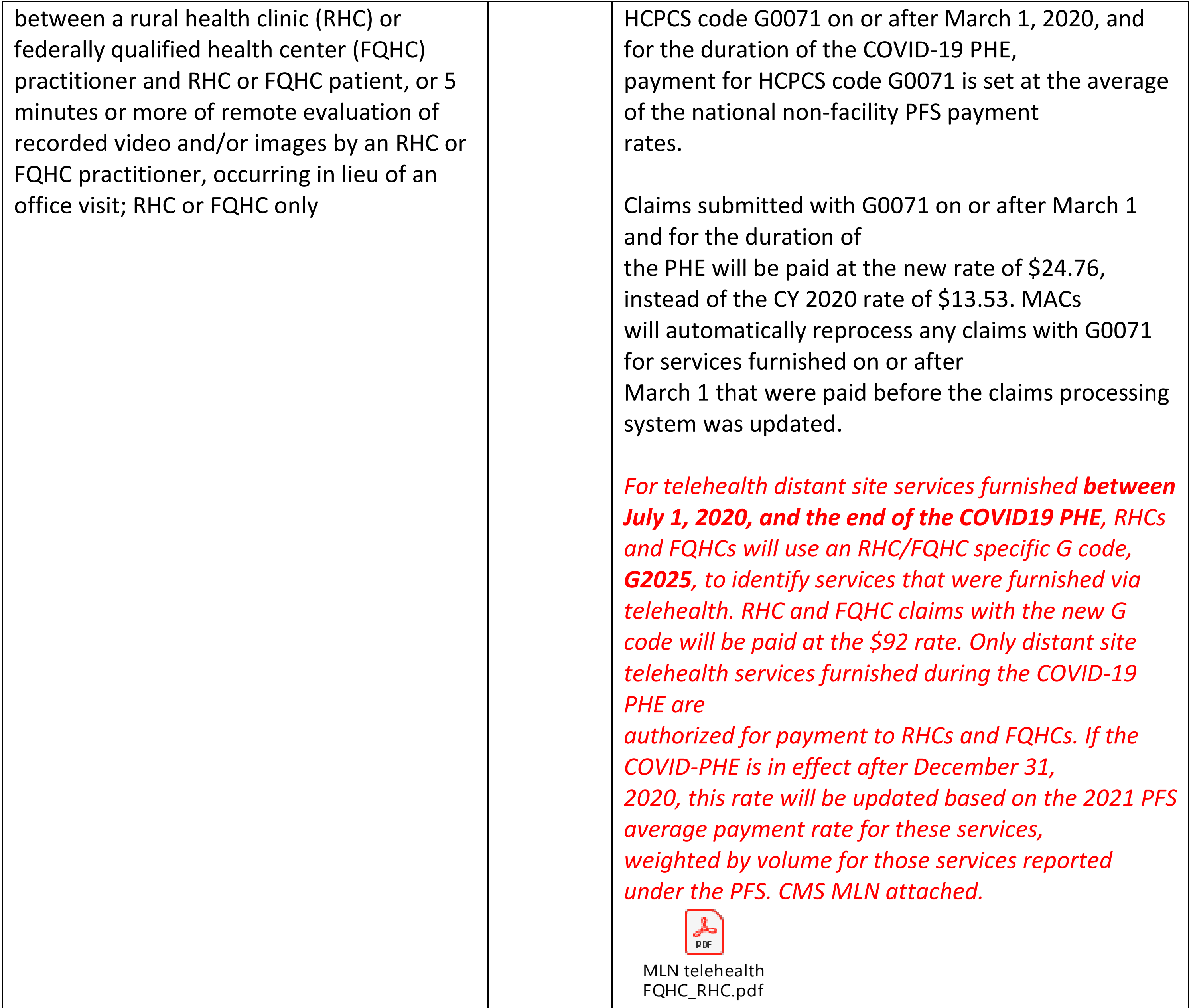

between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only		HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates. Claims submitted with G0071 on or after March 1 and for the duration of the PHE will be paid at the new rate of $24.76, instead of the CY 2020 rate of $13.53. MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid before the claims processing system was updated. *For telehealth distant site services furnished **between July 1, 2020, and the end of the COVID19 PHE**, RHCs and FQHCs will use an RHC/FQHC specific G code, **G2025**, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be paid at the $92 rate. Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS. CMS MLN attached.* MLN telehealth FQHC_RHC.pdf

IMPORTANT NOTES	
AMA and CMS KEY POINTS	The AMA and CMS has worked diligently to applying the greatest flexibility to our physicians in providing care to their patients during this public health crisis resulting in key points to remember when coding and billing for patient care: • The Centers for Medicare & Medicaid Services (CMS) lifted Medicare restrictions on the use of telehealth services during the COVID-19 emergency. Key changes effective March 1, and lasting throughout the national public health emergency include: • Medicare will pay physicians for telehealth services at the same rate as in-person visits for all diagnoses, not just services related to COVID-19. • Patients can receive telehealth services in all areas of the country and in all settings, including at their home.

	• CMS expanded the list of services eligible to be reported via telehealth (link here) • CMS will permit reporting of telehealth E/M office or other outpatient visits based on time or Medical Decision Making (MDM). • The Qualified Healthcare Professionals that are eligible for telehealth has been expanded. Additional codes for these services were also added to the CMS telehealth list. • CMS has clarified that telehealth services are permitted with both new and established patients. • Physicians can reduce or waive cost-sharing for telehealth visits. • Physicians licensed in one state can provide services to Medicare beneficiaries in another state. *State licensure laws still apply.* **Please review AMA scenarios to understand which E/M and HCPCS codes to use with POS.**
ALLOWED TECHONOLOGY	All E/M and other services that are currently eligible under the Medicare telehealth reimbursement policies are included in this waiver. These are list of eligible CPT/HCPCS codes. Use modifier -95 to claim lines that describe the services provided via telehealth. POS code would be whatever would have been reported had the service been provided in person. See the "Modifiers" section below for more information about how to correctly bill for these CPT services. Effective immediately (as of March 17, 2020), the Office for Civil Rights (OCR), the department responsible for enforcing the Health Insurance Portability and Accountable Act of 1996 (HIPAA) regulations, announced they will exercise enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. During the COVID-19 emergency, physicians subject to HIPAA Rules may communicate with patients, and provide telehealth services, through remote communications technologies that may not fully comply with the requirements of the HIPAA Rule, regardless of whether the service is related to the diagnosis and treatment of conditions related to COVID-19. OCR will not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth during the COVID-19 emergency. **PLEASE NOTE:** This federal enforcement discretion will likely not impact individual states' laws and regulations regarding protection and security of health information. Separate state action will be required in certain areas – physicians should assess their state-specific privacy laws prior to moving forward.

	Physicians may use any **non-public facing** remote communication product available to communicate with patients (even if this product is not fully compliant with HIPAA Rules) – examples include: • Apple FaceTime • Facebook Messenger video chat • Google Hangouts video • Skype Examples of public-facing products and applications that **should NOT be used** include: • Facebook Live • Twitch • TikTok **Physicians are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and physicians should enable all available encryption and privacy modes when using such applications** Physicians seeking additional privacy protections should provide telehealth remote communication services through vendors who are HIPAA-compliant and will enter into **a HIPAA Business Associate Agreement (BAA) in connection with the use of their product**. The below list of vendors have indicated they provide HIPAA-compliant platforms (NOTE: OCR has not reviewed these vendors BAAs and is not endorsing the use of or suggesting certification for any of the below products): • Skype for Business • Updox • VSee • Zoom for Healthcare • Doxy.me • Google G Suite Hangouts Meet Additional information from OCR can be found on their website: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html Flexibilities available, as well as obligations that remain in effect under HIPAA as physicians respond to crises or emergencies must also be review on the OCR.
MODIFIERS	**Use of modifiers:** • Telehealth services provided via **real-time interactive audio and video** should be billed with the place of service (POS) code that would have been used had the service been provided in person, such as POS=11 (private practice) instead of 02 (telehealth). • CMS has also directed providers to **append modifier -95** to all telehealth services billed using POS 11. ***This***

	change will enable providers to be reimbursed at the same rate as services provided in person. • During the current COVID-19 Public Health Emergency, telehealth E/M levels can be based on Medical Decision Making (MDM) OR time (total time associated with the E/M on the day of the encounter). Likewise, CMS has also removed any requirements regarding documentation of history and/or physical exam in the medical record for Telehealth visits. • Modifier -95 should **not** be used with virtual visits (G2012) or the digital evaluations (99421-99423). It is for use with all other telehealth codes that use **synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system**. -GQ: Clinicians participating in the federal telemedicine demonstration programs in **Alaska or Hawaii** must submit the appropriate CPT or HCPCS code for the professional service along with the modifier GQ, "via asynchronous telecommunications system." -GO: Use of telehealth for purposes of diagnosing stroke. **Note:** Medicare stopped the use of modifier -GT in 2017 when the place of service code 02 (telehealth) was introduced. However, private payer may still be using the modifier -GT. *No modifiers are needed for telephone calls (99441-99443) as they are not considered telehealth.*
IMPORTANT NOTE ON ORGINATING SITE	During the COVID-19 public health emergency, rural and site limitations are removed. Telehealth services can now be provided regardless of where the enrollee is located geographically and type of site, which allows the home to be an eligible originating site. However, locations that are newly eligible will **not** receive a facility fee.
IMPORTANT NOTE ON USING OUTPATIENT E&M CODES FOR TELEHEALTH	CMS will allow physicians to select the level of office/outpatient E/M visit (CPT codes 99201-99215) furnished via Medicare telehealth **based on medical decision making (MDM) or time**. Documentation must thoroughly explain MDM and meet telehealth requirements. Please refer to CMS Telehealth Provider Fact Sheet which explains requirements. CMS defines **time** as all the time associated with the E/M on *the day of the encounter*. The current typical times associated with office/outpatient E/M codes in CPT are what should be met for the purposes of level selection.
IMPORTANT NOTE ON UTILIZING RESIDENTS DURING PHE (COVID-19)	CMS expanded CPT® codes that may be billed (under 42 CFR 415.174) on and after March 1, 2020 and for the duration of the

	public health emergency. CMS indicates teaching physicians may submit claims with the following stipulations:
	
	• Teaching physicians may submit claims for these services furnished by residents in the absence of a teaching physician using **modifier GE**
	  ○ This service has been performed by a resident without the presence of a teaching physician under the primary care exception
	• Residents furnishing services at primary care centers may provide an expanded set of services to beneficiaries, including:
	  ○ Levels 4-5 of an office/outpatient E/M visits (99204-99205, 99214-99215)
	  ○ Telephone E/M (99441-99443)
	  ○ Transitional care management (99495-99496)
	  ○ Some communication technology-based services (99421-99423, 99452, G2010, and G2012)
	
	Medicare Administrative Contractors (MACs) will automatically reprocess claims billed with modifier GE on or after March 1, 2020, that were denied.
	
	https://www.cms.gov/files/document/2020-07-09-mlnc.pdf

CPT LAB CODE UPDATES	The coronavirus 2019 (COVID-19)pandemic continues to progress, the need to be able to *distinguish the tests for influenza A, influenza B, and RSV that include SARS-CoV-2* from those that do not has become apparent. The CPT Editorial Panel (Panel) acknowledged that such codes would represent a fragmentation of an existing service (87631); however, the substantive need created by the unique circumstances of the SARS-CoV-2 pandemic provides justification to create specific codes to designate such respiratory viral panels. The CPT code revisions include range from 87301-87899. The Panel also approved revised guidelines to correct and clarify reporting of infectious agent antigen studies in the Microbiology subsection in the Pathology and Laboratory section of the CPT code set. To address the urgent clinical need to report testing, the Panel expedited the publication of these additional codes to the AMA website on October 6, 2020, at https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance These codes are *effective immediately* (October 6, 2020) for use in reporting these laboratory tests.

MGMA COVID-19 Coding Cheat Sheet (*Updated Dec. 23, 2020*)

RESOURCES

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

https://www.acponline.org/practice-resources/business-resources/covid-19-telehealth-coding-and-billing-practice-management-tips

https://www.ama-assn.org/system/files/2020-04/covid-19-coding-advice.pdf

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

https://www.icd10monitor.com/cms-announces-broadened-coverage-for-essential-diagnostic-testing-amid-covid-19

https://www.ama-assn.org/system/files/2020-10/cpt-assistant-guide-coronavirus-october-2020.pdf

https://www.ama-assn.org/press-center/press-releases/new-cpt-codes-multi-virus-tests-detect-covid-19-and-flu