Medical Management Plus Inc

MAKING HEALTHCARE *make sense*

# COVID-19 RESOURCE GUIDE

## A Repository of Medicare and other Governmental Agencies Regulatory Updates

*Updated June 2, 2020*

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## Foreword

For over thirty years, Medical Management Plus has made it our mission to help healthcare make sense for our clients. As the potential of Coronavirus (COVID-19) has turned into a reality we are being forced as a nation to come to grips with a new "normal" which includes among other things social distancing, proper hand washing, and for hospitals, preparing for and caring for patients presenting with COVID-19.

There is a wealth of information from many sources (i.e. the CMS, CDC and FDA) that has been released about COVID-19. This guidance has been updated and added to often. Finding the time to sort through what is available while carrying out your daily responsibilities can be a challenge. To that end, this Resource Guide is meant to provide you with key information and links to key resources where you can check for ongoing updates. Specifically, this guide primarily provides coding and billing guidance that has been implemented for COVID-19.

The entire staff at MMP appreciates all of the dedicated healthcare workers on the front lines of this pandemic and thanks you for all you do.

Sincerely,
The MMP Team

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## *Symptoms of Coronavirus*

Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness.

### Watch for symptoms

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms or combinations of symptoms may have COVID-19:

- Cough
- Shortness of breath or difficulty breathing
- *Or at least two of these symptoms:*
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning to you.

### When to Seek Medical Attention

If you have any of these emergency warning signs* for COVID-19 get medical attention immediately:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion or inability to arouse
- Bluish lips or face

*This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning to you.

Call 911 if you have a medical emergency: Notify the operator that you have, or think you might have, COVID-19. If possible, put on a cloth face covering before medical help arrives.

Source: CDC website at: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

## *People Who Are at Higher Risk for Severe Illness*

COVID-19 is a new disease and there is limited information regarding risk factors for severe disease. Based on currently available information and clinical expertise, **older adults and people of any age who have serious underlying medical conditions** might be at higher risk for severe illness from COVID-19.

Based on what we know now, those at high-risk for severe illness from COVID-19 are:

- People 65 years and older
- People who live in a nursing home or long-term care facility
- People of all ages with underlying medical conditions, particularly if not well controlled, including:
- People with chronic lung disease or moderate to severe asthma
- People who have serious heart conditions
- People who are immunocompromised
    - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Source: CDC website at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

# *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*

This interim guidance is for clinicians caring for patients with confirmed infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19). CDC will update this interim guidance as more information becomes available.

The National Institutes of Health recently published guidelines on prophylaxis use, testing, and management of COVID-19 patients. For more information, please visit: National Institutes of Health: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines. The recommendations in the guidelines were based on scientific evidence and expert opinion and will be updated as more data becomes available.

## *Clinical Presentation*

### Incubation period

The incubation period for COVID-19 is thought to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset.[1-3] One study reported that 97.5% of persons with COVID-19 who develop symptoms will do so within 11.5 days of SARS-CoV-2 infection.[3]

### Presentation

The signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, most persons with COVID-19 will experience the following[1,4-9]:

- Fever (83–99%)
- Cough (59–82%)
- Fatigue (44–70%)
- Anorexia (40–84%)
- Shortness of breath (31–40%)
- Sputum production (28–33%)
- Myalgia's (11–35%)

Atypical presentations have been described, and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.[10,11] In one study of 1,099 hospitalized patients, fever was present in only 44% at hospital admission but later developed in 89% during hospitalization.[1] Headache, confusion, rhinorrhea, sore throat, hemoptysis, vomiting, and diarrhea have been reported but are less common (<10%).[1,4-6] Some persons with COVID-19 have experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract signs and symptoms.[9] Anosmia or ageusia preceding the onset of respiratory symptoms has been anecdotally reported[12], but more information is needed to understand its role in identifying COVID-19.

Several studies have reported that the signs and symptoms of COVID-19 in children are similar to adults and are usually milder compared to adults.[13-17] For more information on the

clinical presentation and course among children, see Information for Pediatric Healthcare Providers.

**Asymptomatic and Pre-Symptomatic Infection**

Several studies have documented SARS-CoV-2 infection in patients who never develop symptoms (asymptomatic) and in patients not yet symptomatic (pre-symptomatic).[14,16,18-28] Since asymptomatic persons are not routinely tested, the prevalence of asymptomatic infection and detection of pre-symptomatic infection is not well understood. One study found that as many as 13% of RT-PCR-confirmed cases of SARS-CoV-2 infection in children were asymptomatic.[14] Another study of skilled nursing facility residents infected with SARS-CoV-2 from a healthcare worker demonstrated that half were asymptomatic or pre-symptomatic at the time of contact tracing evaluation and testing.[26] Patients may have abnormalities on chest imaging before the onset of symptoms.[20,21] Some data suggest that pre-symptomatic infection tended to be detected in younger individuals and was less likely to be associated with viral pneumonia.[20,21]

**Asymptomatic and Pre-Symptomatic Transmission**

Epidemiologic studies have documented SARS-CoV-2 transmission during the pre-symptomatic incubation period[20,29-31], and asymptomatic transmission has been suggested in other reports.[22,23,32] Virologic studies have also detected SARS-CoV-2 with RT-PCR low cycle thresholds, indicating larger quantities of viral RNA, and cultured viable virus among persons with asymptomatic and pre-symptomatic SARS-CoV-2 infection.[19,24,26,33] The exact degree of SARS-CoV-2 viral RNA shedding that confers risk of transmission is not yet clear. Risk of transmission is thought to be greatest when patients are symptomatic since viral shedding is greatest at the time of symptom onset and declines over the course of several days to weeks.[33-36] However, the proportion of SARS-CoV-2 transmission in the population due to asymptomatic or pre-symptomatic infection compared to symptomatic infection is unclear.[37]

### *Clinical Course*

**Illness Severity**

The largest cohort of >44,000 persons with COVID-19 from China showed that illness severity can range from mild to critical[38]:

- Mild to moderate (mild symptoms up to mild pneumonia): 81%
- Severe (dyspnea, hypoxia, or >50% lung involvement on imaging): 14%
- Critical (respiratory failure, shock, or multiorgan system dysfunction): 5%

In this study, all deaths occurred among patients with critical illness and the overall case fatality rate was 2.3%.[38] The case fatality rate among patients with critical disease was 49%.[38] Among children in China, illness severity was lower with 94% having asymptomatic, mild or moderate disease, 5% having severe disease, and <1% having critical disease.[14] Among U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 19%.[39] The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 6%.[39]

**Clinical Progression**

Among patients who developed severe disease, the medium time to dyspnea ranged from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and the median time to ICU admission ranged from 10 to 12 days.[5,6,10,11] Clinicians should be aware of the potential for some patients to rapidly deteriorate one week after illness onset. Among all hospitalized patients, a range of 26% to 32% of patients were admitted to the ICU.[6,8,11] Among all patients, a range of 3% to 17% developed ARDS compared to a range of 20% to 42% for hospitalized patients and 67% to 85% for patients admitted to the ICU.[1,4-6,8,11] Mortality among patients admitted to the ICU ranges from 39% to 72% depending on the study.[5,8,10,11] The median length of hospitalization among survivors was 10 to 13 days.[1,6,8]

**Risk Factors for Severe Illness**

Age is a strong risk factor for severe illness, complications, and death.[1,6,8,10,11,38-41] Among more than 44,000 confirmed cases of COVID-19 in China, the case fatality rate was highest among older persons: ≥80 years: 14.8%, 70–79 years: 8.0%, 60–69 years: 3.6%, 50–59 years: 1.3%, 40–49 years: 0.4%, <40 years: 0.2%.[38,42] Early U.S. epidemiologic data suggests that the case fatality was highest in persons aged ≥85 years (range 10%–27%), followed by 3%–11% for ages 65–84 years, 1%–3% for ages 55–64 years, and <1% for ages 0–54 years.[39]

Patients in China with no reported underlying medical conditions had an overall case fatality of 0.9%, but case fatality was higher for patients with comorbidities: 10.5% for those with cardiovascular disease, 7.3% for diabetes, and approximately 6% each for chronic respiratory disease, hypertension, and cancer.[42] Heart disease, hypertension, prior stroke, diabetes, chronic lung disease, and chronic kidney disease have all been associated with increased illness severity and adverse outcomes.[1,6,10,11,38,42,43] Accounting for differences in age and prevalence of underlying condition, mortality associated with COVID-19 in the United States was similar to China.[39,40,44]

**Medications**

It has been hypothesized that angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) may increase the risk of SARS-CoV-2 infection and COVID-19 severity.[45] ACE inhibitors and ARBs increase the expression of angiotensin-converting enzyme 2 (ACE2). SARS-CoV-2 uses the ACE2 receptor to enter into the host cell. There are no data to suggest a link between ACE inhibitors or ARBs with worse COVID-19 outcomes. The American Heart Association (AHA), the Heart Failure Society of America (HFSA), and the American College of Cardiology (ACC) released a statement recommending continuation of these drugs for patients already receiving them for heart failure, hypertension, or ischemic heart disease.[46]

It has also been hypothesized that non-steroidal anti-inflammatory drugs (NSAIDs) may worsen COVID-19. Currently, there are no data suggesting an association between COVID-19 clinical outcomes and NSAID use. More information can be found at Healthcare Professionals: Frequently Asked Questions and Answers.

**Reinfection**

There are no data concerning the possibility of re-infection with SARS-CoV-2 after recovery from COVID-19. Viral RNA shedding declines with resolution of symptoms, and may continue for days to weeks.[11,33,34] However, the detection of RNA during convalescence does not necessarily indicate the

presence of viable infectious virus. Clinical recovery has been correlated with the detection of IgM and IgG antibodies which signal the development of immunity.[36,47-49]

**Diagnostic Testing**

Diagnosis of COVID-19 requires detection of SARS-CoV-2 RNA by reverse transcription polymerase chain reaction (RT-PCR). Detection of SARS-CoV-2 viral RNA is better in nasopharynx samples compared to throat samples.[33,50] Lower respiratory samples may have better yield than upper respiratory samples.[33,50]. SARS-CoV-2 RNA has also been detected in stool and blood.[13,34,47,51] Detection of SARS-CoV-2 RNA in blood may be a marker of severe illness.[52] Viral RNA shedding may persist over longer periods among older persons and those who had severe illness requiring hospitalization. (median range of viral shedding among hospitalized patients 12–20 days).[11,33-36]

Infection with both SARS-CoV-2 and with other respiratory viruses has been reported, and detection of another respiratory pathogen does not rule out COVID-19.[53]

For more information about testing and specimen collection, handling and storage, visit Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) and Frequently Asked Questions on COVID-19 Testing at Laboratories.

### *Laboratory and Radiographic Findings*

**Laboratory Findings**

Lymphopenia is the most common lab finding in COVID-19 and is found in as many as 83% of hospitalized patients.[1,5] Lymphopenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated with greater illness severity.[1,5,6,8,11,54] Elevated D-dimer and lymphopenia have been associated with mortality.[8,11] Procalcitonin is typically normal on admission, but may increase among those admitted to the ICU.[4-6] Patients with critical illness had high plasma levels of inflammatory makers, suggesting potential immune dysregulation.[5,55]

**Radiographic Findings**

Chest radiographs of patients with COVID-19 typically demonstrate bilateral air-space consolidation, though patients may have unremarkable chest radiographs early in the disease.[1,5,56] Chest CT images from patients with COVID-19 typically demonstrate bilateral, peripheral ground glass opacities.[4,8,38,56-65] Because this chest CT imaging pattern is non-specific and overlaps with other infections, the diagnostic value of chest CT imaging for COVID-19 may be low and dependent upon interpretations from individual radiologists.[57,66] One study found that 56% of patients who presented within 2 days of diagnosis had a normal CT[58]. Conversely, other studies have also identified chest CT abnormalities in patients prior to the detection of SARS-CoV-2 RNA.[56,67] Given the variability in chest imaging findings, chest radiograph or CT alone is not recommended for the diagnosis of COVID-19. The American College of Radiology also does not recommend CT for screening or as a first-line test for diagnosis of COVID-19. (See American College of Radiology Recommendations).

### *Clinical Management and Treatment*

**Mild to Moderate Disease**

Patients with a mild clinical presentation (absence of viral pneumonia and hypoxia) may not initially require hospitalization, and many patients will be able to manage their illness at home. The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and the ability of the patient to self-isolate at home. Patients with risk factors for severe illness (see People Who Are at Higher Risk for Severe Illness) should be monitored closely given the possible risk of progression to severe illness in the second week after symptom onset.[5,6,10,11]

For information regarding infection prevention and control recommendations, please see Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings.

**Severe Disease**

Some patients with COVID-19 will have severe disease requiring hospitalization for management. No specific treatment for COVID-19 is currently FDA approved. Corticosteroids have been widely used in hospitalized patients with severe illness in China[6,8,10,11]; however, the benefit of corticosteroid use cannot be determined based upon uncontrolled observational data. By contrast, patients with MERS-CoV or influenza who were given corticosteroids were more likely to have prolonged viral replication, receive mechanical ventilation, and have higher mortality.[68-72] Therefore, corticosteroids should be avoided unless indicated for other reasons, such as management of chronic obstructive pulmonary disease exacerbation or septic shock. More information can be found at Healthcare Professionals: Frequently Asked Questions and Answers.

Inpatient management revolves around the supportive management of the most common complications of severe COVID-19: pneumonia, hypoxemic respiratory failure/ARDS, sepsis and septic shock, cardiomyopathy and arrhythmia, acute kidney injury, and complications from prolonged hospitalization including secondary bacterial infections, thromboembolism, gastrointestinal bleeding, and critical illness polyneuropathy/myopathy.[1,4-6,10,11,38,73-76]

The Infectious Diseases Society of America has released guidelines on the treatment and management of patients with COVID-19. For more information, please visit: Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19 Infection.

The World Health Organization and the Surviving Sepsis Campaign have both released comprehensive guidelines for the inpatient management of patients with COVID-19, including those who are critically ill. For more information visit: Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected (WHO) and Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19)pdf .

For more information on the management of children, see Information for Pediatric Healthcare Providers and the Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children.

**Investigational Therapeutics**

No FDA-approved drugs have demonstrated safety and efficacy in randomized controlled trials for patients with COVID-19. Use of investigational therapies for treatment of COVID-19 should ideally be done in the context of enrollment in randomized controlled trials. Several clinical trials are underway testing multiple drugs with in-vitro antiviral activity against SARS-CoV-2 and/or immunomodulatory effects that may have clinical benefit. For the latest information, see Information for Clinicians on Therapeutic Options for COVID-19 Patients. For the information on registered trials in the U.S., see ClinicalTrials.gov.

**Discontinuation of Transmission-Based Precautions or Home Isolation**

Patients who have clinically recovered and are able to discharge from the hospital but who have not been cleared from their Transmission-Based Precautions may continue isolation at their place of residence until cleared. For recommendations on discontinuation of Transmission-Based Precautions or home isolation for patients who have recovered from COVID-19 illness, please see: Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19, Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19, and Discontinuation of In-Home Isolation for Immunocompromised Persons with COVID-19.

**Additional resources:**

- Information for Pediatric Healthcare Providers
- Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)
- Frequently Asked Questions on COVID-19 Testing at Laboratories
- Healthcare Professionals: Frequently Asked Questions and Answers
- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) or in Healthcare Settings
- World Health Organization. Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected
- Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19)
- Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016
- Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children
- Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America
- ACR Recommendations for the use of Chest Radiography and Computed Tomography (CT) for Suspected COVID-19 Infection

- Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19 Infection
- National Institutes of Health: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines

## References


1. Guan WJ, Ni ZY, Hu Y, et al. Clinical Characteristics of Coronavirus Disease 2019 in China. *The New England journal of medicine*. 2020.
2. Li Q, Guan X, Wu P, et al. Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus-Infected Pneumonia. *The New England journal of medicine*. 2020.
3. Lauer SA, Grantz KH, Bi Q, et al. The Incubation Period of Coronavirus Disease 2019 (COVID-19) From Publicly Reported Confirmed Cases: Estimation and Application. *Annals of internal medicine*. 2020.
4. Chen N, Zhou M, Dong X, et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. *Lancet (London, England)*. 2020;395(10223):507-513.
5. Huang C, Wang Y, Li X, et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. *Lancet (London, England)*. 2020;395(10223):497-506.
6. Wang D, Hu B, Hu C, et al. Clinical Characteristics of 138 Hospitalized Patients With 2019 Novel Coronavirus-Infected Pneumonia in Wuhan, China. *Jama*. 2020.
7. Xu XW, Wu XX, Jiang XG, et al. Clinical findings in a group of patients infected with the 2019 novel coronavirus (SARS-Cov-2) outside of Wuhan, China: retrospective case series. *BMJ (Clinical research ed)*. 2020;368:m606.
8. Wu C, Chen X, Cai Y, et al. Risk Factors Associated With Acute Respiratory Distress Syndrome and Death in Patients With Coronavirus Disease 2019 Pneumonia in Wuhan, China. *JAMA Intern Med*. 2020.
9. Pan L, Mu M, Ren HG, et al. Clinical characteristics of COVID-19 patients with digestive symptoms in Hubei, China: a descriptive, cross-sectional, multicenter study. *Am J Gastroenterol*. 2020;[Epub ahead of print].
10. Yang X, Yu Y, Xu J, et al. Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study. *The Lancet Respiratory medicine*. 2020.
11. Zhou F, Yu T, Du R, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. *Lancet (London, England)*. 2020.
12. Giacomelli A, Pezzati L, Conti F, et al. Self-reported olfactory and taste disorders in SARS-CoV-2 patients: a cross-sectional study. *Clinical Infectious Diseases*. 2020.
13. Cai J, Xu J, Lin D, et al. A Case Series of children with 2019 novel coronavirus infection: clinical and epidemiological features. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2020.
14. Dong Y, Mo X, Hu Y, et al. Epidemiological Characteristics of 2143 Pediatric Patients With 2019 Coronavirus Disease in China. *Pediatrics*. 2020.
15. Liu W, Zhang Q, Chen J, et al. Detection of Covid-19 in Children in Early January 2020 in Wuhan, China. *The New England journal of medicine*. 2020.
16. Lu X, Zhang L, Du H, et al. SARS-CoV-2 Infection in Children. *The New England journal of medicine*. 2020.
17. Wei M, Yuan J, Liu Y, Fu T, Yu X, Zhang ZJ. Novel Coronavirus Infection in Hospitalized Infants Under 1 Year of Age in China. *Jama*. 2020.

18. Chan JF, Yuan S, Kok KH, et al. A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster. *Lancet (London, England)*. 2020;395(10223):514-523.
19. Hoehl S, Berger A, Kortenbusch M, et al. Evidence of SARS-CoV-2 Infection in Returning Travelers from Wuhan, China. *The New England journal of medicine*. 2020.
20. Hu Z, Song C, Xu C, et al. Clinical characteristics of 24 asymptomatic infections with COVID-19 screened among close contacts in Nanjing, China. *Science China Life sciences*. 2020.
21. Wang Y, Liu Y, Liu L, Wang X, Luo N, Ling L. Clinical outcome of 55 asymptomatic cases at the time of hospital admission infected with SARS-Coronavirus-2 in Shenzhen, China. *The Journal of infectious diseases*. 2020.
22. Pan X, Chen D, Xia Y, et al. Asymptomatic cases in a family cluster with SARS-CoV-2 infection. *The Lancet Infectious diseases*. 2020.
23. Bai Y, Yao L, Wei T, et al. Presumed Asymptomatic Carrier Transmission of COVID-19. *Jama*. 2020.
24. Kam KQ, Yung CF, Cui L, et al. A Well Infant with Coronavirus Disease 2019 (COVID-19) with High Viral Load. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2020.
25. McMichael TM CS, Pogosjans S, et al. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020. *MMWR Morbidity and mortality weekly report*. 2020;69:339-342.
26. Kimball A HK, Arons M, et al. Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020. *MMWR Morbidity and mortality weekly report*. 2020;ePub: 27 March 2020.
27. Roxby AC GA, Hatfield KM, et al. Detection of SARS-CoV-2 Among Residents and Staff Members of an Independent and Assisted Living Community for Older Adults — Seattle, Washington, 2020. *MMWR Morbidity and mortality weekly report*. 2020;ePub: 3 April 2020.
28. Mizumoto K, Kagaya K, Zarebski A, Chowell G. Estimating the asymptomatic proportion of coronavirus disease 2019 (COVID-19) cases on board the Diamond Princess cruise ship, Yokohama, Japan, 2020. *Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin*. 2020;25(10).
29. Wei WE LZ, Chiew CJ, Yong SE, Toh MP, Lee VJ. Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020. *MMWR Morbidity and mortality weekly report*. 2020;ePub: 1 April 2020.
30. Tong ZD, Tang A, Li KF, et al. Potential Presymptomatic Transmission of SARS-CoV-2, Zhejiang Province, China, 2020. *Emerging infectious diseases*. 2020;26(5).
31. Qian G, Yang N, Ma AHY, et al. A COVID-19 Transmission within a family cluster by presymptomatic infectors in China. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2020.
32. Rothe C, Schunk M, Sothmann P, et al. Transmission of 2019-nCoV Infection from an Asymptomatic Contact in Germany. *The New England journal of medicine*. 2020;382(10):970-971.
33. Zou L, Ruan F, Huang M, et al. SARS-CoV-2 Viral Load in Upper Respiratory Specimens of Infected Patients. *The New England journal of medicine*. 2020;382(12):1177-1179.
34. Young BE, Ong SWX, Kalimuddin S, et al. Epidemiologic Features and Clinical Course of Patients Infected With SARS-CoV-2 in Singapore. *Jama*. 2020.
35. Liu Y, Yan LM, Wan L, et al. Viral dynamics in mild and severe cases of COVID-19. *The Lancet Infectious diseases*. 2020.
36. To KK-W, Tsang OT-Y, Leung W-S, et al. Temporal profiles of viral load in posterior oropharyngeal saliva samples and serum antibody responses during infection by SARS-CoV-2: an observational cohort study. *The Lancet Infectious Diseases*. 2020.

37. Li R, Pei S, Chen B, et al. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SARS-CoV2). *Science (New York, NY)*. 2020.
38. Wu Z, McGoogan JM. Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72314 Cases From the Chinese Center for Disease Control and Prevention. *Jama*. 2020.
39. CDC COVID-19 Response Team. Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020. *MMWR Morbidity and mortality weekly report*. 2020.
40. Arentz M, Yim E, Klaff L, et al. Characteristics and Outcomes of 21 Critically Ill Patients With COVID-19 in Washington State. *Jama*. 2020.
41. Livingston E, Bucher K. Coronavirus Disease 2019 (COVID-19) in Italy. *Jama*. 2020.
42. Novel Coronavirus Pneumonia Emergency Response Epidemiology T. [The epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19) in China]. *Zhonghua Liu Xing Bing Xue Za Zhi*. 2020;41(2):145-151.
43. CDC COVID-19 Response Team. Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 — United States, February 12–March 28, 2020. *MMWR Morbidity and mortality weekly report*. 2020;ePub: 31 March 2020.
44. McMichael TM CS, Pogosjans S, et al. COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020. *MMWR Morbidity and mortality weekly report*. 2020.
45. Fang L, Karakiulakis G, Roth M. Are patients with hypertension and diabetes mellitus at increased risk for COVID-19 infection? *The Lancet Respiratory Medicine*. 2020.
46. HFSA/ACC/AHA. Using RAAS Antagonists in COVID-19. 2020; https://www.acc.org/latest-in-cardiology/articles/2020/03/17/08/59/hfsa-acc-aha-statement-addresses-concerns-re-using-raas-antagonists-in-covid-19. Accessed March 18, 2020.
47. Zhang W, Du RH, Li B, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. *Emerging microbes & infections*. 2020;9(1):386-389.
48. Zhao J, Yuan Q, Wang H, et al. Antibody responses to SARS-CoV-2 in patients of novel coronavirus disease 2019. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2020.
49. Guo L, Ren L, Yang S, et al. Profiling Early Humoral Response to Diagnose Novel Coronavirus Disease (COVID-19). *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2020.
50. Wang W, Xu Y, Gao R, et al. Detection of SARS-CoV-2 in Different Types of Clinical Specimens. *Jama*. 2020.
51. Wu Y, Guo C, Tang L, et al. Prolonged presence of SARS-CoV-2 viral RNA in faecal samples. *The Lancet Gastroenterology & Hepatology*. 2020.
52. Chen W, Lan Y, Yuan X, et al. Detectable 2019-nCoV viral RNA in blood is a strong indicator for the further clinical severity. *Emerging microbes & infections*. 2020;9(1):469-473.
53. Ding Q, Lu P, Fan Y, Xia Y, Liu M. The clinical characteristics of pneumonia patients co-infected with 2019 novel coronavirus and influenza virus in Wuhan, China. *Journal of medical virology*. 2020.
54. Zhang C, Shi L, Wang FS. Liver injury in COVID-19: management and challenges. *Lancet Gastroenterol Hepatol*. 2020.
55. Qin C, Zhou L, Hu Z, et al. Dysregulation of immune response in patients with COVID-19 in Wuhan, China. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2020.
56. Shi H, Han X, Jiang N, et al. Radiological findings from 81 patients with COVID-19 pneumonia in Wuhan, China: a descriptive study. *The Lancet Infectious diseases*. 2020.
57. Ai T, Yang Z, Hou H, et al. Correlation of Chest CT and RT-PCR Testing in Coronavirus Disease 2019 (COVID-19) in China: A Report of 1014 Cases. *Radiology*. 2020:200642.

58. Bernheim A, Mei X, Huang M, et al. Chest CT Findings in Coronavirus Disease-19 (COVID-19): Relationship to Duration of Infection. *Radiology*. 2020:200463.
59. Lei J, Li J, Li X, Qi X. CT Imaging of the 2019 Novel Coronavirus (2019-nCoV) Pneumonia. *Radiology*. 2020;295(1):18.
60. Shi H, Han X, Zheng C. Evolution of CT Manifestations in a Patient Recovered from 2019 Novel Coronavirus (2019-nCoV) Pneumonia in Wuhan, China. *Radiology*. 2020;295(1):20.
61. Wang Y, Dong C, Hu Y, et al. Temporal Changes of CT Findings in 90 Patients with COVID-19 Pneumonia: A Longitudinal Study. *Radiology*. 2020:200843.
62. Xu X, Yu C, Qu J, et al. Imaging and clinical features of patients with 2019 novel coronavirus SARS-CoV-2. *European journal of nuclear medicine and molecular imaging*. 2020.
63. Yang W, Cao Q, Qin L, et al. Clinical characteristics and imaging manifestations of the 2019 novel coronavirus disease (COVID-19):A multi-center study in Wenzhou city, Zhejiang, China. *The Journal of infection*. 2020.
64. Zhao W, Zhong Z, Xie X, Yu Q, Liu J. Relation Between Chest CT Findings and Clinical Conditions of Coronavirus Disease (COVID-19) Pneumonia: A Multicenter Study. *AJR American journal of roentgenology*. 2020:1-6.
65. Pan F, Ye T, Sun P, et al. Time Course of Lung Changes On Chest CT During Recovery From 2019 Novel Coronavirus (COVID-19) Pneumonia. *Radiology*. 2020:200370.
66. Bai HX, Hsieh B, Xiong Z, et al. Performance of radiologists in differentiating COVID-19 from viral pneumonia on chest CT. *Radiology*. 2020:200823.
67. Xie X, Zhong Z, Zhao W, Zheng C, Wang F, Liu J. Chest CT for Typical 2019-nCoV Pneumonia: Relationship to Negative RT-PCR Testing. *Radiology*. 2020:200343.
68. Zumla A, Hui DS, Perlman S. Middle East respiratory syndrome. *Lancet (London, England)*. 2015;386(9997):995-1007.
69. Arabi YM, Mandourah Y, Al-Hameed F, et al. Corticosteroid Therapy for Critically Ill Patients with Middle East Respiratory Syndrome. *American journal of respiratory and critical care medicine*. 2018;197(6):757-767.
70. Russell CD, Millar JE, Baillie JK. Clinical evidence does not support corticosteroid treatment for 2019-nCoV lung injury. *Lancet (London, England)*. 2020;395(10223):473-475.
71. Corman VM, Albarrak AM, Omrani AS, et al. Viral Shedding and Antibody Response in 37 Patients With Middle East Respiratory Syndrome Coronavirus Infection. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2016;62(4):477-483.
72. Rodrigo C, Leonardi-Bee J, Nguyen-Van-Tam JS, Lim WS. Effect of corticosteroid therapy on influenza-related mortality: a systematic review and meta-analysis. *The Journal of infectious diseases*. 2015;212(2):183-194.
73. Guo T, Fan Y, Chen M, et al. Cardiovascular Implications of Fatal Outcomes of Patients With Coronavirus Disease 2019 (COVID-19). *JAMA Cardiology*. 2020.
74. Inciardi RM, Lupi L, Zaccone G, et al. Cardiac Involvement in a Patient With Coronavirus Disease 2019 (COVID-19). *JAMA Cardiology*. 2020.
75. Shi S, Qin M, Shen B, et al. Association of Cardiac Injury With Mortality in Hospitalized Patients With COVID-19 in Wuhan, China. *JAMA Cardiology*. 2020.
76. Tang N, Bai H, Chen X, Gong J, Li D, Sun Z. Anticoagulant treatment is associated with decreased mortality in severe coronavirus disease 2019 patients with coagulopathy. *Journal of thrombosis and haemostasis : JTH*. 2020.

Page last reviewed: April 6, 2020
Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

Link to page on CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

## *COVID-19: Timeline to a New Code*

The CDC announced the release of a new code specifically for reporting COVID-19 during the March 18th ICD-10-CM Coordination and Maintenance Committee Meeting. This codes will be available for use on April 1st, 2020. Following is a timeline of events prompting the speed with which this code is being made available for use:

- January 30, 2020: The World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern.

- January 31, 2020: Emergency meeting convened by WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC). A new ICD-10 emergency code was established by the WHO.
    - U07.1 – 2019-nCoV acute respiratory disease

- February 11, 2020: During the January 31st meeting, the team noted "2019-nCoV" was a temporary name and likely to change. On February 11th the WHO announced the official name of the virus: COVID-19.

- March 11, 2020: The Novel Coronavirus Disease, COVID-19, was declared a pandemic by the World Health Organization (WHO).

- March 13, 2020: A National Emergency was declared in the United States concerning the COVID-19 Outbreak.

- March 18, 2020: The Coordination and Maintenance Committee Meeting met virtually. It was announced that the COVID-19 code effective date was changed from October 1, 2020 to April 1, 2020 due to the national health emergency. The code that will be effective is U07.1.

# *CDC ICD-10-CM Official Coding Guidelines – Supplement*

**Coding encounters related to COVID-19 Coronavirus Outbreak**
**Effective: February 20, 2020**

**Introduction**
The purpose of this document is to provide official diagnosis coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV.

The COVID-19 caused an outbreak of respiratory illness, and was first identified in 2019 in Wuhan, Hubei Province, China. Since then, thousands of cases have been confirmed in China, and COVID-19 has also spread internationally, including in the United States. Investigations are ongoing. The most recent situation updates are available from the CDC web page, About 2019 Novel Coronavirus (COVID-19).
https://www.cdc.gov/coronavirus/2019-ncov/index.html

The confirmed COVID-19 infections can cause a range of illness, from little to no symptoms, to those affected being severely ill and even dying. Symptoms can include fever, cough, and shortness of breath. Symptoms may appear from 2 to 14 days after exposure, based on the incubation period for other coronaviruses, such as the MERS (Middle East Respiratory Syndrome) viruses. https://www.cdc.gov/coronavirus/2019-ncov/about/symptoms.html

This guidance is intended to be used in conjunction with the current ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting (effective October 1, 2019) and will be updated to reflect new clinical information as it becomes available. https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.

The ICD-10-CM codes provided in this document are intended to provide information on the coding of encounters related to coronavirus. Other codes for conditions unrelated to coronavirus may be required to fully code these scenarios in accordance with the *ICD-10-CM Official Guidelines for Coding and Reporting*. A hyphen is used at the end of a code to indicate that additional characters are required.

**General Guidance**
Pneumonia
For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Acute Bronchitis
For a patient with acute bronchitis confirmed as due to COVID-19, assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29, Other coronavirus as the cause of diseases classified elsewhere. Bronchitis not otherwise specified (NOS) due to the COVID-19

should be coded using code J40, Bronchitis, not specified as acute or chronic; along with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

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, with code B97.29, Other coronavirus as the cause ofdiseases classified elsewhere. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be appropriate to assign code J98.8, Other specified respiratory disorders, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.
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. https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

Cases with ARDS due to COVID-19 should be assigned the codes J80, Acute respiratory distress syndrome, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

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 Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

**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 such as:

- R05 Cough
- R06.02 Shortness of breath
- R50.9 Fever, unspecified

Note: 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).

This coding guidance has been developed by CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

Reference:
COVID-10 clinical presentation:
https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Link to pdf document:
https://www.cdc.gov/nchs/data/icd/interim-coding-advice-coronavirus-March-2020-final.pdf

## *New ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19), April 1, 2020*

Effective: March 18, 2020

**On March 11, 2020 the Novel Coronavirus Disease, COVID-19, was declared a pandemic by the World Health Organization. On March 13, 2020 a national emergency was declared in the United States concerning the COVID-19 Outbreak.**

**Given these developments, and the urgent need to capture the reporting of this condition in our nation's claims and surveillance data, the Centers for Disease Control (CDC), under the National Emergencies Act Section 201 and 301, is announcing a change in the effective date of new diagnosis code U07.1, COVID-19, from October 1, 2020 to April 1, 2020. This off-cycle update is unprecedented and is an exception to the code set updating process established under HIPAA.**

On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern.

As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus. A new International Classification of Diseases, Tenth Revision (ICD-10) emergency code (U07.1, 2019-nCoVacute respiratory disease)has been established by WHO.

At that time, the WHO Classification Team had noted that the virus name '2019-nCoV' was temporary and is likely to change (to be independent of date and virus family, and for consistency with international virus taxonomy). Note: On February 11, 2020 the WHO announced the official name of the virus: COVID-19.

Consistent with this WHO update to the ICD-10, the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) will implement a new diagnosis code into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting, effective with the next update, October 1, 2020. Full addenda information regarding the new code and the final title will be presented at the March 2020

ICD10 Coordination and Maintenance Committee meeting. ICD-10-CM interim coding guidance can be found at: (https://www.cdc.gov/nchs/icd/icd10cm.htm)

For more information about the 2019 Novel Coronavirus (COVID-19) please visit the CDC and WHO websites, respectively:
https://www.cdc.gov/coronavirus/index.htmlhttps://www.who.int/health-topics/coronavirus

Link to pdf document: https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-3-18-2020.pdf

## *ICD-10-CM Tabular List of Diseases and Injuries*
## *April 1, 2020 Addenda*

B34 Viral infection of unspecified site
B34.2 Coronavirus infection, unspecified
Add Excludes1: COVID-19 (U07.1)
pneumonia due to SARS-associated coronavirus (J12.81)

New chapter Chapter 22
Add Codes for special purposes (U00-U85)
New section Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)
New category U07 Emergency use of U07
New code U07.0 Vaping-related disorder
Add Dabbing related lung damage
Add Dabbing related lung injury
Add E-cigarette, or vaping, product use associated lung injury [EVALI]
Add Electronic cigarette related lung damage
Add Electronic cigarette related lung injury
Add Use additional code, to identify manifestations, such as:
Add abdominal pain (R10.84)
Add acute respiratory distress syndrome (J80)
Add diarrhea (R19.7)
Add drug-induced interstitial lung disorder (J70.4)
Add lipoid pneumonia (J69.1)
Add weight loss (R63.4)

New code U07.1 COVID-19
Add Use additional code to identify pneumonia or other manifestations
Add Excludes1: Coronavirus infection, unspecified (B34.2)
Add Coronavirus as the cause of diseases classified elsewhere (B97.2-)
Add Pneumonia due to SARS-associated coronavirus (J12.81)
Add Coronavirus (infection)
Add - as cause of diseases classified elsewhere B97.29
Add - coronavirus-19 U07.1Add- COVID-19 U07.1
Add - SARS-associated B97.21

Damage
Add - lung
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0

| | |
|---|---|
| Add | - - vaping (associated) (device) (product) (use) U07.0 |
| Add | - organ |
| Add | - - dabbing (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |
| | |
| | Disease, diseased - see also Syndrome |
| Add | -COVID-19 U07.1 |
| | - lung |
| Add | - - dabbing (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |
| Add | - organ |
| Add | - - dabbing (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |
| | |
| | Disorder |
| | - lung, interstitial, drug-induced J70.4 |
| Add | - - dabbing (related) U07.0 |
| Add | - - e -cigarette (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) (related) U07.0 |
| | |
| | Infection, infected, infective (opportunistic) B99.9 |
| Add | - coronavirus-2019 U07.1 |
| | - coronavirus NEC B34.2 |
| | - - as cause of disease classified elsewhere B97.29 |
| | - - severe acute respiratory syndrome (SARS associated) B97.21 |
| Add | - COVID-19 U07.1 |
| | - virus, viral NOS B34.9 |
| Add | - - COVID-19 U07.1 |
| | |
| | Injury |
| Add | - lung Add- - dabbing (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - EVALI - [e-cigarette, or vaping, product use assoc'd] U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |

Link to pdf document: https://www.cdc.gov/nchs/data/icd/ICD-10-CM-April-1-2020-addenda.pdf

# *ICD-10-CM Official Coding and Reporting GuidelinesApril 1, 2020 through September 30, 2020*

1. Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

**g. Coronavirus Infections**

**1) COVID-19 Infections (Infections due to SARS-CoV-2)**

**a) Code only confirmed cases**

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.

Presumptive positive COVID-19 test results should be coded as confirmed. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC). CDC confirmation of local and state tests for COVID-19 is no longer required.

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) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

**b) Sequencing of codes**

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients as indicated in Section . I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium.

*For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock*

*See Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium*

**c) Acute respiratory illness due to COVID-19**

**(i) Pneumonia**

For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes U07.1, COVID-19, and J12.89, Other viral pneumonia.

**(ii) Acute bronchitis**

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. Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.

**(iii) 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, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned. If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.

(iv) Acute respiratory distress **syndrome**

For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

**d) 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 an 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. If the exposed individual tests positive for the COVID-19 virus, see guideline a).

**e) Screening for COVID-19**

For asymptomatic individuals w ho are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, Encounter for screening for other viral diseases. For individuals who are being screened due to a possible or actual exposure to COVID-19, see guideline d).

If an asymptomatic individual is screened for COVID-19 and tests positive, see guideline g).

**f) Signs and symptoms without definitive diagnosis of COVID-19**

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, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code. This is an exception to guideline I.C.21.c.1, Contact/Exposure.

**g) Asymptomatic individuals who test positive for COVID-19**

For asymptomatic individuals who test positive for COVID-19, assign code U07.1, COVID-19. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

**15. Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)**

**s) COVID-19 infection in pregnancy, childbirth, and the puerperium**

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of COVID-19 should receive a principal diagnosis code of O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, followed by code U07.1, COVID-19, and the appropriate codes for associated manifestation(s). Codes from Chapter 15 always take sequencing priority.

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

# *ICD-10-CM Official Coding Guidelines – Supplement Coding encounters related to E-cigarette, or Vaping, Product Use*

Post Date: October 17, 2019

**Introduction**

The purpose of this document is to provide official diagnosis coding guidance for healthcare encounters related to the 2019 health care encounters and deaths related to e-cigarette, or vaping, product use associated lung injury (EVALI). This guidance is consistent with current clinical knowledge about e-cigarette, or vaping, related disorders.

As necessary, this guidance will be updated as new clinical information becomes available. The clinical scenarios described below are not exhaustive and may not represent all possible reasons for health care encounters that may be related to e-cigarette, or vaping, product use. Proposals for new codes that are intended to address additional detail regarding use of e-cigarette, or vaping, products will be presented at the March 2020 ICD-10 Coordination and Maintenance Committee Meeting.

This guidance is intended to be used in conjunction with current ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting (effective October 1, 2019). https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf. The ICD-10-CM codes provided in the clinical scenarios below are intended to provide e-cigarette, or vaping, product use coding guidance only. Other codes for conditions unrelated to e-cigarette, or vaping products maybe required to fully code these scenarios in accordance with the ICD-10-CM Official Guidelines for Coding and Reporting. A hyphen is used at the end of a code to indicate that additional characters are required.

**General Guidance**

**Lung-related complications**

For patients documented with electronic cigarette (e-cigarette), or vaping, product use associated lung injury (EVALI), assign the code for the specific condition, such as:

- J68.0, Bronchitis and pneumonitis due to chemicals, gases, fumes and vapors; includes chemical pneumonitis
- J69.1, Pneumonitis due to inhalation of oils and essences; includes lipoid pneumonia
- J80, Acute respiratory distress syndrome
- J82, Pulmonary eosinophilia, not elsewhere classified
- J84.114, Acute interstitial pneumonitis
- J84.89, Other specified interstitial pulmonary disease

For patients with acute lung injury but without further documentation identifying a specific condition (pneumonitis, bronchitis), assign code:

- J68.9, Unspecified respiratory condition due to chemicals, gases, fumes, and vapors

**Poisoning and toxicity**

Acute nicotine exposure can be toxic. Children and adults have been poisoned by swallowing, breathing, or absorbing e-cigarette liquid through their skin or eyes. For these patients assign code:

- T65.291-, Toxic effect of other nicotine and tobacco, accidental (unintentional); includes Toxic effect of other tobacco and nicotine NOS.

For a patient with acute tetrahydrocannabinol (THC) toxicity, assign code:

- T40.7X1- Poisoning by cannabis (derivatives), accidental (unintentional).

**Substance use, abuse, and dependence**

For patients with documented substance use/abuse/dependence, additional codes identifying the substance(s) used should be assigned.

When the provider documentation refers to use, abuse and dependence of the same substance (e.g. nicotine, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence.

Assign as many codes, as appropriate. Examples:

Cannabis related disorders: F12.---

Nicotine related disorders: F17.----

Specifically, for vaping of nicotine, assign code:

- F17.29-, Nicotine dependence, other tobacco products. Electronic nicotine delivery systems (ENDS) are non-combustible tobacco products.

**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 such as:

- M79.10 Myalgia, unspecified site
- R06.00 Dyspnea, unspecified
- R06.02 Shortness of breath
- R06.2 Wheezing
- R06.82 Tachypnea, not elsewhere classified
- R07.9 Chest pain, unspecified
- R09.02 Hypoxemia
- R09.89 Other specified symptoms and signs involving the circulatory and respiratory systems (includes chest congestion)
- R10.84 Generalized abdominal pain
- R10.9 Unspecified abdominal pain

- R11.10 Vomiting, unspecified
- R11.11 Vomiting without nausea
- R11.2 Nausea with vomiting, unspecified
- R19.7 Diarrhea, unspecified origin
- R50.- Fever of other and unknown
- R53.83 Other fatigue
- R61 Generalized hyperhidrosis (night sweats)
- R63.4 Abnormal weight loss
- R68.83 Chills (without fever)

This coding guidance has been approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

References:
Ghinai I, Pray IW, Navon L, et al. E-cigarette Product Use, or Vaping, Among Persons with Associated Lung Injury —Illinois and Wisconsin, April–September 2019. MMWR Morb Mortal Wkly Rep 2019;68:865–869. DOI: http://dx.doi.org/10.15585/mmwr.mm6839e2

National Academies of Sciences, Engineering, and Medicine. 2018.Public Health Consequences of E-Cigarettes. Washington, DC: The National Academies Press. https://doi.org/10.17226/24952.

Perrine CG, Pickens CM, Boehmer TK, et al. Characteristics of a Multistate Outbreak of Lung Injury Associated with E-cigarette Use, or Vaping — United States, 2019. MMWR Morb Mortal Wkly Rep 2019;68:860–864. DOI: http://dx.doi.org/10.15585/mmwr.mm6839e1

Schier JG, Meiman JG, Layden J, et al. Severe Pulmonary Disease Associated with Electronic-Cigarette–Product Use — Interim Guidance. MMWR Morb Mortal Wkly Rep 2019;68:787–790. DOI: http://dx.doi.org/10.15585/mmwr.mm6836e2

Siegel DA, Jatlaoui TC, Koumans EH, et al. Update: Interim Guidance for Health Care Providers Evaluating and Caring for Patients with Suspected E-cigarette, or Vaping, Product Use Associated Lung Injury — United States, October 2019. MMWR Morb Mortal Wkly Rep. ePub: 11 October 2019. DOI: http://dx.doi.org/10.15585/mmwr.mm6841e3

Link to pdf document:
https://www.cdc.gov/nchs/data/icd/Vapingcodingguidance2019_10_17_2019.pdf

## *New ICD-10-CM code for vaping-related disorder to be implemented April 1, 2020*

In response to the recent occurrences of vaping related disorders and in consultation with the World Health Organization (WHO) Framework Convention on Tobacco Control, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) was convened to discuss a diagnosis code for vaping related illness for immediate use.

As a result of this meeting, a new International Classification of Diseases, Tenth Revision (ICD-10)emergency code has been established by WHO. The code became valid for immediate use as of September 24, 2019.

U07.0, Vaping-related disorder

Consistent with this WHO update to the ICD-10, the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) is implementing a new diagnosis code into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting vaping-related disorder effective April 1, 2020. The incorporation of this diagnosis code is also consistent with certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for diagnosis coding, including the Official ICD–10–CM Guidelines for Coding and Reporting, as maintained and distributed by the U.S. Department of Health and Human Services (HHS).

Full addenda information for the new code will be posted December 2019 on the following websites:

https://www.cdc.gov/nchs/icd/icd10cm.htm
https://www.cms.gov/Medicare/Coding/ICD10/index.html

As part of our outreach and education efforts, we will continue to work closely with industry stakeholders on the implementation of this new ICD-10-CM diagnosis code.

Link to pdf document: https://www.cdc.gov/nchs/data/icd/Vaping-Announcement-final-12-09-19.pdf

## *ICD-10-CM Tabular List of Diseases and Injuries*
## *April 2020 Addenda*

New chapter Chapter 22

Add Codes for special purposes (U00-U85)

New section Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)

Add Note: Codes U00-U49 are to be used by WHO for the provisional assignment of new diseases of uncertain etiology.

New category U07 Conditions of uncertain etiology

New code U07.0 Vaping-related disorder
Add Dabbing related lung damage
Add Dabbing related lung injury
Add E-cigarette, or vaping, product use associated lung injury [EVALI]
Add Electronic cigarette related lung damage
Add Electronic cigarette related lung injury

Add Use additional code, to identify manifestations, such as:
Add abdominal pain (R10.84)
Add acute respiratory distress syndrome (J80)
Add diarrhea (R19.7)
Add drug-induced interstitial lung disorder (J70.4)
Add lipoid pneumonia (J69.1)
Add weight loss (R63.4)

Damage
Add - lung
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (associated) (device) (product) (use) U07.0
Add - organ
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (device) (product) (use) (associated) U07.0

Disease, diseased - see also Syndrome
- lung
Add - - dabbing (related) U07.0

| | |
|---|---|
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |
| Add | - organ |
| Add | - - dabbing (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |
| | |
| | Disorder |
| | - lung, interstitial, drug-induced J70.4 |
| Add | - - dabbing (related) U07.0 |
| Add | - - e -cigarette (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - vaping (device) (product) (use) (associated) (related) U07.0 |
| | |
| | Injury |
| Add | - lung Add- - dabbing (related) U07.0 |
| Add | - - electronic cigarette (related) U07.0 |
| Add | - - EVALI - [e-cigarette, or vaping, product use assoc'd] U07.0 |
| Add | - - vaping (device) (product) (use) (associated) U07.0 |

Link to pdf document: https://www.cdc.gov/nchs/data/icd/Chapter-22-new-vaping-code-FINAL3.pdf

## *National Uniform Billing Committee Announcement for COVID-19 Claims*

The NUBC met on March 23 2020 and issued guidance identifying institutional claims related to COVID-19 treatment. Additionally, the committee issued guidance on coding for hospitals utilizing off-campus testing locations. The following guidance reflects an update on April 15, 2020:

**Usage of the "DR" condition code:**
Without codes to specifically indicate COVID-19 (including those cases for which services were provided but the patient ultimately tested negative), the ability of payers to trigger special handling of institutional claims for COVID-19 related services has been significantly limited.

**NUBC Recommendation:** In order to ensure appropriate flagging of COVID-19 related care, institutional claims for COVID-19 diagnosis or treatment should include"

1. The "DR" condition code, which is used to identify claims that are or may be impacted by specific policies related to a national or regional disaster/emergency.
2. One of the following diagnosis codes, as included in the interim or final ICD-10-CM Official Guidelines for Coding and Reporting (for more information, see https://www.cdc.gov/nchs/icd/icd10cm.htm):
    - B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for services provided before April 1, 2020
    - U07.1 (COVID-19) for services provided on or after April 1, 2020
    - Z03.818 (Encounter for observation for suspected exposure to other biological agents ruled out)
    - Z11.59 (Encounter for screening for other viral diseases)
    - Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases)
3. An appropriate service date. The "DR" condition code should be utilized for COVID-19 relatedcare occurring since January 27th, the date that the Department of Health and Human Servicesdeclared the COVID- 19 crisis as a federal public health emergency (January 27th, 2020)

**Utilization of Hospital Outpatient Bill Type for COVID Testing Locations:**
In order to meet patient needs, many hospitals and health systems have moved testing locations from hospitals to off-campus facilities (e.g. parking lots, parks, football stadiums). In such cases, the NUBC recommends usage of the Hospital Outpatient Type of Bill (013x), the main hospital address and National Provider Identifier (NPI). When paired with the DR condition code (as directed above), the claim will help payers correctly apply site of service restrictions/edits

Link to guidance: https://www.nubc.org/nubc-announcement-covid-19-claims

## *Special Edition MLNConnects April 7, 2020: Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services: Guidance for use of "CS" Modifier*

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; 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 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 wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.

For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

Additional CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Source: Special Edition MLNconnects Tuesday, April 7, 2020

Link to eNewsletter: https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913

## *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing*

The FAQs in this document supplement the following previously released FAQs: 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf, and Without 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.

**FAQ Topics in this Document:**

- Payment for Specimen Collection for Purposed of COVID-19 Testing
- Diagnostic Laboratory Services
- Diagnostic Laboratory Services – Serology Testing
- High Throughput COVID-19 Testing
- Hospital Services
- Ambulance Services
- Ambulance Services – Vehicle and Staffing Requirements for Ambulance Providers and Suppliers
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Expansion of Virtual Communication Services for FQHCs/RHCs
- Revision of the Home Health Agency Shortage Area Requirement for Visiting Nursing Services Furnished by RHCs and FQHCs
- Medicare Telehealth
- Physician Services
- Home Infusion Services
- Accountable Care Organizations (ACO)
- Cost Reporting
- Opioid Treatment Programs (OTPs)
- Inpatient Rehabilitation Facility Services
- Skilled Nursing Facility Services
- General Billing Requirements
- Home Health
- Drugs and Vaccines under Part B
- National Coverage Determinations (NCD)
- Medicare Payment to Facilities Accepting Government Resources
- Oxygen
- Temporary Department of Defense Sites
- Military Treatment Facilities (MTFs)
- Hospice
- Ambulatory Surgical Centers (ASC)

Link to Document: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

***MMP Recommends checking this document often as it is frequently updated by CMS.***

## *April 30, 2020 CMS Memorandum (20-06-CLIA): CMS SARS-CoV-2 Laboratory Testing Compare*

**Memorandum Summary**

- CMS is committed to taking critical steps to ensure America's clinical laboratories can respond to the threat of the 2019 Novel Coronavirus (COVID-19) and other respiratory illnesses to ensure patient health and safety.
- Laboratories need a Clinical Laboratory Improvement Amendments (CLIA)certificate to perform severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing. Under CLIA, laboratories are prohibited from testing human specimens for the purpose of diagnosis, prevention, treatment, or health assessment without a valid CLIA certificate. This also applies to facilities not typically considered to be laboratories that are performing SARS-CoV-2 testing.
- This guidance is a part of the Centers for Medicare & Medicaid Services (CMS) effort to clarify:
    - The types of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing and whether the tests are being offered under an Emergency Use Authorization (EUA) issued by FDA or as described in FDA's COVID-19 Test Guidance
    - The CLIA certifications under which each test can be performed
    - An explanation of requirements under eachtesting scenario
    - Information for Medicare beneficiaries on testing services and coverage

Link to Memorandum: https://www.cms.gov/files/document/admin-info-20-06-clia.pdf

**Additional Resources**
CMS Document: Laboratories: Medicare Flexibilities to Fight COVID-19:
https://www.cms.gov/files/document/covid-19-laboratories.pdf
List of lab test codes for COVID-19, Influenza, RSV (4/30/20):
https://www.cms.gov/files/document/covid-ifc-2-flu-rsv-codes.pdf

## *Price Transparency: Requirements for Providers to Make Public Cash Prices for COVID-19 Diagnostic Testing*

**1. Question:** What price transparency requirement was passed in the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act?
**Answer:** The CARES Act was enacted on March 27, 2020. Section 3202(b) of the CARES Act requires providers of diagnostic tests for COVID-19 to make public the cash price for a COVID-19 diagnostic test on the provider's public internet website.

**2. Question:** For how long is this price transparency requirement in effect?
**Answer:** The requirement enacted in section 3202(b) of the CARES Act is effective upon enactment of the CARES Act and continues in effect for the duration of the COVID-19 public health emergency (PHE)declared under section 319 of the Public Health Service Act (PHS Act). For more information about PHE declarations and timing, please refer to HHS' Public Health Emergency Q&As.

**3. Question:** How does the price transparency requirement to post the cash price of COVID-19 diagnostic testing relate to other provisions in the CARES Act and the Families First Coronavirus Response Act (FFCRA)?
**Answer:** The FFCRA was enacted on March 18, 2020. Section 6001 of the FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively in this document as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

Section 3201 of the CARES Act amended section 6001 of the FFCRA to include a broader range of diagnostic items and services for the detection of SARS-CoV-2 or the diagnosis of COVID-19 that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements. Additionally, section 3202(a) of the CARES Act generally requires plans and issuers providing coverage for the items and services described in section 6001(a) of the FFCRA to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on its public website. The plan or issuer may negotiate a rate with the provider that is lower than the cash price. More information about the FFCRA can be found in FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42.

Document released by CMS 5/12/2020
Link to Document: https://www.cms.gov/files/document/covid-ffs-price-transparency-faqs.pdf

## *Medicare Administrative Contractor (MAC) COVID-19 Test Pricing*

**MAY 19, 2020**

On March 5 and February 13, CMS announced new Healthcare Common Procedure Coding System (HCPCS) codes for healthcare providers and laboratories to test patients for SARS-CoV2. Starting in April, laboratories performing the test can bill Medicare and other health insurers for services that occurred after February 4, 2020, using the newly created HCPCS code (U0001). This code is only to be used for the tests developed by the Centers for Disease Control and Prevention (CDC). Laboratories performing non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19) can bill for them using a different HCPCS code (U0002). Additionally, the American Medical Association (AMA) created CPT code 87635 for infectious agent detection by nucleic acid tests on March 13, 2020 as well as CPT codes 86769 and 86328 for serology tests on April 10, 2020. Laboratories performing these tests may bill Medicare for services that occurred after their respective effective dates.

Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. The payment amounts are identified below. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

Note: For dates of service on or after April 14, 2020, Medicare pays $100 for laboratory tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 making use of high throughput technologies using:

U0003: 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, making use of high throughput technologies as described by CMS-2020-01-R.

U0004: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.

Neither HCPCS code U0003 nor U0004 should be used for tests that detect COVID-19 antibodies.

The Medicare payment rate for these HCPCS codes was established by CMS-Ruling 2020-1-R; they do not appear in the chart below.

| MAC Jurisdiction | MAC States/Territories | U0001 Test Price | U0002 Test Price | 87635 Test Price | 86769 Test Price | 86328 Test Price |
|---|---|---|---|---|---|---|
| J6 – NGS | Illinois, Minnesota, Wisconsin | $35.91 | $51.31 | $51.31 | $42.13 | $45.23 |
| JK – NGS | Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont | $35.91 | $51.31 | $51.31 | $42.13 | $45.23 |
| JH – Novitas | Arkansas, Colorado, New Mexico, Oklahoma, Texas Louisiana, Mississippi | $35.92 | $51.31 | $51.31 | $42.13 | $45.23 |
| JL – Novitas | Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania; Part B services include Arlington and Fairfax counties in VA, and the city of | $35.92 | $51.31 | $51.31 | $42.13 | $45.23 |
| JN – FCSO | Florida, Puerto Rico, U.S. Virgin Islands | $35.92 | $51.31 | $51.31 | $42.13 | $45.23 |
| JJ–Palmetto | Alabama, Georgia, Tennessee | $35.91 | $51.31 | $51.31 | $42.13 | $45.23 |
| JM–Palmetto | North Carolina, South Carolina, Virginia, West Virginia | $35.91 | $51.31 | $51.31 | $42.13 | $45.23 |
| JE -- Noridian | California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands | $35.91 | $51.31 | $51.31 | $42.13 | $45.23 |
| JF – Noridian | Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming | $35.91 | $51.31 | $51.31 | $42.13 | $45.23 |
| J5 – WPS | Iowa, Kansas, Missouri, Nebraska | $35.92 | $51.31 | $51.31 | $42.13 | $45.23 |
| J8 – WPS | Indiana, Michigan | $35.92 | $51.31 | $51.31 | $42.13 | $45.23 |
| J15 – CGS | Kentucky, Ohio | $35.92 | $51.31 | $51.31 | $42.13 | $45.23 |

Link to Guidance: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf

## *Antibody Test Oversight & Use for COVID-19 (FDA)*

**What is an antibody test and how is it used?**

Antibody tests, a type of serological test, detect antibodies present in the blood when the body is responding to or has responded to a specific infection, such as COVID-19. Antibody tests detect the body's immune response to the infection caused by the virus rather than detecting the virus itself. This is why they should not be used to diagnose current SARS-CoV-2 infection.

Antibody tests can be used to determine if individual patients may have been exposed to and infected with a virus, and also can be used to understand to understand how many people in a population have antibodies ( known as "surveillance tests," or sero-surveys).

- Testing individuals may help identify who has developed antibodies against SARS-CoV-2 . The result of ongoing research are needed before it is know whether these antibodies are associated with protection from future infection. Current results can help inform who may qualify to donate blood that can be used to manufacture convalescent plasma, an investigational product for use with those who are seriously ill from COVID-19.

- When used for surveillance, the results can help determine how widely the virus has spread in communities. Results from tests used for surveillance only are generally not shared with individual patients.

**Who regulates antibody tests?**

**FDA:** The U.S. Food and Drug Administration (FDA) regulates, among other products, tests intended for the diagnosis of a disease or condition (a type of "device") under the Federal Food, Drug, and Cosmetic Act. Outside of a declared public health emergency, serological tests generally require FDA premarket review through one of the established premarket pathways (de novo, 510(k) or PMA). T he FDA has issued emergency use authorizations (EUAs) , an authorization available to certain products in a declared public health emergency, for some antibody tests based on the data submitted to the Agency after determining that the applicable statutory criteria had been met. FDA has also announced a policy ofenforcement discretion for certain laboratories certified under the Clinical Laboratory Improvement Amendments (CLIA) for performing high-complexity testing to develop and validate their own serological tests ( called laboratory-developed tests, or LDTs ), as outlined in the FDA's COVID-19 Testing Guidance. The FDA does not generally regulate antibody tests that are used for surveillance purposes only, where test results are not returned to patients or healthcare providers.

**CMS:** The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA), part of the Public Health Service Act. In total, CLIA

covers approximately 260,000 laboratory entities. The CLIA program regulates laboratories that perform testing on patient specimens in order to ensure accurate and reliable test results. When a laboratory develops a test system such as an LDT, and FDA has not yet categorized the test (e.g., because the test has not been categorized in an EUA), the law requires that the test be performed only in a lab certified under CLIA to perform high-complexity testing. The laboratory must establish the performance characteristics of the test, including analytical validity, for the use of that test system in the laboratory's own environment prior to reporting patient results. In other words, if a test has not been reviewed by FDA, and thus has not been categorized by FDA, under CLIA, that test mus t only be used by laboratories certified under CLIA to perform high-complexity testing; this is another measure that helps to ensure the test performance is validated.

**CDC:** The U.S. Centers for Disease Control and Prevention (CDC) develops guidelines on the use of different tests, including for surveillance.

**States:** Under FDA's current policy, States or territories may also take responsibility for certain COVID-19 testing by high-complexity CLIA-certified laboratories (using LDTs) in that S tate/territory during the COVID-19 outbreak to expedite testing. A State or territory choosing to authorize laboratories within that State or territory to develop and perform a test for COVID-19 does so under authority of its own State law, and under a process that it establishes. Some States have done this, and they are listed on FDA's website. As stated in Section IV.B of the guidance, the FDA will not be reviewing the process adopted by the State or territory under this policy. The FDA has provided technical assistance to States on test validation measures under this policy.

Link to Fact Sheet: https://www.fda.gov/media/137599/download

## *Coronavirus (COVID-19) Update: FDA Authorizes First Antigen Test to Help in the Rapid Detection of the Virus that Causes COVID-19 in Patients*

*The following is attributed to FDA Commissioner Stephen M. Hahn, M.D. and Jeff Shuren, M.D., director of FDA's Center for Devices and Radiological Health*

The U.S. Food and Drug Administration has issued the first emergency use authorization (EUA) for a COVID-19 antigen test, a new category of tests for use in the ongoing pandemic. These diagnostic tests quickly detect fragments of proteins found on or within the virus by testing samples collected from the nasal cavity using swabs. The EUA was issued late Friday to Quidel Corporation for the Sofia 2 SARS Antigen FIA. This test is authorized for use in high and moderate complexity laboratories certified by Clinical Laboratory Improvement Amendments (CLIA), as well as for point-of-care testing by facilities operating under a CLIA Certificate of Waiver.

Diagnostic testing is one of the pillars of our nation's response to COVID-19 and the FDA continues to take actions to help make these critical products available, including by issuing EUAs. During this pandemic, there have been two types of tests for which the FDA has issued EUAs. One type are polymerase chain reaction (PCR) tests, a molecular diagnostic testing technique that detects the genetic material from the virus and can help diagnose an active COVID-19 infection. The other type are serological tests that look for antibodies to the virus, which can help identify individuals who have developed an adaptive immune response to the virus, as part of either an active infection or a prior infection (serological, or antibody, tests should not be used to diagnose active infection).

This latest FDA authorization is for an antigen test, which is a new type of diagnostic test designed for rapid detection of the virus that causes COVID-19. Each category of diagnostic test has its own unique role in the fight against this virus. PCR tests can be incredibly accurate, but running the tests and analyzing the results can take time. One of the main advantages of an antigen test is the speed of the test, which can provide results in minutes. However, antigen tests may not detect all active infections, as they do not work the same way as a PCR test. Antigen tests are very specific for the virus, but are not as sensitive as molecular PCR tests. This means that positive results from antigen tests are highly accurate, but there is a higher chance of false negatives, so negative results do not rule out infection. With this in mind, negative results from an antigen test may need to be confirmed with a PCR test prior to making treatment decisions or to prevent the possible spread of the virus due to a false negative.

Antigen tests are also important in the overall response against COVID-19 as they can generally be produced at a lower cost than PCR tests and once multiple manufacturers enter the market, can potentially scale to test millions of Americans per day due to their simpler design, helping our country better identify infection rates closer to real time.

This is just the first antigen test to be authorized and we expect more to follow. We also anticipate providing an EUA template for antigen tests, similar to ones we've released for other test types, to help manufacturers streamline submissions and help expedite our review and issuance of additional EUAs.

Antigen tests will play a critical role in the fight against COVID-19 and we will continue to offer support and expertise to help with the development of accurate tests, and to review and monitor marketed tests to ensure accuracy, while balancing the urgent need for these critical diagnostics.

Link to May 8, 2020 Announcement:
http://s2027422842.t.en25.com/e/es?s=2027422842&e=331289&elqTrackId=376c7bc788024cd5a73d955f2e3dcbdc&elq=c52e613f2b8a474d812b96d56cb97048&elqaid=12466&elqat=1

## *Appendix A: Additional Resources*

CMS Coronavirus (COVID-19) Partner Toolkit (Resource link added 5/22/20): https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit

CMS Current Emergencies: 2020 Coronavirus webpage: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

CMS Waivers and Flexibilities webpage: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Coronavirus.gov webpage: https://www.coronavirus.gov/

Centers for Disease Control and Prevention (CDC): Information for Healthcare Professionals about Coronavirus (COVID-19)
Link to webpage: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

U.S. Department of Health & Human Services: Public Health Emergency website (Resource link added 5/29/20): https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

U.S. Food and Drug Administration (FDA) COVID-19 webpage: https://www.fda.gov/emergency-preparedness-and-response/counterterrorism-and-emerging-threats/coronavirus-disease-2019-covid-19

Office of Inspector General (OIG) COVID-19 Portal:
https://oig.hhs.gov/coronavirus/index.asp?utm_source=web&utm_medium=web&utm_campaign=covid19-landing-page

Medicaid.gov Coronavirus Disease 2019 (COVID-19) at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/covid19/index.html

AMA COVID-19 Resources at: https://www.ama-assn.org/search?search=COVID+19

Environmental Protection Agency (EPA) Coronavirus Disease 2019 (COVID-19) at:
https://www.epa.gov/coronavirus

### *Telehealth Resources*

MLN Matters Article SE20011: Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)
This article includes information about:

- Billing for Professional Telehealth Distant Site Services During the Public Health Emergency,
- Families First Coronavirus Response Act Waived Coinsurance and Deductible for Additional COVID-19 Related Service,
- COVID-19 Expanded Use of Ambulance Origin/Destination Modifiers,
- New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing, and
- Beneficiary Notice Delivery Guidance in Light of COVID-19.

Link to MLN Article: https://www.cms.gov/files/document/se20011.pdf

CMS March 17, 2020 Fact Sheet: Medicare Telemedicine Health Care Provider Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Medicare Telehealth FAQs: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak
Link to Policy Statement: https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

OIG Fact Sheet Regarding Telehealth Policy Statement:
https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/factsheet-telehealth-2020.pdf

Office of Civil Rights Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency
Link to Notification: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth
Link to document: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf

Medicaid & Children's Health Insurance Program (CHIP) Telehealth Toolkit during 2019 Novel Coronavirus (COVID-19) Emergency
Link to Toolkit: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf

### *COVID-19 and Cybersecurity*

The Cybersecurity and Infrastructure Security Agency (CISA) Notice: Defending Against COVID-19 Cyber Scams
Link to Notice: https://www.us-cert.gov/ncas/current-activity/2020/03/06/defending-against-covid-19-cyber-scams

The Office of Civil Rights (OCR) released the following COVID-19 Cyber Threat Resources on April 30, 2020: Cyber-criminals may take advantage of the current COVID-19 global pandemic for their own financial gain or other malicious motives. However, resources are available to raise awareness of

COVID-19 related cyber threats and help organizations detect, prevent, respond, and recover from these threats. Below are resources that may be of interest to the healthcare community:

- Cyber Attack Quick Response Checklist: Following the WannaCry ransomware attack in 2017, the HHS Office for Civil Rights (OCR) developed a checklist and corresponding Infographic that identifies the steps for a HIPAA covered entity or business associate to take in response to a cyber-related security incident. With the increase in COVID-19 related malicious activity, HIPAA covered entities and business associates are encouraged to review this checklist and infographic for steps to take in the event it encounters a cyber-related security incident.
- COVID-19 Email Phishing Against U.S. Healthcare Providers: The FBI issued a notice regarding email phishing attempts targeting healthcare providers. These phishing attempts leverage COVID-19 related subject lines and content in an attempt to distribute malicious attachments. The notice includes information on how to identify specific phishing attacks and recommends actions to take when such attacks are encountered.
- Online Extortion Scams Increasing During The Covid-19 Crisis: The Internet Crime Complaint Center (IC3) released an advisory regarding an increase in reports of online extortion scams. This advisory includes information on how to recognize online extortion scams and steps to take protect oneself from these scams.
- Selecting and Safely Using Collaboration Services for Telework: Due to the COVID-19 global pandemic, many people are working from home using various video conferencing and online collaboration tools. The National Security Agency (NSA) published a notice that includes criteria to consider when selecting an online collaboration tool as well as information on how to use online collaboration tools securely.
- COVID-19 VTC Exploitation: The increased use of video conferencing and online collaboration tools has led to an increase in malicious activity seeking to exploit the unsecure use of these tools. The HHS Health Sector Cybersecurity Coordination Center (HC3) released a white paper outlining ways these tools could be exploited and recommendations to mitigate these issues.
- COVID-19 Cyber Threats: The HC3 also produced a brief on COVID-19 related cyber threats. This brief includes details on the increase in COVID-19 related malicious activity as well as information on how COVID-19 themed phishing attacks and websites are used as lures to trick users into downloading malicious software or directing users to malicious websites.
- OCR's Cyber Security Guidance Material may be found here: https://www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity/index.html.

## *COVID-19 and HIPAA*

HHS.Gov HIPAA, Civil Rights and COVID-19 webpage at https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html

COVID-19 & HIPPA Bulletin: Waiver of HIPAA Sanctions and Penalties During a Nationwide Public Health Emergency
Link to Document: https://www.hhs.gov/sites/default/files/hipaa-and-covid-19-limited-hipaa-waiver-bulletin-508.pdf

Office of Civil Rights (OCR) webinar for health IT stakeholders on HIPAA privacy and security issues related to COVID-19 and recent OCR actions related to the pandemic. Webinar Topics: COVID-19 and Permissible Disclosures under the HIPAA Privacy Rule

- Enforcement Discretion and Guidance for Telehealth Remote Communications
- Guidance for Disclosures to First Responders and Public Health Authorities
- Enforcement Discretion for Business Associates to Use and Disclose PHI for Public Health and Health Oversight Activities
- Enforcement Discretion for Community-Based Testing Sites

A recording of this webinar is now available on YouTube: https://youtu.be/2C6iOdS_FR0.
The slides from this presentation may be viewed at: https://go.usa.gov/xvExS.

# *Appendix B: MMP Weekly COVID-19 Articles:*

## Coding and Billing Guidance

### March 13, 2020: AMA Announces New CPT Code to Report Novel Coronavirus Test

The CPT editorial panel expedited approval of a unique CPT code to report laboratory testing services that diagnose the presence of the novel coronavirus.

- CPT code and long descriptor: 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
- Note, the code is effective immediately for use for reporting of tests for the novel coronavirus.

Press Release: https://www.ama-assn.org/press-center/press-releases/new-cpt-code-announced-report-novel-coronavirus-test

Link to further guidance from the AMA regarding the CPT including a CPT Fact Sheet: https://www.ama-assn.org/practice-management/cpt/cpt-releases-new-coronavirus-covid-19-code-description-testing

### March 23, 2020: CMS Posts ICD-10 MS-DRG Version 37.1 R1 Effective April 1, 2020

The CDC and National Center for Health Statistics is implementing the new diagnosis code, U07.1, COVID-19, into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) effective April 1, 2020. The ICD-10 MCE Version 37.1 R1 uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after April 1, 2020. The ICD-10 MS-DRG Grouper software package to accommodate this new code, Version 37.1R1, is effective for discharges on or after April 1, 2020. Assignment of new ICD-10-CM diagnosis code U07.1, COVID-19, is as follows:

| Dx Code | Description | CC | MDC | MS-DRGs |
|---|---|---|---|---|
| U07.1 | COVID-19 | MCC | 04: Respiratory | 177,178,179: Respiratory Infections & Inflammation with MCC, with CC, without CC/MCC respectively |
| | | | 15: Newborn & Other Neonates (Perinatal Period) | 791: Prematurity with Major Problems 793: Full Term Neonate with Major Problems |
| | | | 25: Human Immunodeficiency Virus Infection | 974,975,976: HIV with Major Related Condition with MCC, with CC, without CC/MCC respectively |
| Source: CMS MS-DRG Classifications and Software | | | | |

This announcement also indicates that if diagnosis code U07.1, COVID-19, is reported as a principal diagnosis, it will only exclude itself from acting as a MCC under the CC Exclusion List.

## March 24, 2020: AHA and AHIMA FAQs Regarding ICD-10-CM Coding for COVID-19 Revised

This FAQ Document was jointly developed and approved by the American Hospital Association Central Office on ICD-10-CM/PCS and the American Health Information Management Association. MMP encourages you to share this information with your Coders and Clinical Documentation Integrity (CDI) Specialists.

## March 27, 2020: The Coronavirus Aid, Relief, and Economic Security (CARES) Act signed into Law

The CARES Act is jam packed with efforts to provide relief to hospitals, businesses and individuals during the National State of Emergency due to Coronavirus (COVID-19). Following are resources to help you learn more about this Act.

- The *CARES Act*: https://files.taxfoundation.org/20200325223111/FINAL-FINAL-CARES-ACT.pdf
- U.S. Committee or Small Business and Entrepreneurship Small Business Owner's Guide to the *CARES Act*: https://www.sbc.senate.gov/public/_cache/files/2/9/29fc1ae7-879a-4de0-97d5-ab0a0cb558c8/1BC9E5AB74965E686FC6EBC019EC358F.the-small-business-owner-s-guide-to-the-cares-act-final-.pdf
- Senate Health, Education, Labor and Pensions (HELP) Committee Summary https://www.help.senate.gov/imo/media/doc/CARES%20Section-by-Section%20FINAL.PDF

### SEC. 3710. MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM ADD-ON PAYMENT FOR COVID–19 PATIENTS DURING EMERGENCY PERIOD.

Section 3710 of the CARES Act indicates that "for discharges occurring during the emergency period, in the case of a discharge of an individual diagnosed with COVID-19, the Secretary shall increase the weighting factor that would otherwise apply to the diagnosis-related group to which the discharge is assigned by 20 percent. The Secretary shall identify a discharge of such an individual through the use of diagnosis codes, condition codes, or other such means as may be necessary." Note, this add-on payment will be available through the duration of the COVID-19 emergency.

## March 31, 2020: ICD-10-CM Official Coding Guidelines for COVID-19 April 1, 2020 – September 30, 2020

ICD-10-CM Official Guidelines for COVID-19 for April 1, 2020 through September 30, 2020 were released. Included in this document are the following topics:

- **Code only confirmed cases**
- Sequencing of codes,
- Acute Respiratory Illness due to COVID-19,
- Exposure to COVID-19,
- Screening for COVID-19,

- Signs and Symptoms without definitive diagnosis of COVID-19,
- Asymptomatic individuals who test positive for COVID-19; and
- COVID-19 infection in pregnancy, childbirth and the puerperium

I would like to call attention to the specific guidance regarding **coding confirmed cases**. The guidelines indicate that you are to "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."

With the add-on payment for hospitals treating COVID-19 patients only occurring when a patient is identified by diagnosis codes, it is essential for Physicians to document when a case is confirmed so that Coding Professionals can code the new ICD-10-CM code U07.1 that became effective April 1, 2020.

The complete guidelines are available on the CDC ICD-10-CM webpage and the CMS 2020-ICD-10-CM webpage.

## March 31, 2020: Cigna COVID-19 Billing Guidelines and FAQ Document for Providers

This March 31, 2020 document includes the following new guidance as of March 31st pertaining to reimbursement for treatment of confirmed cases of COVID-19:

"Effective 3/30/2020, customer cost-share (if applicable depending on the customer's benefit plan) for COVID-19 treatment (inpatient and outpatient) for in-network and out-of-network providers is waived until 5/31/2020.This applies to treatment with dates of service of 2/3/2020 to 5/31/2020. Covered treatment includes all services covered under Medicare and applicable state regulations for the management of a COVID-19 diagnosis. In-network providers will be reimbursed consistent with their fee schedules for services rendered. Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the customer's benefit plan. When COVID-19 is confirmed, the following codes should be used for treatment once COVID-19 is confirmed.

| Code | Use | Customer cost-share | Description |
|---|---|---|---|
| B97.29 | Treatment | Waived | Other coronavirus as the cause of diseases classified elsewhere. |
| U07.1 | Treatment | Waived | 2019-nCoV acute respiratory disease. New code with implementation date of 4/1/2020. |

**If these codes are not used, regular plan benefits apply."

## March 31, 2020: Special Edition MLN Connects:

In a March 31st Special Edition of MLN Connects, CMS further expounded upon the sweeping Blanket Waivers and Flexibilities announced on March 30th, provided information about Professionals billing for Telehealth Services during the Public Health Emergency and provided the

following information about new specimen collection codes for laboratories billing for COVID-19 Testing:

Clinical diagnostic laboratories: To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

These codes are billable by clinical diagnostic laboratories.

## April 1, 2020: Update to ICD-10-CM for Vaping Related Disorder and 2019 Novel Coronavirus (COVID-19)

MLN Article MM11623 was revised on April 1st to reflect updated Change Request (CR) 11623 which added the new ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19).

## April 3, 2020: Special Edition MLN Connects: COVID-19 Telehealth Billing Correction, Nursing Home Recommendations, Billing for Multi-Function Ventilators, New ICD-10 Diagnosis Code

CMS issued a Special MLN Connects newsletter on April 3rd highlighting revised telehealth billing information, nursing home recommendations released earlier the day, billing for multi-function ventilators and the new ICD-10 COVID-19 Diagnosis code U07.1.
https://www.cms.gov/files/document/2020-04-03-special-edition.pdf

**Telehealth: Billing Distant Site Services during Public Health Emergency (PHE) Revised**

CMS notes this information corrects a prior message that appeared in our March 31, 2020 Special Edition. Specifically, CMS will now allow for more than 80 additional services to be furnished via telehealth. Professional claims for all telehealth services with dates of service on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE) are to be billed with the following:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person, and
- Modifier 95, indicating that the service rendered was actually performed via telehealth.

CMS is not requiring the CR modifier. However, CMS does describe two scenarios that do require modifiers on Medicare telehealth professional claims.

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier, and
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier.

**Billing for Multi-Function Ventilators (HCPCS Code E0467)**

Effective immediately, CMS is suspending claims editing for multi-function ventilators when there are claims for separate devices in history that have not met their reasonable useful lifetime.

- For more information on multi-function ventilators, see MLN Matters Special Edition Article SE20012.

## April 10, 2020: Special MLNConnects – Sequestration Adjustment Suspended

CMS announced in an April 10th Special Edition MLNConnects that Section 3709 of the CARES Act temporarily suspends the 2% payment adjustment currently applied to all Medicare Fee-for-Service (FFS) claims due to sequestration. The suspension is effective for claims with dates of service from May 1 through December 31, 2020.

## April 10, 2020: AMA Announces Expedited Updates to CPT for COVID-19 Antibody Tests

The CPT Editorial Panel expedited the review of proposed changes and approved them on April 10th. In the announcement AMA President Patrice A. Harris, M.D., M.A. said that "The expedited approval of new CPT codes for COVID-19 antibody tests is an important step that enhances the reporting of innovative tools now available to advance medicine's overarching goals of reducing the COVID-19 disease burden, improving health outcomes and reducing long-term care costs."

- Code 86328 has been established for antibody testing using a single step method immunoassay.
- Code 86769 has been established for antibody testing using a multiple step method.

Prior to these two new Category I CPT codes approval, the CPT Editorial Panel approved a new code to report molecular testing to detect the SARS-CoV-2 virus:

- 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

**Note: All AMA COVID-19 Coding Guidance to date is available on the AMA's COVID-19 Coding and Guidance webpage at https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance**

## April 24, 2020: Alabama Medicaid Alert

Alabama Medicaid indicated in a Provider Alert that all previously published expiration dates related to the COVID-19 emergency are being extended with a new expiration date of May 30, 2020 or at the conclusion of the COVID-19 National emergency, whichever occurs first.

Also included in this Alert is the reminder that "during the COVID-19 emergency, it is important to file claims as quickly as possible to ensure payment from Medicaid is made to Medicaid providers close to the date of service. The Centers for Medicare and Medicaid Services has increased the federal matching percentage for the emergency time frame, but states can only receive the increased match on claims that are paid during the emergency. Providers should include appropriate COVID-19 diagnosis code(s) on claims submitted to help with tracking of COVID-19."

You can view a listing of prior Provider Alerts and all actions in response to the COVID-19 National emergency on the Agency's COVID-19 at: https://medicaid.alabama.gov/news_detail.aspx?ID=13729

## April 27, 2020: MLN Matters MM11765: Addition of the QW Modifier to HCPCS Code U0002 and 87635

Provider Types affected by information in MLN MM11765 are facilities with a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver. Specifically, the article advised the need for the addition of the QW modifier to:

- HCPCS code U0002 (2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC), and
- 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.]

Medicare will permit the use of Codes U0002QW and 87635QW for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after March 20, 2020. The official instruction, CR 11765, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10066OTN.pdf.

## April, 28 2020: AHA and AHIMA FAQs Regarding ICD-10-CM Coding for COVID-19 Revised

The American Hospital Association and American Health Information Management Association released this joint FAQs regarding ICD-10-CM Coding for COVID-19 document on March 24, 2020. Since then several FAQs have been added with the most recent additions being on April 28, 2020.

MMP encourages you to visit the AHA COVID-19 FAQ webpage often for new information that can be downloaded and shared with your Coders and Clinical Documentation Integrity (CDI) Specialists.

## April 28, 2020: Alabama Hospitals allowed to Resume Medical Procedures

Alabama's Safer At Home Order signed on April 28, 2020 amended the *Order of the State Health Officer Suspending Certain Public Gathering Due to the Risk of Infection by COVID-19* document. This is good news for Alabama hospitals as the following information for hospitals regarding resuming medical procedures was included in the amended document:

"Medical procedures. Effective April 30, 2020, at 5:00 P.M., dental, medical, or surgical procedures may proceed unless the State Health Officer or his designee determines that performing such procedures, or any category of them (whether statewide or regionally), would unacceptably reduce access to personal protective equipment or other resources necessary to diagnose and treat COVID-19. Providers performing these procedures shall follow all applicable COVID-19-related rules adopted by a state regulatory board or by the Alabama Department of Public Health. In the absence of such rules, providers should take reasonable steps to comply with applicable COVID-19-related guidelines from the Centers for Medicare and Medicaid Services (CMS) and the CDC, including "Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I" from CMS, available at https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf, and

"Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19)" from the CDC, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html."

### May 5, 2020: FDA Continues to Update FAQs on Testing for SARS-CoV-2

The FDA has recently added several FAQs to their growing list of questions related to Testing for SARS-CoV-2. As of May 5th, FAQs Topics available on this webpage include the following:

- What Laboratories and Manufacturers are Offering Tests for COVID-19?
- General FAQs
- What If I Do Not Have…?
- Clinical Laboratory Diagnostic Test FAQs
- Test Kit Manufacturer Diagnostic Test FAQs
- Serology/Antibody Test FAQs

The FDA plans to update this page regularly and provides the opportunity for you to sign up for email alerts.

### May 7, 2020: MLNConnects: COVID-19 Modified Ordering Requirements for Laboratory Billing

During the COVID-19 Public Health Emergency, CMS is relaxing billing requirements for laboratory tests (PDF) required for a COVID-19 diagnosis. Any health care professional authorized under state law may order tests. Medicare will pay for tests without a written order from the treating physician or other practitioner:

- If an order is not written, an ordering or referring National Provider Identifier (NPI) is not required on the claim
- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines

For More Information:

- Laboratory Tests (PDF) with modified requirements
- Interim Final Rule

### May 7, 2020: MLNConnects: New Coronavirus Specimen Collection Code

To identify and pay for specimen collection for COVID-19 testing, CMS established a new Level II HCPCS code for billing Medicare under the Outpatient Prospective Payment System (OPPS).

The new code, C9803, Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source, is effective for services provided on or after March 1, 2020.
OPPS claims received on or after May 1, 2020, with Coronavirus Specimen Collection HCPCS Codes G2023 and G2024 will be returned to you with edit W7062. Resubmit returned claims as a packaged service to include Code C9803, when appropriate.

### May 8, 2020: Telehealth Video: Medicare Coverage and Payment of Virtual Services

CMS has posted an updated video providing answers to common questions about the expanded Medicare telehealth services benefit under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

## May 17, 2020: New CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again – May 2020

This CDC Document was posted to the CDC website on May 17th. In addition to highlighting CDC activities and initiatives, this document includes the following appendices:

- Appendix A: Surveillance for COVID-19,
- Appendix B:Healthcare System Surveillance,
- Appendix C: Guidance on Infection Control and Contact Tracing,
- Appendix D: Guidance on Test Usage (Asymptomatic Populations and Serology),
- Appendix E: Assessing Surveillance and Hospital Gating Indicators, and
- Appendix F: Setting Specific Guidance.

Appendix F offers interim guidance for child care programs, interim guidance for schools and day camps, interim guidance for employers with workers at high risk, interim guidance for restaurants and bars, and interim guidance for mass transit administrators. The CDC notes the guidance in Appendix F is meant to assist establishments as they open. Further, they will update guidance as more is learned about COVID-19 and best practices to prevent its spread.

## May 18, 2020: Guidance to Safely Reopen Nursing Homes

New guidance for the safe reopening of nursing homes was announced in a CMS Press Release as part of *Guidelines for Opening Up America Again*. This guidance details critical steps to be taken prior to relaxing nursing home restriction including "rigorous infection prevention and control, adequate testing, and surveillance." CMS further recommends the following steps:

- Do not advance through any phase of reopening or relax restrictions until all residents and staff have received results from a baseline test,
- Have State survey agencies inspect nursing homes experiencing a significant outbreak prior to reopening, and
- Nursing homes should remain in the current state of highest restriction and be among the last to reopen within the community.

"Nursing homes may receive visitors during phase three, which is when there has been a sustained decrease in COVID-19 cases." This Press Release provides links to the Guidance, an FAQ document and a full list of CMS Public Health Actions for Nursing Home on COVID-19 to date.

## May 19, 2020: Re-entry Guidance for Health Care Facilities and Medical Device Representatives

The release of this Guidance is a joint effort of the American Hospital Association (AHA), the Association of perioperative Registered Nurses (AORN), and the Advanced Medical Technology Association (AdvaMed).

An AdvaMed Press Release indicates that "the guidance for re-entry builds on the April 17 joint statement by AHA, AORN, the American College of Surgeons, and the American Society of Anesthesiologists – entitled "Roadmap for Resuming Elective Surgery" – with expanded, clinically based recommendations supporting the safe return of medical device representatives into health care facilities, consistent with the AdvaMed Code of Ethics. The guidance seeks to align access standards and processes across health care facilities, with principles and considerations rooted in health authority guidance, including from the CDC, FDA, and state and local authorities."

### May 19, 2020: CDC Clinical Outreach and Communication Activity (COCA) Webinar: Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 2019 (COVID-19)

During this call, clinical characteristics of this syndrome, how cased have been diagnoses and treated, and how clinicians are have been responding to recently reported cases associated with COVID-19. A video and slides from this presentation are available on the CDC website at https://emergency.cdc.gov/coca/calls/2020/callinfo_051920.asp?deliveryName=USCDC_1052-DM28705.

### May 19, 2020: Special Edition MLNConnects: COVID-19: Which Laboratory Claims Require the NPI of the Ordering/Referring Professional?

"During the COVID-19 Public Health Emergency, CMS is relaxing billing requirements for a limited number of laboratory tests (PDF) required for a COVID-19 diagnosis. Any health care professional authorized under state law may order these tests. Medicare will pay for these tests without a written order from the treating physician or other practitioner:

- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim
- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines

For More Information:

- Laboratory Tests (PDF) with modified requirements
- Interim Final Rule"

Link to May 19, 2020 Special Edition MLN Connects: https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-05-19-mlnc-se

### May 20, 2020: Wednesday@One COVID-19 in the News Resource Spotlight: Coronavirus Waivers and Flexibilities

This week's spotlight is on a May 4th pdf document titled COVID-19 Regulations & Waivers to Enable Health System Expansion highlighting how CMS has enabled significant health system flexibility during the COVID-19 Public Health Emergency (PHE) through Medicare 1135 blanket waivers and the passage of two interim final rules. You can also find this presentation on the CMS Coronavirus Waivers and Flexibilities webpage.

### May 20, 2020: COVID-19 Blanket Swing Bed Waiver for Addressing Barriers to Nursing Home Placement for Hospitalized Individuals

MLN Matters SE20018 provides answers to questions hospitals may have when looking at the option to provide post-hospital Skilled Nursing Facility (SNF) swing-bed services for non-acute care patients in your hospital. Q&A's fall into the following topics in this eight page document:

- Swing Beds and Hospitals,
- Swing Bed Waiver during the Public Health Emergency (PHE),
- Swing Beds and the Required MDS,
- Billing and Payment for Swing Bed Services, and
- Additional Information.

## May 22, 2020: Alabama Medicaid Alert: COVID-19 Emergency Expiration Date Extended to June 30

The Alabama Medicaid Agency provided the following information in a May 22nd Alert:

> "All previously published expiration dates related to the Coronavirus (COVID-19) emergency are once again extended by the Alabama Medicaid Agency (Medicaid). **The new expiration date is the earlier of June 30, 2020, the conclusion of the COVID-19 National emergency, or any expiration date noticed by the Alabama Medicaid Agency through a subsequent ALERT.**
>
> A listing of previous Provider Alerts and notices related to the health emergency is available by selecting the Agency's COVID-19 page in the link below: https://medicaid.alabama.gov/news_detail.aspx?ID=13729."

## May 29, 2020: Alabama Medicaid Alert: Additional Laboratory Testing for COVID-19

Alabama Medicaid announced in an Alert that Providers may begin submitting claims on June 1, 2020, for dates of service on or after April 1, 2020 for the following testing procedure codes:

- 86328 Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).
- 86769 Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).


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