COVID-19 Coding Guide

Updated 5/8/2023

For answers to frequently asked questions, including cost-sharing waiver effective and end dates for COVID-19 testing, testing-related visits, and treatment, go to the PRC FAQs and download the pdf. Note: **This Coding Guide is updated frequently.** Please check the Provider Resource Center (prc.hmsa.com) for more updates. Changes from the previous version are highlighted.

The U.S. Department of Health and Human Services announced that it would allow the federal Public Health Emergency for COVID-19 to expire at the end of the day on May 11, 2023. Codes cancelled as a result of the end of the PHE will be indicated below and labeled as: CANCELLED 5/11/2023 end of day (EOD) due to the end of the PHE.

COVID-19 Vaccines and Vaccine Administration

The current vaccine and vaccine administration codes are listed below. Their effective dates depend on the Emergency Use Approval date. For commercial and QUEST Integration plan members, the benefit is limited to the administration codes while the federal government covers the cost of COVID-19 vaccines. The benefit began or will begin on the same day that the Advisory Committee on Immunization Practices (ACIP) approves. These guidelines are quickly changing, so please refer to the CDC COVID-19 ACIP Vaccine Recommendations for the most up-to-date guidelines.

Effective on 05/12/2023 COVID-19 vaccine and vaccine administration will apply regular standard plan benefits, please reference members benefit plan.

Code	Description	Vaccine Name(s)	Admin Code(s)	Effective Date of Codes	ACIP/EUA Approval Date
***91300**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use.	Pfizer-BioNTech COVID-19 Vaccine	*0001A (1st dose) *0002A (2nd dose)	December 11, 2020	December 12, 2020
			*0003A (3rd dose)	August 12, 2021	August 13, 2021
			*0004A (Booster dose)	September 22, 2021	September 23, 2021
***91301**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-	Moderna COVID-19 Vaccine	*0011A (1st dose) *0012A (2nd dose)	December 18, 2020	December 19, 2020
			*0013A (3rd dose)	August 12, 2021	August 13, 2021

	LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use.				
91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use	Janssen COVID-19 Vaccine	0031A (single dose)	February 27, 2021	February 28,2021
			0034A (Booster dose)	October 20, 2021	October 21, 2021
91304	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage, for intramuscular use	Novavax COVID-19 Vaccine	0041A (1st dose) 0042A (2nd dose)	May 4, 2021	July 13, 2022
			0044A (Booster dose)	October 19, 2022	October 19, 2022
***91305**	Severe acute respiratory syndrome coronavirus 2 (SAR-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	Pfizer-BioNTech COVID-19 Vaccine	*0051A (1st dose) *0052A (2nd dose) *0053A (3rd dose) *0054A (Booster dose)	October 29, 2021	October 29, 2021
***91306**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use	Moderna COVID-19 Vaccine Booster	*0064A (Booster dose)	October 20, 2021	October 21, 2021

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***91307**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use.	Pfizer-BioNTech COVID-19 Vaccine <u>Pediatric Use</u> (Ages 5 years through 11 years old)	*0071A (1st dose) *0072A (2nd dose)	October 6, 2021	November 2, 2021
			*0073A (3rd dose)	January 03, 2022	January 03, 2022
			*0074A (Booster dose)	May 17, 2022	May 17, 2022
***91308**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	Pfizer-BioNTech COVID-19 Vaccine <u>Pediatric Use</u> (Ages 6 months through 4 years old)	*0081A (1st dose) *0082A (2nd dose) *0083A (3rd dose)	June 17, 2022	June 17, 2022
***91309**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	Moderna COVID-19 Vaccine <u>Pediatric Use</u> (Ages 6 years through 11 years old)	*0091A (1st dose) *0092A (2nd dose) *0093A (3rd dose)	July 6, 2022	June 17, 2022
		Moderna COVID-19 Vaccine Booster	*0094A (2nd Booster dose)	March 29, 2022	March 29, 2022

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***91311**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	Moderna COVID-19 Vaccine Pediatric Use (Ages 6 months through 5 years old)	*0111A (1st dose) *0112A (2nd dose) *0113A (3rd dose)	June 17, 2022	June 17, 2022
91312	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19[) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	Pfizer-BioNTech Bivalent	0121A (single dose)	April 18, 2023	April 18, 2023
			0124A (Additional dose)	August 31, 2022	August 31, 2022
91313	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	Moderna Bivalent	0134A (Additional dose)	August 31, 2022	August 31, 2022
91314	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	Moderna Bivalent Pediatric Use (Ages 6 years through 11 years old)	0141A (1st dose) 0142A (2nd dose)	April 18, 2023	April 18, 2023
			0144A (Additional dose)	October 12, 2022	October 12, 2022
91315	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine,	Pfizer-BioNTech Bivalent Pediatric Use	0151A (single dose)	April 18, 2023	April 18, 2023
			0154A (Additional dose)	October 12, 2022	October 12, 2022

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	mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	(Ages 5 years through 11 years old)			
91316	Severe acute respiratory syndrome coronavirus 2 (SAR-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 10mcg/0.2 mL dosage, for intramuscular use	Moderna Bivalent Pediatric Use (Ages 6 months through 5 years old)	0164A (Additional dose)	December 8, 2022	December 8, 2022
91317	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	Pfizer-BioNTech COVID-19 Vaccine Pediatric Use (Ages 6 months through 4 years old)	0171A (1st dose) 0172A (2nd dose)	April 18, 2023	April 18, 2023
			0173A (3rd dose)	December 8, 2022	December 8, 2022
			0174A (Additional dose)	March 14, 2023	March 14, 2023

*The original monovalent vaccines' emergency use authorization (EUA) has been rescinded and those vaccines are not longer recommended for use. As a result, vaccine product and administration codes for the original monovalent Pfizer and Moderna vaccines will be deleted at a future date.

Commercial

Providers should continue to follow guidelines for billing immunizations and their administration. For additional details on administration, refer to prc.hmsa.com/s/article/Immunizations. For details on billing immunization administration when done with other services, see prc.hmsa.com/s/article/Immunization-Administration-Billed-with-Other-Services.

Medicare Advantage

Providers administering the COVID-19 vaccine to HMSA Medicare Advantage members in 2020 and 2021 should **submit claims directly to CMS Medicare Administrative Contractor (MAC)** using product-specific codes for each vaccine approved. When COVID-19 vaccine doses are provided by the government without charge, only bill for the vaccine administration. Don't include the vaccine codes on the claim when the vaccines are free.
Important note: Effective service dates on or after January 01, 2022, Akamai Advantage plans will begin paying for COVID-19 vaccines (if not received for free) and its administration fee. COVID-19 vaccines administered within the 2020 and 2021 CY, the payment for the COVID-19 vaccine and its administration are made through fee-for-service Medicare program. Plans will follow the CMS Medicare billing guidance from COVID-19 vaccine and administration.
For more information on Medicare billing for COVID-19 vaccine shot administration, refer to cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration.

QUEST Integration

Effective on the date of ACIP approval, HMSA will reimburse providers for vaccine administration. For details on QUEST Integration Immunizations, please refer to prc.hmsa.com/s/article/QUEST-Integration-Immunizations.

COVID Vaccine Adverse Reaction

HMSA will waive cost-sharing for treatment for an adverse reaction to the COVID-19 vaccine for all fully insured Commercial, Medicare and QUEST Integration members. Waivers will be in place until the end of the public health emergency (as determined by the U.S. Secretary of Health and Human Services). This includes copayments, coinsurance and deductibles.

When treating a patient who has had an adverse reaction to a COVID-19 vaccine, use the most appropriate ICD-10 diagnosis code listed below **and** modifier CR to apply the cost-sharing waiver. Existing benefit limitations and rules will apply.

ICD-10	Description
T50.B95A	Adverse effect of other viral vaccines, initial encounter
T50.B95D	Adverse effect of other viral vaccines, subsequent encounter

Modifier	Description
CR	Catastrophe/Disaster Related

Current CDC diagnosis codes used with COVID-19 diagnosis, treatment and adverse reaction to vaccine

CDC Diagnosis Codes	Requirements	Eligible Members	Eligible Providers	Notes
U07.1	Effective April 1, 2020, use to identify patients who have tested positive for COVID-19.	HMSA members	HMSA providers	**Don't assign code U07.1** for suspected, possible, or probable COVID-19. Instead, assign codes explaining the reason for the encounter.
J12.82	Pneumonia due to coronavirus disease 2019	HMSA members	HMSA providers	Effective Jan. 1, 2021
B97.29	Used for dates of service on or before March 31, 2020, to identify patients who have tested positive for COVID-19.	HMSA members	HMSA providers	Other coronavirus as the cause of diseases classified elsewhere. **Don't assign code B97.29** for suspected, possible, or probable COVID-19. Instead, assign codes explaining the reason for the encounter.
T50.B95A **T50.B95D**	Use the most appropriate diagnosis code when treating a patient for an adverse reaction to a COVID-19 vaccine	HMSA members	HMSA providers	See guidelines for COVID Vaccine Adverse Reaction above
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out.	HMSA members	HMSA providers	Use if a patient had a possible exposure to COVID-19, but it was deemed not to be an exposure after evaluation.
Z20.822	Contact with and (suspected) exposure to COVID-19.	HMSA members	HMSA providers	Effective Jan. 1, 2021
Z20.828	Contact with and suspected exposure to other viral communicable diseases.	HMSA members	HMSA providers	Used for encounters through Dec. 31, 2020. Beginning Jan. 1, 2021, use Z20.822 for patients with suspected exposure to COVID-19.
Z11.52	Encounter for screening for COVID-19.	HMSA members	HMSA providers	See guidelines for Asymptomatic COVID-19 Testing below.
Z11.59	Encounter for screening for other viral diseases. Used for asymptomatic individuals who were being screened for COVID-19 and had no known exposure to the virus and the test results are either unknown or negative.	HMSA members	HMSA providers	See guidelines for Asymptomatic COVID-19 Testing below.

Z86.16	Personal history of COVID-19	HMSA members	HMSA providers	Effective Jan. 1, 2021
B34.2	Coronavirus infection, unspecified.	HMSA members	HMSA providers	Diagnosis code is not generally appropriate for COVID-19 because almost all confirmed cases have universally included respiratory tract symptoms, so the site won't be unspecified.

Laboratory tests for COVID-19

Providers should follow CDC and DOH guidelines for testing in medical encounters.

Based on CDC guidelines, we cover serologic testing in limited scenarios.

Only tests that are FDA approved or FDA/EUA approved can be reimbursed. See billing guidelines below.

We don't cover testing related to travel and avoiding travel-related quarantine. Guidance as of Feb. 26, 2021, supports testing for asymptomatic individuals. However, we don't cover testing related to travel and avoiding travel-related quarantine.

For point-of-care tests, see guidelines below.

If you're a provider who's collecting a specimen and sending it to a lab, bill only an appropriate specimen collection code (see below). Do not bill for the laboratory test itself.

Laboratory Testing Codes	Requirements	Eligible Members	Eligible Providers	Notes
U0001	CDC 2019 Novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel for test samples sent to the CDC lab.	HMSA members	HMSA providers	Not common except very early in outbreak.
U0002	2019-ncov coronavirus, sars-cov-2/2019-ncov (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC.	HMSA members	HMSA providers	Providers may bill U0002 for rapid testing conducted in-office for payment. See guidelines for billing and reimbursement below.

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.	HMSA members	HMSA providers	U0003 should identify tests that would otherwise be identified by CPT code 87635 but are being performed with these high throughput technologies. Not to be used to identify tests detecting antibodies. [Cancelled 5/11/2023 EOD due to the end of the PHE]
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.	HMSA members	HMSA providers	U0004 should identify tests that would otherwise be identified by U0002 but are being performed with these high throughput technologies. Not to be used to identify tests detecting antibodies. [Cancelled 5/11/2023 EOD due to the end of the PHE]
U0005	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, completed within two calendar days from date of specimen collection (list separately in addition to either HCPCS code U0003 or U0004) as described by CMS-2020-01-R2.	HMSA members	HMSA providers	See guidelines for billing and reimbursement below. [Cancelled 5/11/2023 EOD due to the end of the PHE]
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B.	HMSA members	HMSA providers	Providers may bill 87428 for rapid testing conducted in-office for payment. See guidelines for billing and reimbursement below.
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.	HMSA members	HMSA providers	Providers may bill 87635 for rapid testing conducted in-office for payment. See guidelines for billing and reimbursement below.

87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique.	HMSA members	HMSA providers	
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique.	HMSA members	HMSA providers	
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single strip method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]).	HMSA members	HMSA providers	Covered in limited scenarios. See guidelines below.
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]).	HMSA members	HMSA providers	Covered in limited scenarios. See guidelines below.
87426	Infectious agent antigen detection by immunoassay technique (e.g. enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severed acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2) [COVID-19]).	HMSA members	HMSA providers	Providers may bill 87426 for rapid testing conducted in-office for payment. See guidelines for billing and reimbursement below.
87811	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).	HMSA members	HMSA providers	Providers may bill 87811 for rapid testing conducted in-office for payment. See guidelines for billing and reimbursement below.

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87913	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)	HMSA members	HMSA providers	87913 pends for medical necessity review requiring clinical documentation.
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected.	HMSA members	HMSA providers	
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected.	HMSA members	HMSA providers	
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including several acute respiratory syndrome coronavirus 2 (SARS CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported or detected or not detected.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected.			Not covered because it doesn't meet payment determination criteria.
0224U	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.

0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.
0226U	Surrogate viral neutralization test (SVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), ELISA, plasma, serum.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.
86409	Neutralizing antibody, sarscov2 titer neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative.	N/A	N/A	Not covered because it doesn't meet payment determination criteria.

High-Throughput COVID testing

For Medicare Advantage plan members: Effective Jan. 1, 2021, laboratories using high-throughput technology that meet the requirements of the amended Administrative Ruling (CMS-2020-1-R2) can bill add on code U0005 with U0003 and U0004 when appropriate. To bill U0005, laboratories must meet the following two requirements:

- Completion of the COVID-19 CDLT in two calendar days or less from the date of specimen collection.
- The majority of their COVID-19 CDLTs performed using high throughput technology in the previous calendar month were completed in two calendar days or less for all of their patients (not just their Medicare patients).

HCPCS code U0005 should be billed on the same claim as either HCPCS codes U0003 or U0004 when appropriate. For FAQs related to CMS COVID-10 billing, see cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

For commercial and QUEST Integration members: Effective Jan. 1, 2021, U0005 isn't separately reimbursable and will deny as integral to the primary procedure. Effective March 1, 2021, commercial and QUEST Integration will align with CMS and begin to separately reimburse for U0005 to encourage faster testing. Laboratories should only bill U0005 when the CMS requirements outlined above are met. HCPCS code U0005 should be billed on the same claim as either HCPCS codes U0003 or U0004 when appropriate.

Point-of-Care Testing

Rapid testing done at the point-of-care (POC) should be billed using the code that best aligns with the testing methodology**.** Providers doing POC are expected to follow FDA guidelines and to operate under a CLIA Certificate of Waiver or Certificate of Compliance/Certificate of Accreditation. For more information, see excerpt from the CDC below or the FDA page here in the General FAQs
Use modifier QW for applicable tests when performed in a facility having a CLIA certificate of waiver.

CDC excerpt (source):

"The U.S. Food and Drug Administration (FDA) recently clarified that, when it grants an Emergency Use Authorization (EUA) for a point-of-care test, that test is deemed to be CLIA-waived. For the duration of the national emergency declaration for COVID-19, such tests can be performed in any patient care setting that operates under a CLIA Certificate of Waiver or Certificate of Compliance/Certificate of Accreditation."

COVID-19 Rapid Testing Codes:

Code	Description
87426	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])
87428	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B
87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

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

Asymptomatic COVID-19 laboratory testing

For service dates prior to Feb. 26, 2021, HMSA will not pay for asymptomatic COVID-19 laboratory testing in the absence of a suspected or confirmed exposure except for nursing facilities per a CMS requirement. Laboratory services billed with applicable codes below as the only diagnosis on the claim will be denied.

For service dates on or after Feb. 26,2021, asymptomatic COVID-19 laboratory testing is covered.

ICD-10	Description
Z11.59	Encounter for screening for other viral diseases
Z11.52	Encounter for screening for COVID-19

COVID-19 Testing for Travel

HMSA covers medically appropriate diagnostic tests for COVID-19 and does not cover diagnostic testing for COVID-19 for travel purposes, such as to avoid quarantines associated with business or leisure travel.

Effective with a process date of February 15, 2021, COVID-19 tests billed with Z71.84 alone or Z71.84 with Z11.52 or Z11.59 (see description below) will deny as a not a benefit. For Commercial and Medicare Advantage plans, the member will be held liable for the charges.

ICD-10	Description
Z71.84	Encounter for health counseling related to travel
Z11.52	Encounter for screening for COVID-19
Z11.59	Encounter for screening for other viral diseases

If a member is required to travel for medical reasons, please indicate so with modifier SC. Do not use when testing to avoid quarantine rules.

Modifier	Description
SC	Medically necessary service or supply

Antibody/Serology Testing for COVID-19

In accordance with updated guidance from the CDC released May 24, 2020, and updated Aug. 1, 2020, HMSA will pay for serologic testing (CPT 86328, 86769) when the following criteria are met:

1. Serologic testing can be offered as a method to support diagnosis of acute COVID-19 illness for persons who present late complications nine – 14 days after illness onset.

    - Must be billed for the same service date as recommended direct detection methods (PCR tests represented by U0001 – U0004, 87635).
    - Claim line (1500) or claim should have one of the following applicable diagnosis codes in any position:

ICD-10 Code	Code Description
B97.29	Other coronavirus as the cause of diseases classified elsewhere
J12.82*	Pneumonia due to coronavirus disease 2019
J12.89	Other viral pneumonia
J20.8	Acute bronchitis due to other specified organisms
J22	Unspecified acute lower respiratory infection
J40	Bronchitis, not specified as acute or chronic
J96.20	Acute and chronic respiratory failure, unspecified with hypoxia or hypercapnia
J96.21	Acute and chronic respiratory failure with hypoxia
J96.22	Acute and chronic respiratory failure with hypercapnia
J96.00	Acute respiratory failure, unspecified with hypoxia or hypercapnia
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapnia
J96.90	Respiratory failure, unspecified, unspecified with hypoxia or hypercapnia
J96.91	Respiratory failure, unspecified with hypoxia
J96.92	Respiratory failure, unspecified with hypercapnia
J80	Acute respiratory distress syndrome
J98.8	Other specified respiratory disorders
R05	Cough (cancelled eff 09/30/2021)
R05.1	Acute cough (new eff 10/01/2021)
R05.2	Subacute cough (new eff 10/01/2021)
R05.3	Chronic cough (new eff 10/01/2021)

R05.4	Cough syncope (new eff 10/01/2021)
R05.8	Other specified cough (new eff 10/01/2021)
R05.9	Cough, unspecified (new eff 10/01/2021)
R06.02	Shortness of breath
R06.03	Acute respiratory distress
R09.02	Hypoxemia
R50.9	Fever, unspecified
U07.1	COVID-19

* Effective Jan. 1, 2021

2. For members 21 years old or younger, we will cover serologic testing when patients present with complications of COVID-19 illness, such as multisystem inflammatory syndrome in children (MIS-C).

Applicable codes billed in any position:

ICD-10 Code	Description
A48.3	Toxic shock syndrome
B30.2	Viral pharyngoconjunctivitis
B30.8	Other viral conjunctivitis
B30.9	Viral conjunctivitis, unspecified
B97.29	Other coronavirus as the cause of diseases classified elsewhere
H10.30	Unspecified acute conjunctivitis, unspecified eye
H10.31	Unspecified acute conjunctivitis, right eye
H10.32	Unspecified acute conjunctivitis, left eye
H10.33	Unspecified acute conjunctivitis, bilateral
H10.89	Other conjunctivitis
H10.9	Unspecified conjunctivitis
I88.8	Other nonspecific lymphadenitis
I88.9	Nonspecific lymphadenitis, unspecified
J02.8	Acute pharyngitis due to other specified organisms
J02.9	Acute pharyngitis, unspecified
J06.0	Acute laryngopharyngitis
J12.89	Other viral pneumonia
J20.8	Acute bronchitis due to other specified organisms
J22	Unspecified acute lower respiratory infection

J40	Bronchitis, not specified as acute or chronic
J80	Acute respiratory distress syndrome
J98.8	Other specified respiratory disorders
L04.9	Acute lymphadenitis, unspecified
M30.3	Mucocutaneous lymph node syndrome [Kawasaki]
M35.81*	Multisystem inflammatory syndrome
M35.89*	Other specified systematic involvement of connective tissue
R59.0	Localized enlarged lymph nodes
R05	Cough (cancelled eff 9/30/2021)
R05.1	Acute cough (new eff 10/01/2021)
R05.2	Subacute cough (new eff 10/01/2021)
R05.3	Chronic cough (new eff 10/01/2021)
R05.4	Cough syncope (new eff 10/01/2021)
R05.8	Other specified cough (new eff 10/01/2021)
R05.9	Cough, unspecified (new eff 10/01/2021)
R06.02	Shortness of breath
R10.X	Abdominal pain
R11.0	Nausea
R11.11	Vomiting without nausea
R11.2	Nausea with vomiting, unspecified
R19.7	Diarrhea, unspecified
R21	Rash and other nonspecific skin eruption
R50.9	Fever, unspecified

*Effective Jan. 1, 2021

Serologic tests for QUEST Integration members will follow CDC guidance issued May 24, 2020. HMSA will only pay for serologic testing using FDA-approved emergency use authorization (EUA) tests for these members. These tests will be billed for QUEST Integration using the following codes:

CPT Code	Description
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single strip 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]).

Specimen Collection for COVID-19 laboratory testing

Laboratory Testing Codes	Requirements	Eligible Members	Eligible Providers	Notes
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), any specimen source.	HMSA members	HMSA providers	This code is billable by clinical diagnostic laboratories. [Cancelled 5/11/2023 EOD due to the end of the PHE]
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 an HHA, any specimen source.	HMSA members	HMSA providers	This code is billable by clinical diagnostic laboratories. [Cancelled 5/11/2023 EOD due to the end of the PHE]
C9803	Hospital outpatient clinic visit specimen collection for SARS-CoV-2 (COVID-19), any specimen source (Medicare only).	HMSA Members	HMSA providers	**Outpatient Facility Hospitals only** Medicare Advantage: Effective May 1, OPPS must use instead of G2023 and G2024.
99211	Level 1 E/M visit and furnished for COVID-19 assessment and specimen collection for both new and established patients.	HMSA members	HMSA providers	Follow the guidelines below for billing COVID-19 visits (CS modifier).

HMSA Akamai Advantage® is a PPO plan with a Medicare contract. Enrollment in HMSA Akamai Advantage depends on contract renewal.

Preprocedural testing for COVID-19

To support the safety of our local ambulatory surgery centers, facilities, and specialists as they reschedule and resume elective surgeries and gastrointestinal endoscopic procedures, HMSA will cover preprocedural RT-PCR testing (U0001, U0002, U0003, U0004, 87635) for asymptomatic patients before surgery when rendered by a participating provider from April 1, 2020, through the end of the public health emergency. This exception is for commercial, Medicare Advantage, and QUEST Integration lines of business. Cost-sharing waivers will align with the end of the PHE. Serologic testing isn't covered.

Preoperative testing must include one of the following diagnosis codes in the primary position:

ICD-10 code	Description
Z01.812	Encounter for preprocedural laboratory examination
Z01.818	Encounter for other preprocedural examination

Please see guidance below for appropriate use of modifier CS when billing for visits or services leading to testing.

Employer Required COVID-19 Testing

Services related to obtaining or maintaining employment reasons are not covered.

Employer related services are identified by one of the following ICD-10 diagnosis codes:

ICD-10 code	Description
Z02.1	Encounter for pre-employment examination
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Office, Urgent Care, and ER Visits for COVID-19

From March 1, 2020, through the end of the PHE, if a patient comes in for an office, urgent care, or emergency room visit, the provider shouldn't charge the patient a copayment or deductible (cost share) for the collection of a COVID-19 test specimen: Use appropriate Office Visit E/M code: E/M coding guidelines must be applied for all E/M provided

Use ICD-10 Diagnosis:

- **Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out** when the patient has a suspected exposure to COVID-19.

- **Z20.822 Contact with and (suspected) exposure to COVID-19 (effective Jan. 1, 2021).**
- **Z20.828 Contact with and exposure to other viral communicable disease** when the patient has been exposed to a confirmed case of COVID-19. Effective Jan. 1, 2021. Please use Z20.822.

1. Use **modifier CS** to indicate diagnostic services related to COVID-19.

For Medicare Advantage plan members: Providers and suppliers should use the **CS modifier** to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services. Medicare Advantage plans will use the modifier and/or the above criteria to identify services that will waive the cost share

For fully insured commercial and QUEST Integration plan members: Before May 1, 2020, diagnosis codes Z03.818 and Z20.828 will be used to identify COVID-19 diagnosis related services. On or after May 1, 2020, use modifier CS with the appropriate diagnosis code to identify diagnostic services.

Treatment of COVID-19

When treating a patient who has a confirmed COVID-19 diagnosis, use appropriate ICD-10 diagnosis code listed below to apply the cost-sharing waiver through December 31, 2022. Cost-share waivers for COVID-19 treatment will end on January 1, 2023. This includes copayments, coinsurance and deductibles.

- **U07.1 COVID-19** for dates of service on or after April 1, 2020.
- **B97.29 Other coronavirus as the cause of diseases classified elsewhere** for dates of service on or before March 31, 2020.

Monoclonal Antibodies

If a drug or supply is provided at no cost from the federal government, no charges should be billed to HMSA for the cost of drug.

Administration fees will be reimbursed. Examples of drugs that may have been provided at no cost are noted below along with their associated administration code.

Please also make sure you are reviewing the most recent Observation Services medical policy (here) before billing for observation. Typically, monoclonal antibody infusions will not qualify for observation services unless there are extenuating circumstances.

Monoclonal Antibody Codes	Description	Eligible Members	Eligible Providers	Notes
Q0239	Injection, bamlanivimab--xxxx, 700 MG	HMSA members	HMSA providers	Do not bill if drug was provided at no cost. Effective April 16, 2021 the FDA revoked the EUA for bamlanivimab when billed alone. CMS has terminated these codes and HMSA will no longer reimburse for services rendered on or after April 16, 2021.
M0239	Intravenous infusion bamlanivimab-xxxx, includes infusion and post administration monitoring	HMSA members	HMSA providers	Effective April 16, 2021 the FDA revoked the EUA for bamlanivimab when billed alone. CMS has terminated these codes and HMSA will no longer reimburse for services rendered on or after April 16, 2021.
Q0240	Injection, casirivimab and imdevimab, 600mg	HMSA members	HMSA providers	Do not bill if drug was provided at no cost. Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and

				imdevimab on or after January 24, 2022.
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	HMSA members	HMSA providers	Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and imdevimab on or after January 24, 2022.
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 Public Health Emergency, subsequent repeat doses	HMSA members	HMSA providers	Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and imdevimab on or after January 24, 2022.
Q0243	Injection, casirivimab and imdevimab, 2400 MG	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost. Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and imdevimab on or after January 24, 2022.
Q0244	Injection, casirivimab and imdevimab, 1200 MG	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost. Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and imdevimab on or after January 24, 2022.

M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection and post-administration monitoring	HMSA members	HMSA providers	Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and imdevimab on or after January 24, 2022.
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency.	HMSA Members	HMSA providers	Effective January 24, 2022 the FDA announced that casirivimab and imdevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse casirivimab and imdevimab on or after January 24, 2022.
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost. Effective January 24, 2022 the FDA announced that bamlanivimab and etesevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse bamlanivimab and etesevimab on or after January 24, 2022.
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	HMSA Members	HMSA providers	Effective January 24, 2022 the FDA announced that bamlanivimab and etesevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse bamlanivimab and etesevimab on or after January 24, 2022.
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency.	HMSA Members	HMSA providers	Effective January 24, 2022 the FDA announced that bamlanivimab and etesevimab aren't currently authorized in any U.S. region. HMSA will no longer reimburse bamlanivimab and etesevimab on or after January 24, 2022.

Q0247	Injection, sotrovimab, 500 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost. Effective April 5, 2022 the FDA announced that sotrovimab isn't currently authorized in any U.S. region. HMSA will no longer reimburse sotrovimab on or after April 5, 2022.
M0247	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring	HMSA Members	HMSA providers	Effective April 5, 2022 the FDA announced that sotrovimab isn't currently authorized in any U.S. region. HMSA will no longer reimburse sotrovimab on or after April 5, 2022.
M0248	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency	HMSA Members	HMSA providers	Effective April 5, 2022 the FDA announced that sotrovimab isn't currently authorized in any U.S. region. HMSA will no longer reimburse sotrovimab on or after April 5, 2022.
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost.
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	HMSA Members	HMSA providers	
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2	HMSA Members	HMSA providers	

	years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose			
Q0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 300 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost.
Q0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 600 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost.
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended	HMSA Members	HMSA providers	

	due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring			
M0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	HMSA Members	HMSA providers	
J0248	Injection, remdesivir, 1 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost.
Q0222	Injection, bebtelovimab, 175 mg	HMSA Members	HMSA providers	Do not bill if drug was provided at no cost. Effective November 30, 2022 the FDA announced that bebtelovimab isn't currently authorized in any U.S. region. HMSA will no longer reimburse bebtelovimab on or after November 30, 2022.
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring	HMSA Members	HMSA providers	Effective November 30, 2022 the FDA announced that bebtelovimab isn't currently authorized in any U.S. region. HMSA will no longer reimburse bebtelovimab on or after November 30, 2022.

M0223	Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	HMSA Members	HMSA providers	Effective November 30, 2022 the FDA announced that bebtelovimab isn't currently authorized in any U.S. region. HMSA will no longer reimburse bebtelovimab on or after November 30, 2022.

COVID-19 Convalescent Plasma

Code	Description	Eligible Members	Eligible Providers	Notes
C9507	Fresh frozen plasma, high titer COVID-19 convalescent, frozen within 8 hours of collection, each unit	HMSA members	HMSA providers	C9507 pends for medical necessity review requiring clinical documentation. Documentation must be supported and in alignment with the FDA revised emergency use authorization letter, found here: https://www.fda.gov/media/141477/download

Supplies and Additional Time

We don't separately reimburse for additional supplies or time spent with the patient during a PHE represented by the following service code:

- **99072:** Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE as defined by law due to respiratory-transmitted infectious disease.

Use of Modifier CR and Condition Code DR

Use CR modifier and the DR condition code on disaster/emergency-related services when submitting for services covered under 1135 blanket waivers for Medicare Advantage plans. Use of condition code DR and modifier CR isn't a determinant that cost sharing will be waived.

1. Use condition code DR (disaster related) for institutional claims only.
2. Use modifier CR (catastrophe/disaster related) for institutional and professional claims.

See the CMS FAQs for blanket waivers. (Note: Download this document to access the link for the CMS FAQs.)

Previously processed claims

See below.

Telehealth Coding Guide

Updated 5/2/2023

The U.S. Department of Health and Human Services announced that it would allow the federal Public Health Emergency for COVID-19 to expire at the end of the day on May 11, 2023. After PHE ends, standard plan benefits apply. Please reference members benefit plan.

Telehealth Visits	HCPS/CPT Code	Eligible Members	Eligible Providers	Notes
A patient visit with a provider who uses telecommunication systems (i.e., interactive audio and video telecommunication systems that permits real-time communication between the distant site and the patient at home).	Common telehealth services include: **99201-99215** (Office or other outpatient visits). **G0425-G0427** (Telehealth consultations, emergency department or initial inpatient). **G0406-G0408** (Follow-up inpatient telehealth consultations furnished to patients in hospitals or SNFs). Bill with appropriate place of service (02) or modifier (95, GT, GQ or G0). For Medicare Advantage plans, please follow Medicare billing guidelines listed below this table.	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS won't conduct audits to ensure that such a prior relationship existed for claims submitted during this PHE.	Medicare recognizes the following distant site practitioners: a) Physician. b) Nurse practitioner. c) Physician assistant. d) Nurse-midwife. e) Clinical nurse specialist. f) Clinical psychologist. g) Clinical social worker. h) Registered dietitian or nutrition professional. i) Certified registered nurse anesthetist. j) Registered dietitians or nutrition professional. The CARES Act also allows federally qualified health centers and rural health clinics to be recognized as distant site practitioners. For the duration of the PHE, CMS will allow providers who are eligible to independently bill professional services to provide services via telehealth. See the telehealth FAQs in the HMSA Provider Resource Center for details.	**For a complete list, visit** cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes **For a list of expanded telehealth services covered during an emergency proclamation, visit** https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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E-Visits	HCPS/CPT Code	Eligible Members	Eligible Providers	Notes
A communication between a patient and provider through an online patient portal.	**E&M services:** **CPT codes 99421 – 99423** **HCPCS code G2061-G2063, **98970-98972** *See below for additional guidance for PT/OT/ST when billing Medicare FQHCs and RHCs G0071.	New and established patients	Physicians and other qualified health care practitioners who can bill E&M services: **CPT codes 99421 - 99423** Qualified non-physician health care professionals, including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, or speech language pathologists: **HCPCS code G2061 – G2063, **CPT codes 98970-98972**	Effective Jan. 1, 2021, commercial plans no longer separately reimburse for e-Visits. **G2061-G2063 have been canceled as of Dec. 31, 2020. Effective Jan. 1, 2021, we recognize 98970-98972 for Medicare Advantage and QUEST Integration members.
Virtual Check-in (e.g. Audio only check-in)	**HCPS/CPT Code**	**Eligible Members**	**Eligible Providers**	**Notes**
A brief check-in with a patient by telephone or other telecommunication device to determine if an office visit or other service is needed.	**G2012** (5-10 min E/M provider) **G2252** (11-20 min E/M provider) **G2251** (5-10 min non-E/M provider) *See below for additional guidance for PT/OT/ST when billing Medicare.	New and established patients	Physicians and other qualified health care practitioners who can bill E&M services: **G2012, G2252** Qualified non-physician health care professionals, including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, or speech language pathologists: **G2251, G2250 (Medicare only):**	Please follow CMS and code description guidelines when billing virtual check-ins. Services should not be originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

A remote evaluation of recorded video and/or images submitted by the patient.	**G2010** (E/M provider) **G2250** (non-E/M provider). **NOTE**: G2250 does not meet medical necessity criteria for QI and PB members and will be denied as provider liable	New and established patients	Physicians and other qualified health care practitioners who can bill E&M services: **HCPCS: G2010** Qualified non-physician health care professionals, including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, or speech language pathologists: **HCPCS: G2250 (Medicare only)**	Please follow CMS and code description guidelines when billing virtual check-ins. Services should not be originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

Phone Visits	HCPS/CPT Code	Eligible Members	Eligible Providers	Notes
Phone (non-face-to-face) evaluation or assessment and management visits.	E/M services: **CPT codes 99441-99443** **CPT codes 98966-98968**	New and established patients Effective Aug. 1, 2021 applicable to Commercial, QUEST Integration, and Medicare Advantage members Effective January 1, 2021through July 31, 2021 limited to Medicare Advantage and QUEST Integration members	A broad range of clinicians, including physicians, can now provide certain services by phone to patients. Physicians and other qualified health care practitioners who can bill E&M services: **CPT codes 99441-99443** Qualified health care professionals, including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, or speech language pathologists: **CPT codes 98966-98968**	Effective service dates Aug. 1, 2021, through the end of PHE on 5/11/2023 EOD, commercial plans will cover audio-only visits (phone visits) once more. For coding guidelines, see Audio-Only Coverage for Medical and Behavioral Health Visits – Coding Guidelines. Effective Jan. 1, 2021 through July 31, 2021, commercial plans deny audio-only visits (phone visits) as not covered. They're denied as a member liability. Please discuss the member liability with your patients before providing these services. Please use virtual check-in codes (above) as appropriate. **Check HHIN Home Page Announcement for a list of plans that are excluded.**

Remote Patient Monitoring	HCPS/CPT Code	Eligible Members	Eligible Providers	Notes
Remote patient monitoring for both acute and chronic conditions can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.	**99091** **99457-99458** **99473-99474** **99493-99494**	New and established patients		Effective Jan. 1, 2021, commercial plans no longer separately reimburse for remote patient monitoring codes 99091, 99473-99474,99493-99494.
Interprofessional Consultations	**HCPS/CPT Code**	**Eligible Members**	**Eligible Providers**	**Notes**
	99446-99449 **99451** **99452**	QUEST Integration and Medicare Advantage – new and established members	**99446-99449, 99451** reported only by a consultant when requested by another physician/QHP. **99452** reported by the physician/QHP who is treating the patient and requesting the non-face-to-face consult for medical advice or opinion – and not for a transfer of care or a face-to-face consult. Additional limits apply to interprofessional codes and national guidelines should be followed.	These services aren't a benefit of commercial plans. QI coverage for **99446 – 99449** is limited to the PHE period.

Cardiac Rehab and Intensive Cardiac Rehab	HCPS/CPT Code	Eligible Members	Eligible Providers	Notes
	93797- 93798 **G0422 - G0423**	New and established patients (refer to the PRC or HHIN for program limitations and member eligibility)	Intensive cardiac rehab **(G0422 - G0423)** is limited to contracted providers.	Cardiac rehab **(93797-93787)** is not a benefit of commercial plans. Coverage for services via telehealth limited to the PHE period.

Medicare Advantage & QUEST Integration Expanded Telehealth Billing Guidelines

For Medicare Advantage plans, use the following guidelines when billing professional claims for expanded telehealth services, including nontraditional telehealth services that are temporarily covered from March 1, 2020, through the duration of the PHE:

- Place of service (POS) equal to what it would've been if the service was provided in person.
- Modifier 95, indicating that the service was rendered via telehealth. Services that aren't billed with modifier 95 will pay at the plan benefit level as they won't be recognized as a telehealth service.
- Claims for nontraditional telehealth services temporarily covered during the PHE will be denied if billed with POS 02. Nontraditional telehealth services temporarily covered during the PHE are identified in the CMS list of telehealth codes available here.

Medicare Advantage Expanded Telehealth Billing Guidelines

As a reminder, CMS isn't requiring the CR modifier on telehealth services. However, to be consistent with the current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

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

Independent PT, OT, ST providers must append modifier GO, GP, or GN when billing for G2010, G2012, G2061, G2062, G2063, G2251, G2252 and 98966–98968. Codes are considered "sometimes therapy" codes.

Expansion of Virtual Communication Services for FQHCs/RHCs

- FQHCs/RHCs can bill for online digital E/M with codes 99421 – 99423.
- RHCs and FQHCs can bill for online digital evaluation and management services using the HCPCS code G0071 effective March 1, 2020. Code G0071 is bundled into CPT codes 99421, 99422, and 99423.
- G0071 is for a minimum seven-day period, so it cannot be billed more than once every seven days.
- During the PHE, FQHC and RHCs can serve as distant site providers of telehealth. Providers must use modifier 95 for distant site service provided between January 27, 2020 – June 30, 2020. After July 1, 2020, modifier 95 may be included but is not required. Please see updated CMS guidelines for billing G2025 https://www.cms.gov/files/document/se20016.pdf when rendering services for a Medicare Advantage member. QUEST Integration provides should continue to follow MedQUEST guidelines.

Previously processed claims

Note: Applies to COVID-19 and Telehealth Coding Guides.

Please see our Telehealth FAQ and COVID-19 testing and treatment FAQ for up-to-date benefit information.

We've completed laboratory testing system updates and have reprocessed claims.

We've completed updates to our system for telehealth claims and are currently reprocessing claims.

We've completed updating our systems for diagnostic and treatment services. We're completing claims reprocessing.

For COVID-19 treatment claims with a service date on or after January 1, 2021, we will identify and send claims for reprocessing if a cost-share was applied.

If you submitted a claim for an audio-only visit (99441-99443 or 98966-98968) rendered from Jan. 1, 2021 through July 31, 2021, you may resubmit using virtual check-in codes if appropriate (G2010, G2012, G2251, G2252).

Due to the recent surge in COVID-19 cases in Hawaii, HMSA is in the process of making updates to our system to cover audio-only visits (99441-99443 or 98966-98968) once more. For claims related to this update with a service date on or after August 1, 2021, we will identify and send claims for reprocessing.