

Part B News

partbnews.com

COLLECT EVERY DOLLAR
YOUR PRACTICE DESERVES



PBN Perspectives

As growth of NPs and PAs accelerates, expect practice duties to rise too

The role of nurse practitioners (NP) and physician assistants (PA) is growing — but so is the shortage of physician health care providers. This is expected to lead to an expansion in the practice capabilities of these providers, and you're likely to see some changes in their relationship with physicians.

Health care is one of the hottest sectors of the American economy, and employment across the industry is up. NPs and PAs are seeing particularly strong growth. While the U.S. Bureau of Labor Statistics (BLS) expects employment of physicians and surgeons to grow by 4% from 2019 to 2029, it expects jobs for PAs to grow by 31% and for NPs to increase by 52%.

For purposes of comparison, among other advanced practice registered nurses (APRN), the Bureau sees jobs for nurse midwives gaining by 12% and nurse anesthetists by 14%. Medical assistant employment is predicted to rise by 19%.

The labor growth of NPs and PAs is perhaps a predictable outcome of growing shortages of physician access in the U.S. In June, the Association of American Medical Colleges (AAMC) warned “that physician demand will grow faster than supply, leading to a projected total physician shortage of between 54,100 and 139,000 physicians by 2033.” This includes a primary care physician shortage of as many as 55,000 and a specialty physician shortage between 33,700 and 86,700. At the same time, the U.S. population is aging, presaging a greater demand for health care services.

In this issue

- 1 **PBN Perspectives**
As growth of NPs and PAs accelerates, expect practice duties to rise too
- 4 **Coding**
Ahead of Oct. 1 start, master 2021 ICD-10-CM coding for nervous system conditions
- 5 **Benchmark of the week**
In recent years, nurse practitioners gobble up shares of E/M office visit claims
- 8 **Ask Part B News**
Asymptomatic but wants a COVID test? Press for medical necessity in notes, use Z-code

Maximize revenue with E/M prolonged service update

Practices must prepare for changes to the prolonged services section of the CPT manual so they can earn the additional revenue they're due when treating clinicians or clinical staff spend extra time on patient care. Coding and compliance expert Brenda Edwards will walk you through what you need to know during the Oct. 6 webinar **Prolonged Services Update: New Rules for the Additional Revenue**. Learn more: <https://codingbooks.com/ympta100620>.

Concerted effort to promote

The pace of PA and NP enrollment growth may help fill the physician gap. Currently, some 290,000 NPs work within the U.S. health care system, according to the American Association of Nurse Practitioners (AANP). About 125,500 PAs join them, according to BLS. At BLS' predicted rate of growth over the next 10 years, that would add roughly 151,000 NPs and 39,000 PAs to the mix.

Educational funders, both private and governmental, are rising to the challenge. September alone saw multiple investment opportunities. Idaho State University announced that it was instituting a Physician Assistant Grit Scholarship, funded by \$1.4 million awarded by the U.S. Health Resources and Services Administration (HRSA); Inland Empire Health Plan (IEHP) is giving Loma Linda University in California \$4.2 million to fund 28 medical students, including 10 in the NP program, who will commit to working in underserved local communities; the University of California at San Diego received a \$7 million endowment for a PA education program; and the University of Connecticut got \$3 million from HRSA for a "PATH to PCNP" [primary care nurse practitioner] program.

Corporate partnerships also are pushing the ball forward. The health information network Availity, based in Jacksonville, Fla., announced a new partnership with Jacksonville University to establish an Availity Nurse Practitioner Scholars Fund, through which NPs "may begin to earn the educational credits needed to offer independent primary care without an attending doctor, as outlined under a new state law," according to the announcement.

The Florida state law in question allows NPs to offer primary care without an attending physician if the NP can demonstrate 3,000 hours of practice experience under physician supervision, plus either three credit hours of graduate-level coursework or 45 continuing education units (CEU) in advanced pharmacology and differential diagnosis, within the preceding five years.

"We truly believe that nurse practitioners are an underutilized asset, especially here in Florida, considering we have an aging population with chronic conditions and comorbidities," says Molly Miles, Availity's vice president for marketing.

Primary, and also specialty, growth

PAs and NPs are customarily considered primary care providers. According to AANP, 90% of NPs are

certified in an area of primary care. But accumulation of specialty knowledge and certification is on the rise among PAs. The National Commission on Certification of Physician Assistants (NCCPA) reports in its 2019 annual statistical profile that about as many PAs — approximately 19% — report practicing in surgical subspecialties as in family medicine or general practice.

While several other certifying bodies can give specialty certifications to PAs and NPs, their scope of practice is determined by state licensing laws and is not expanded by these certifications. Typically, the certifications are advertised as ways to "publicly share

Simplify
Compliance
Learn, Comply, Succeed

**SUBSCRIBER
INFORMATION**

Have questions on a story? Call or email us.

PART B NEWS TEAM

Maria Tsigas, x6023

Product Director, Information, Print Subscription
Products and Services
mtsigas@decisionhealth.com

Marci Geipe, x6022

Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Steven Andrews, x3171

Managing Editor, Coding
sandrews@hcpro.com

Richard Scott, 267-758-2404

Associate Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031

Editor
redroso@decisionhealth.com

Medical Practice & Hospital community!

www.facebook.com/DecisionHealthPAC

www.twitter.com/DH_MedPractice

www.linkedin.com/groups/12003710

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customer@decisionhealth.com

DECISIONHEALTH PLEDGE OF INDEPENDENCE:

Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US

Visit us online at: www.partbnews.com.

CEUS

Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customer@decisionhealth.com.

ADVERTISING

To inquire about advertising in *Part B News*, call 1-855-CALL-DH1.

COPYRIGHT WARNING

Copyright violations will be prosecuted. *Part B News* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations contact: Brad Forrester at 1-800-727-5257 x8041 or email bforrester@btr.com.

REPRINTS

To request permission to make photocopy reprints of Part B News articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

Part B News® is a registered trademark of DecisionHealth.
Part B News is published 48 times/year by DecisionHealth, 100
Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 0893-
8121. pbcustomer@decisionhealth.com Price: \$647/year.

DecisionHealth
a Simplify Compliance brand

Copyright © 2020 DecisionHealth, all rights reserved. Electronic or print redistribution without prior written permission of DecisionHealth is strictly prohibited by federal copyright law.

your specialty experience, skills and knowledge” and “add practice-related credibility” to a resume. Nonetheless, specialty employers often ask for specialty certifications when advertising an NP or PA position to be filled.

For NPs and PAs, specialty education may also be accumulated by practical experience. “I spent the first 15 years of my career doing orthopedic surgery,” says Kim Zuber, PA-C and executive director of the American Academy of Nephrology PAs (AANPA). “It is physically impossible to hold a fracture together and drill and put in pins at the same time — somebody has to reduce the fracture while the other person casts.” Zuber’s work on amputations for diabetic patients introduced her to nephrology practitioners, which is how she got into that discipline.

Zuber estimates that a PA will typically work in at least three specialties over the course of a career. And she believes the opportunity to switch is part of the draw for young students: “If you’re tired of [a specialty] after 10 years, you can move into something else you can do, versus physicians who have spent years of training for their specialty and, no matter what it is or how they feel about it, have to stick at it.”

How COVID advances the profession

The COVID-19 public health emergency (PHE) has expanded the authority of NPs and PAs to practice independently of a physician. For example, CMS has allowed NPs and PAs to be supervised via telehealth, and has waived supervision on several procedures performed by them including “virtual check-ins” and supervision of diagnostic tests ([PBN 4/9/20](#), [8/6/20](#)).

Other regulators also have eased restrictions. “Eight states have temporarily waived physician supervision rules via executive orders,” notes Lauren Bates-Rowe, vice president, state advocacy and outreach at AAPA, “while other states have waived supervision due to existing laws related to an emergency.”

The hope among NP and PA advocates is that CMS, as well as the states, will note the popularity of the changes with patients and make them permanent. “States must build on their progress and remove outdated administrative burdens for PAs to practice to the full extent of their education, training and experience,” Bates-Rowe says.

“There is not an area in health care in which we practice where you don’t see growth,” says Sophia L. Thomas, president of AANP. “Also, when outdated regulatory requirements of a written collaboration agreement with

a physician are reduced, this improves access, specifically through the COVID-19 emergency, and through heightened awareness of health disparities among rural and minority communities.”

Growing pains

As the role of NPs and PAs progresses, some doctor groups have at times reacted defensively. On Sept. 3, several emergency medicine groups, including the American College of Emergency Physicians and the American College of Osteopathic Emergency Physicians, released a statement regarding post-graduate training of NPs and PAs seeking to clarify terms associated with residents’ training:

“Although all who provide care in the emergency department setting must be appropriately trained,” the statement reads, “education of emergency medicine resident physicians and medical students must not be compromised or diluted. The terms ‘resident,’ ‘residency,’ ‘fellow,’ and ‘fellowship’ in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs.”

AANP and other nursing organizations said they “strongly oppose the view that emergency care is solely ‘physician-led’ or that physicians should dictate education and practice standards for advanced practice registered nurses.” Other practitioner groups, including PAs for Tomorrow and the American College of Clinical Pharmacy, took their side.

For its part, the larger NP and PA community is decidedly less tolerant than it once was of terms such as “mid-level” and “extender” for their practices. The AAPA’s “A Guide for Writing and Talking About PAs” says these terms “are not only offensive to PAs but are also relics of the past and should not be used.” AAPA asks that you “use ‘PA’ as the title of the profession, not ‘physician assistant,’ in all copy.” Given the range of their responsibilities, “physician ‘assistant’ is kind of a misnomer,” Zuber says.

“I think this [new Florida] law is acknowledging that nurse practitioner training, particularly in primary care, is being deemed as equivalent with physician training,” says Christine Sapienza, Ph.D., provost, senior vice president of academic affairs at Jacksonville University in Florida.

A doctor demurs

Bonnie Litvack, M.D., president of the Medical Society of the State of New York, applauds the growth and expanding outreach of NPs and PAs, but adds, “I think we have to be really cautious here, because particularly talking about PAs and NPs, while they are essential members of the team, it’s not in their training to practice independently. ... When you’re talking about complex medical conditions, the physician is the one who’s trained to identify those.”

Zuber acknowledges that PAs are part of the clinical team with a specific role, just as M.D.s are: “Medicine is a group effort,” Zuber says. “I need the dietitians just as much as I need the nurses, just as much as I need my social workers.”

When to hire?

While NPs and PAs are in some sense the wave of the future, Litvack says it’s specifically your own future you should consider when deciding whether and when to hire them into your practice.

“Let’s take a surgical specialty,” Litvack says. “If they have a lot of follow-up care and chronic care management, that would be a situation where it would be helpful for them to have a [PA or NP]. But on the other hand, if such a practice is really interested in expanding the amount of surgery that they’re doing, and they have a large patient population that they’re not able to get in for surgery, it makes more sense to hire a new surgeon. So I think it depends on you know what the practice is looking for.

“There’s a big role there for the NPs in that they can spend a little bit more time with the patient than the M.D.,” Litvack adds. “A lot of that focus is on, for example, nutrition counseling, hypertension counseling, discussing ways that they can manage their illnesses.”
— Roy Edroso (redroso@decisionhealth.com) ■

RESOURCES

- AAMC, “The Complexities of Physician Supply and Demand: Projections From 2018 to 2033”: www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf
- Joint Statement Regarding Post-Graduate Training of Nurse Practitioners and Physician Assistants: www.aaem.org/UserFiles/file/AllEMorgjointstatementrepostgradtrainingofNPandPAs.pdf

Coding

Ahead of Oct. 1 start, master 2021 ICD-10-CM coding for nervous system conditions

The fiscal year (FY) 2021 update to the ICD-10-CM code set includes 26 new codes for nervous system conditions, such as cerebellar ataxia, Dravet syndrome and cerebral spinal fluid (CSF) leaks.

You’ll find a comprehensive review of nervous system code changes and associated updates to the ICD-10-CM Official Guidelines for Coding and Reporting, set to go into effect October 1.

Cerebellar ataxia

Acute cerebellar ataxia is caused by damage to the cerebellum, the part of the brain that controls balance and muscle coordination. This condition commonly affects children between the ages of 2 and 7 and is marked by sudden uncoordinated muscle movements, according to Shannon McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS, CCDS-O, director of HIM and coding for HCPro in Middleton, Mass.

Other symptoms of acute cerebellar ataxia include difficulty walking, eye movement abnormalities, gait abnormalities, tremors and trouble eating and swallowing. Ataxia is frequently caused by viruses that attack the nervous system such as chickenpox, mumps and Epstein-Barr virus, according to the National Institutes of Health.

The ICD-10-CM update adds three new codes for cerebellar ataxia:

- **G11.10** (Early onset cerebellar ataxia, unspecified).
- **G11.11** (Friedreich ataxia).
- **G11.19** (Other early-onset cerebellar ataxia).

Unlike early-onset cerebellar ataxia, Friedreich’s ataxia is inherited. “This rare autosomal recessive genetic disease causes difficulty walking, a loss of sensation in the arms and legs, and impaired speech,” McCall says. “Symptoms start between 5 and 15 years of age and worsen over time.”

(continued on p. 6)

Benchmark of the week

In recent years, nurse practitioners gobble up shares of E/M office visit claims

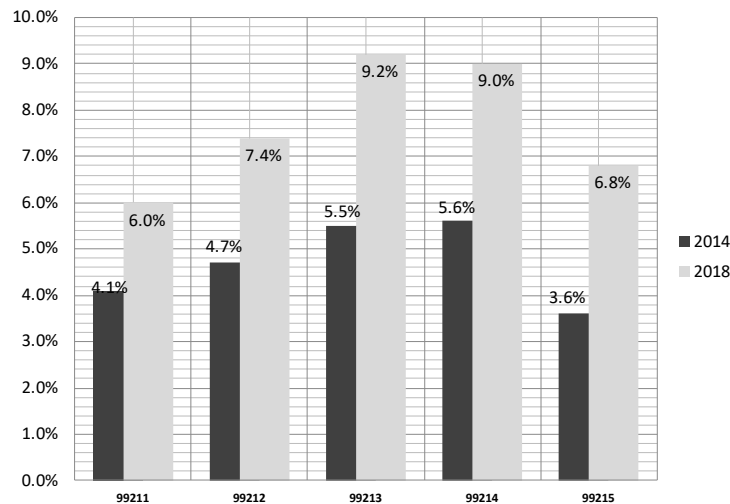
The number of office E/M codes that nurse practitioners (NP) are reporting under Medicare Part B has been on a significant upswing in recent years. Total claims for their most-billed office code, **99214**, are up 114% from 2014 to 2018.

As the chart below details, NPs reported roughly 9.7 million 99214 claims in 2018, the latest year of available Medicare claims data. That's up from 4.5 million claims in 2014, and it gives NPs a 9% share of all 99214 claims reported nationally. In 2014, NPs' share of 99214 claims was under 5%. With 9.1 million **99213** claims in 2018, NPs also took responsibility for about 9.2% of all patient encounters that ended in a 99213, the specialty's second most frequently reported office service.

As NPs handle a greater number of E/M office visits, their Medicare reimbursement has increased as well. In 2014, the NP specialty gained \$515 million in payments for the suite of established office visit codes (**99211-99215**). By 2018, the payment total for the five codes increased to more than \$957 million, marking an 86% jump.

The increase in E/M established visit claims follows a similar pattern among NPs' wider utilization trends. In recent years, total NP claims have shot up nearly 50% (*PBN 1/20/20*). — Richard Scott (rscott@decisionhealth.com)

Nurse practitioner share of E/M claims, 2014 vs. 2018



Nurse practitioner 99211-99215 claims, 2014-2018



Source: Part B News analysis of Medicare claims data

(continued from p. 4)

Epilepsy

The code update also adds the following new codes to category **G40.-** (Epilepsy and recurrent seizures):

- **G40.42** (Cyclin-Dependent Kinase-Like 5 (CDKL5) Deficiency Disorder).
- **G40.833** (Dravet syndrome, intractable, with status epilepticus).
- **G40.834** (Dravet syndrome, intractable, without status epilepticus).

CDKL5 deficiency disorder (CDD) is a rare developmental epileptic encephalopathy (DEE) caused by mutations in the CDKL5 gene, according to the National Organization for Rare Disorders (NORD). CDD is classified as a DEE because it causes seizures and developmental impairments.

Mutations on the CDKL5 gene have also been associated with X-linked infantile spasm syndrome and Rett syndrome. Dravet syndrome, previously known as severe myoclonic epilepsy of infancy, is an autosomal dominant genetic disorder that causes a severe form of epilepsy, with prolonged seizures that are often triggered by hot temperatures or fever, according to McCall. It often begins before the child's first birthday and is difficult to treat with anticonvulsant medications.

Congenital myopathies

A congenital myopathy is a disease present from birth that causes direct damage to muscular tissue. Patients with myopathic conditions suffer from muscle weakness, damage and paralysis. Signs and symptoms vary in type and severity, although the manifesting conditions often remain stable or progress slowly.

Currently, all congenital myopathies are reported using the nonspecific ICD-10-CM code **G71.2** (Congenital myopathies), says Raemarie Jimenez, CPC, CPB, CPMA, CPPM, CPC-I, CCS, vice president of membership and certification solutions at the American Academy of Professional Coders (AAPC) in Salt Lake City.

The FY 2021 update introduces the following new ICD-10-CM codes for congenital myopathies:

- **G71.20** (Congenital myopathy, unspecified).
- **G71.21** (Nemaline myopathy).
- **G71.220** (X-linked myotubular myopathy).
- **G71.229** (Other centronuclear myopathy).

- **G71.29** (Other congenital myopathy).

Nemaline myopathy is a rare genetic disorder that primarily affects skeletal muscles. Characteristic symptoms of the disorder include muscle weakness, diminished muscle tone (hypotonia), and reduced or absent reflexes. Affected individuals may also experience feeding and swallowing difficulties, abnormal curvature of the spine, and joint deformities (contractures).

There are six different clinical presentations of nemaline myopathy, according to NORD. Listed from most to least common, these are:

- Typical congenital nemaline myopathy.
- Intermediate congenital nemaline myopathy.
- Severe congenital (neonatal) nemaline myopathy.
- Childhood-onset nemaline myopathy.
- Adult-onset nemaline myopathy.
- Amish nemaline myopathy.

Typical congenital nemaline myopathy is the most common form of nemaline myopathy, accounting for approximately half of all cases, according to NORD.

Centronuclear myopathies are a group of congenital myopathies characterized by the misplacement of cell nuclei in muscle fibers. Typically, the nuclei of skeletal muscle cells are located in the periphery. In centronuclear myopathy, the cell nuclei are centrally located, according to the Muscular Dystrophy Association. Common symptoms of centronuclear myopathies include muscle weakness and hypotonia.

There are two types of centronuclear myopathies: X-linked myotubular myopathy, described by the new ICD-10-CM code **G71.220**, and autosomal centronuclear myopathy, described by **G71.299**, according to Jimenez. Unlike other centronuclear myopathies, which are caused by abnormalities on non-sex chromosomes, X-linked myotubular myopathy results from mutations on the X-chromosome.

“The X-linked type presents with more severe symptoms; therefore, there is a need to track this condition separately from other centronuclear myopathies,” Jimenez says. It is also believed that X-linked myotubular myopathy is underdiagnosed and that the creation of code **G71.220** will lead to better tracking of this condition.

Spontaneous cerebrospinal fluid leaks

CSF is a watery fluid that circulates through the brain's ventricles and around the brain and spinal cord. This fluid cushions the brain and spinal cord, protecting them

from injury. A CSF leak results from a tear in the dura, the outermost layer of the meninges, according to John Hopkins Medicine. However, spontaneous leaks can also occur for no known reason.

CSF leaks are classified into two main types: cranial leaks and spinal leaks. Spinal leaks are more common. Cranial leaks occur in the head and may result in CSF leaking from the nose or ear, McCall says.

Previously, there was a single nonspecific CSF leak ICD-10-CM code. The code 2021 update adds the following new codes for CSF leaks:

- **G96.00** (Cerebrospinal fluid leak, unspecified).
- **G96.01** (Cranial cerebrospinal fluid leak, spontaneous).
- **G96.02** (Spinal cerebrospinal fluid leak, spontaneous).
- **G96.08** (Other cranial cerebrospinal fluid leak).
- **G96.09** (Other spinal cerebrospinal fluid leak).

Code G96.08 may be used to report a postoperative cranial cerebrospinal fluid leak or traumatic cranial cerebrospinal fluid leak. Similarly, code G96.09 may be used to report a postoperative spinal cerebrospinal fluid leak or traumatic spinal cerebrospinal fluid leak.

Other nervous system conditions

The 2021 ICD-10-CM update also adds new codes for intracranial hypotension and meningeal cysts.

Beginning October 1, coders may report the following codes for intracranial hypotension:

- **G96.810** (Intracranial hypotension, unspecified).
- **G96.811** (Intracranial hypotension, spontaneous).
- **G96.819** (Other intracranial hypotension).

Code G96.819 may be used for iatrogenic cases or hypotension caused by medical examination or treatment. However, before assigning this code, coders should ensure that there is not a more specific code in category **G97.-** for intraoperative and postprocedural complications and disorders of nervous system, not elsewhere classified.

The ICD-10-CM update adds two specific codes to category G97.- for intracranial hypotension due to cranial procedures:

- **G97.83** (Intracranial hypotension following lumbar cerebrospinal fluid shunting).
- **G97.84** (Intracranial hypotension following other procedure).

Finally, coders should take note of new code **G96.191** for perineural cysts. A perineural cyst, also known as a Tarlov cyst, is a fluid-filled sac that most often affects nerve roots in the sacrum, the group of bones at the base of the spine.

Perineural cysts may be drained and shunted to relieve pressure and pain, but relief is often only temporary as fluid build-up tends to recur. — *Sarah Gould* (pbnfeedback@decisionhealth.com) ■

Editor's note: Information for this article was taken from the HCPPro webinar, "Just-Coding's 2021 ICD-10-CM Code Updates." Learn more: <https://hcmarketplace.com/2021-icd-10-cm-updates>.

Please pass this coupon to a colleague who could benefit from a subscription to *Part B News*.

YES! I want news and guidance to accurately bill and code for physician services so my practice gets the full, correct reimbursement that it's due. Please enter my one year subscription at \$647.

Name: _____

Org: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

Email: _____

www.partbnews.com

Payment enclosed. Make checks payable to *Simplify Compliance*; (Federal ID#: 26-0753128)

Send me an invoice (PO _____)

Charge my:    

Card #: _____

Exp. Date _____

Signature: _____

Mail to: **Simplify Compliance**

100 Winners Circle, Suite 300

Brentwood, TN 37027

Toll free: 1-855-CALL-DH1

PAS 2020

Ask Part B News

Asymptomatic but wants a COVID test? Press for medical necessity in notes, use Z-code

Question: My patient is visiting aged relatives and wants a COVID test before she goes to reduce the chance of infecting them. How should I code this? And will Medicare deny the charge for lack of medical necessity, as my patient lacks any symptoms?

Answer: Despite the public health emergency (PHE) enduring for more than six months, a lack of clarity around testing — and whether the testing will get reimbursed — remains.

“CMS has not established a national policy, either through rulemaking or a national coverage determination, regarding when COVID-19 testing is necessary and therefore the medically necessary standard is applicable for coverage,” says Abbye E. Alexander, chair of the health care/managed care practice group at Kaufman Dolowich & Voluck in Orlando, Fla. “Absent national policy, coverage of these tests is determined by the Medicare administrative contractors [MACs] themselves.”

But there are diagnosis codes and CPT codes that you will want to make sure you apply, and your providers should make the best possible case for necessity.

Make sure your provider’s examination asks about and documents the possibility of the patient’s infection with COVID-19, as well as complications that might ensue from it, advises Vasilios Nassiopoulous, vice president of platform strategy and innovation with Hayes Management Consulting in Wellesley, Mass.

For instance, Nassiopoulous suggests asking the following questions: “Was there any possible exposure? Did the patient travel to a high-risk area? Is the patient or another family member at risk? Are there comorbidities that might affect a possible infection outcome? Are mortality levels high if the patient or family is infected?”

If the patient claims proximity to a suspected infection source, you should consult the latest CDC guidelines, counsels Shannon McCall, director of HIM and coding for HCPro in Middleton, Mass. The CDC guidelines say, “If the provider documents ‘suspected,’ ‘possible,’ ‘probable’ or ‘inconclusive’ COVID-19, do not assign code **U07.1**— that is, the code for COVID-19. Instead, “assign a code(s) explaining the reason for encounter,” such as a fever. Or you should assign code

Z20.828 (Contact with and [suspected] exposure to other viral communicable diseases), the CDC says.

If the asymptomatic patient tests positive, you should assign U07.1, McCall says.

If the reason for testing of the asymptomatic person is due to travel quarantine without any specified infection evidence or risk, you would opt for code **Z71.84** (Encounter for health counseling related to travel), notes Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, of Enos Medical Coding, Warwick, R.I. If an infection is detected, you would switch back to U07.1.

Some states have mandated COVID-19 testing for tracing and tracking purposes, in which case you should “check with your state health departments about state supplied/provided tests,” since they should be handling those, Enos says.

Use test codes, or pivot to E/M

Don’t forget to report the correct AMA-approved COVID-19 laboratory testing codes, advises Barbara Schabert, an associate with Kaufman Dolowich & Voluck. Current COVID-19 lab codes include:

- **U0001** (CDC 2019-n-CoV Real-Time RT-PCR diagnostic panel).
- **U0002** (2019-nCoV Coronavirus, SARS-CoV-2/2019 [COVID-19], any technique, multiple types or subtypes [including targets], non-CDC).
- **87635** (Infectious agent detection by nucleic acid [DNA or RNA]; severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [COVID-19], amplified probe technique) — these are respiratory swab tests.
- **86769** (Antibody; severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] Coronavirus disease [COVID-19]).
- **86328** (Immunoassay for infectious agent antibody[ies], qualitative or semiquantitative, single-step method [eg, reagent strip]).

Note that on September 8 AMA added a new antibody test code, **86413** (Severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease (COVID-19)] antibody, quantitative). McCall adds that Medicare pays for assessment and specimen collection for COVID-19 testing using the Level 1 E/M code CPT code **99211** ([PBN 5/18/20](#)). — Roy Edroso (redroso@decisionhealth.com) ■

RESOURCE

- CDC, “ICD-10-CM Official Coding and Reporting Guidelines, April 1, 2020 through September 30, 2020”: www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf