IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT202048 APRIL 21, 2020

IHCP COVID-19 Response: IHCP provides coding guidance for COVID-19

The Indiana Health Coverage Programs (IHCP) provides the information in this bulletin as guidance for codes used in billing for COVID-19-related procedures or services.

Newly covered CPT and HCPCS codes related to COVID-19

Testing for COVID-19 is covered for all IHCP members, including members in limited-benefit categories, such as Emergency Services Only (ESO), Family Planning Eligibility Program, and all Presumptive Eligibility (PE) benefit programs. In addition, there may be recent updates to reimbursement information that differs from the information published in the April 2020 Healthcare Common Procedure Coding System (HCPCS) quarterly release (*IHCP Bulletins* BT202027 and BT202038). The IHCP has identified pricing information from the Centers for Medicare & Medicaid Services (CMS) and has made updates accordingly, effective April 21, 2020. For outpatient claims, the fee-for-service claim-processing system has updated revenue code linkages, retroactive to the effective date of the code. Any claims that previously denied due to invalid revenue code linkages may be resubmitted at this time. This information will also be reflected in the next update to the Professional and Outpatient Fee Schedules, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. The codes listed in Table 1 will be added to *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Note: The IHCP is aware of additional Current Procedural Terminology (CPT®[1]) COVID testing codes developed by the American Medical Association (AMA), as well as revised codes, effective as of April 10, 2020. The IHCP is also aware of new codes recently announced by the CMS in CMS-Ruling 2020-1-R, available at cms.gov. These codes are under review, and coverage and billing information will be announced as soon as possible.

Additional resources from the AMA regarding COVID-19 can be found on the *COVID-19 coding and guidance* page at ama-assn.org.

Table 1 – Newly covered CPT and HCPCS procedure codes related to COVID-19

Procedure code	Description	Effective date	Coverage notes	Reimbursement notes
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	3/13/2020	Covered for all programs, including limited-benefit programs	*Professional claim*: 30% billed charges *Outpatient claim*: Linked to revenue code 300/310*; 15% billed charges

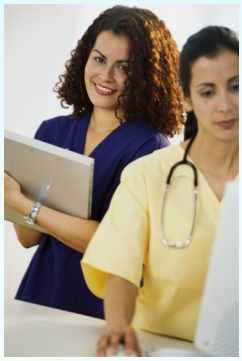
**Indicates a change or update from previously posted information.*

Table 1 – Newly covered CPT and HCPCS procedure codes related to COVID-19 (Continued)

Procedure code	Description	Effective date	Coverage notes	Reimbursement notes
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source	3/1/2020	Covered for all programs, including limited-benefit programs	*Professional claim*: Max fee $23.46* *Outpatient claim:* Linked to revenue code 300*
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source	3/1/2020	Covered for all programs, including limited-benefit programs	*Professional claim*: Max fee $25.46* *Outpatient claim*: Linked to revenue 300*
U0001	CDC 2019 novel coronavirus (2019-nCoV) real-time rt-pcr diagnostic panel	2/4/2020	Covered for all programs, including limited-benefit programs	*Professional claim*: Max fee $35.92 *Outpatient claim*: Linked to revenue code 300/310*
U0002	Non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)	2/4/2020	Covered for all programs, including limited-benefit programs	*Professional claim*: Max fee $51.31 *Outpatient claim*: Linked to revenue code 300/310*

**Indicates a change or update from previously posted information.*

Additional guidance for COVID-19 testing



Under the Clinical Laboratory Improvement Amendment (CLIA) regulations, only CLIA-certified labs may bill for the actual COVID-19 tests. The CMS has issued the following guidance regarding CLIA during the COVID-19 public health emergency in memorandum QSO-20-21-CLIA at cms.gov.

Generally, if the patient is assessed or screened in person and the sample is swabbed during the office visit, the swab collection will be included in the cost of the office visit (see the following section for diagnosis coding). If the screening occurs during a telemedicine visit, and it is determined that a test is necessary, then the provider bills the telemedicine visit in accordance with IHCP's currently established policies, and any of the following scenarios may apply:

- The member goes to an office or group practice for specimen collection: The office or group practice may bill with 99211 for the visit, and modifier 25, if the service is on the same day as the telemedicine assessment.
- The member goes to an independent testing location: The testing location may bill 99001 for the handling and/or conveyance charge.
- Clinical diagnostic laboratories may bill procedure codes G2023 and G2024 for specimen collection, as directed by the CMS (*Source:* *COVID-19: Regulatory Changes, Telehealth Billing, and Specimen Collection Codes* at cms.gov).

Coverage for COVID-19-related testing services is allowed for all members, regardless of their benefit package.

Diagnosis coding guidance for testing

Table 2 provides information for the use of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM), including information for limited-benefit categories. In general, the IHCP recommends that providers follow the U.S. Centers for Disease Control and Prevention (CDC) coding guidance published in the *ICD-10-CM Official Coding and Reporting Guidelines* at cdc.gov/nchs for dates of service (DOS) from April 1, 2020, through September 30, 2020. These diagnosis codes will be added to *Presumptive Eligibility for Pregnant Women Codes* and *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. For these limited-benefit categories, claims must be submitted with an approved diagnosis from the appropriate code set.

Table 2 – Diagnosis coding for COVID-19 testing

ICD-10-CM code	Code description	CDC guidance	IHCP guidance	Limited-benefit categories
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out	For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation	Same as CDC guidelines Added to the *Emergency Department Autopay List* announced in *BT202043*	*Professional claim*: This diagnosis (or other diagnosis approved for the program) must be indicated at the detail level. (ESO claims must include an emergency indicator at the detail level for the procedure code billed.) *Outpatient claim*: This diagnosis must be primary (principal) on the claim.
Z11.59	Encounter for screening for other viral diseases	For use with asymptomatic individuals who are being screened for COVID-19 with no known exposure	Same as CDC guidelines	*Professional claim:* This diagnosis (or other diagnosis approved for the program) must be indicated at the detail level. *Outpatient claim:* This diagnosis must be primary (principal) on the claim. *Note: This diagnosis has **not** been approved for ESO.*
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases	Use if COVID infection is suspected, possible, probable, or inconclusive Typically would be used if individual is displaying symptoms of the virus	Same as CDC guidelines Added to the *Emergency Department Autopay List* announced in *BT202021*	*Professional claim*: This diagnosis (or other diagnosis approved for the program) must be indicated at the detail level. (ESO claims must include an emergency indicator at the detail level for the procedure code billed.) *Outpatient claim*: This diagnosis must be primary (principal) on the claim.

Diagnosis coding for COVID-19-positive members

The following guidance is in accordance with the recommendations from the CDC:

- DOS from February 20, 2020, through March 31, 2020 (Source: *ICD-10-CM Official Coding Guidelines – Supplement: Coding encounters related to COVID-19 Coronavirus Outbreak*)

  Generally, the guidance is to first code the manifestations of the illness. A list of common diagnoses is provided in Table 3. This list is not intended to be inclusive of all possible diagnoses. The secondary diagnosis would be B97.29 – *Other coronavirus as the cause of disease classified elsewhere*.

- DOS from April 1, 2020, through September 30, 2020 (Source: *ICD-10-CM Official Coding and Reporting Guidelines*)

  As announced in *IHCP Bulletin* *BT202028*, the CDC in coordination with the CMS has authorized implementation of a new ICD-10 diagnosis for COVID-19. Diagnosis code U07.1 – *2019-nCoV acute respiratory disease* is for use when the member has been tested and the result is confirmed positive (by the CDC) or is presumptive positive (returned as positive but not yet confirmed by the CDC). When the reason for the visit meets the qualifications to code COVID-19 as the primary (principal) diagnosis, the provider should do so. Physical manifestations of the infection may be billed with codes such as those listed in Table 3 as secondary.

- Pregnant women – DOS from April 1, 2020, through September 30, 2020 (Source: *ICD-10-CM Official Coding and Reporting Guidelines*)

  The CDC guidelines state that, for pregnant women, providers should code first O98.5 – *Other viral diseases complicating pregnancy, childbirth and the puerperium*, followed by U07.1, and then any associated manifestations of signs or symptoms. For DOS prior to April 1, 2020, use secondary diagnoses such as those listed in Table 3.

Table 3 – COVID-19-common associated manifestations

ICD-10-CM code	Description	When to code
J12.89	Other viral pneumonia	Pneumonia
J20.8	Acute bronchitis due to other specified organisms	Acute bronchitis
J22	Unspecified acute lower respiratory infection	Lower or acute respiratory infection, not otherwise specified (NOS)
J80	Acute respiratory distress syndrome	Acute respiratory distress syndrome
J98.8	Other specified respiratory disorders	Other respiratory infections NOS

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