



Coding and Billing for COVID-19 Testing and PPE

This coding paper provides a summary of SARS-CoV-2 coding and billing guidance to be used as a reference when coding for COVID-19 testing and PPE. Based on the nature of urgency to address the public health crisis of the pandemic and in an effort to expedite diagnostic testing, new dental and medical codes along with detailed guidance have been created to adapt to the rapid changes in healthcare as the COVID-19 outbreak continues to evolve.

The CDC, CMS, AMA and ADA have worked quickly to create diagnosis and billing codes to accommodate the pandemic. AAOMS advises members to refer to the CPT and CDT coding guidance published by the AMA and ADA for complete coding guidelines.

Coverage policies and billing procedures related to SARS-CoV-2 testing vary among payers. Therefore, OMSs are encouraged to confirm benefits and billing protocols with each payer prior to submitting claims and review managed care contract terms prior to balance billing patients.

Also, the ability for an OMS to perform COVID-19 testing varies by state. Therefore, it is each OMS's responsibility to confirm such services are within the scope of his or her license(s) as directed by the state Dental Practice Act and/or state Medical Practice Act.

CODING FOR COVID-19 TESTING AND COVERAGE RESOURCES

According to the CDC, two types of tests are available for COVID-19 testing:

- **Viral test** – shows if a patient has a current infection.
- **Antibody test** – shows if a patient has a previous infection.

Viral tests are used to diagnose COVID-19. These tests reveal if a patient currently has an infection with the virus that causes COVID-19. Many viral tests are available. All viral tests identify the virus in respiratory samples, such as from swabs from inside the nose.

Antibody testing checks a sample of a person's blood and looks for antibodies to the virus that cause COVID-19. If a patient has been diagnosed with COVID-19, his or her body would normally make antibodies. However, it typically takes one to three weeks to develop these antibodies. Some patients may take even longer to develop antibodies, and others may not develop antibodies. A positive result from an antibody test may prove a patient was previously infected with the coronavirus regardless of any signs or symptoms.

Note: Antigen testing is not on the market yet but is seeking FDA approval for at-home test kits.

The CDC issued [multiple resources](#) regarding recommended guidance for testing individuals who are asymptomatic or have signs or symptoms consistent with COVID-19. According to CMS, full coverage for coronavirus testing must be deemed "when medically appropriate for the individual, as determined by the individual's attending health care provider in accordance with accepted standards of current medical practice."

OMSs may recommend patients be tested for COVID-19 as a precautionary measure before a surgical procedure is performed. Options for testing may vary dependent on availability and permissions within the OMS's scope of practice. Other options for patient testing may be referring to an offsite facility or laboratory. Some tests are point-of-care tests, meaning results may be available at the testing site in less than an hour. Other tests must be sent to a laboratory to analyze, a process that may take 1-2 days once received by the lab, so scheduled surgeries may need to be flexible based on test result accessibility.

Dental

Currently, there is not a specific CDT code for COVID-19 testing. Therefore, *CDT D0999 unspecified diagnostic procedure*, by report may be reported. Because this is a "by report" code, a narrative explaining the details of the testing would need to accompany the claim. At this time, AAOMS is unaware of any dental plans covering COVID-19 testing performed in the OMS practice.

Medical

The AMA recognized an immediate need to develop CPT codes to report SAR-CoV-2 testing. One CPT code was established March 13, 2020, to detect the COVID-19 virus. Two others were added April 10 to identify the presence of COVID-19 antibodies. An additional code was adopted June 25 to report antigen testing of patients suspected of coronavirus infection. While these new codes will take effect retroactively to April 10, they will be published in the 2021 CPT code set under the Pathology and Laboratory chapter.

The new codes are:

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

It is worthwhile noting there is no specific code for COVID-19 swab collection as this component is included in the Evaluation and Management service.

The AMA released detailed documents explaining the [long](#), [medium](#) and [short](#) descriptors of the new Category I, Pathology and Laboratory CPT codes. The AMA also released a series of [CPT Assistant fact sheets](#) that provide detailed coding guidelines and enhanced clinical examples and descriptions of COVID-19 testing procedures.

CMS requires group and individual health plans to cover visits that result in the administration of diagnostic testing or the diagnosis of COVID-19 provided on or

Coding Paper



after March 18, 2020, without prior authorization or cost sharing, including telehealth and non-traditional care settings. This benefit will be effective until the public health emergency status has been lifted. CMS supplies a fact sheet for [COVID-19 Frequently Asked Questions \(FAQs\) on Medicare Fee-for-Service \(FFS\) Billing](#) regarding diagnostic testing and Medicaid shares [State Plan Amendments](#) outlining cost sharing for testing along with coverage and reimbursement for COVID-19-related services.

America's Health Insurance Plans (AHIP) [has been tracking](#) third-party payer coverage summaries for COVID-19 testing and other related services. Many third-party payers have implemented specific coding and billing requirements and continue to update their policies during the COVID-19 public health crisis. For the most updated policy changes in relation to billing and coding for COVID-19-related services, visit the payer's direct website. As increased knowledge of the virus continues to progress, coding and billing guidance will continue to change.

The [Families First Coronavirus Response Act](#) waives coinsurance and deductibles for COVID-19 testing-related services. CMS issued [guidance](#) to providers who bill Medicare Part B services furnished March 18, 2020, and through the end of the public health emergency. [CMS recommends](#) providers consider reporting CPT code 99211 to bill for assessment and specimen collection, unless reporting another E/M code for simultaneous services. Modifier CS should be appended on applicable claim lines to identify the service is associated to the cost-sharing waiver for COVID-19. Providers should not charge Medicare beneficiaries for coinsurance and/or deductible amounts for those services.

In addition, based on the applicability of the CS modifier and the intent to systematically identify services where cost sharing has been waived, it is anticipated other payers will request this modifier as well. However, it is important to reach out to the individual payer for guidance.

Diagnostic coding

Parallel to the need for COVID-19 procedural testing codes, the CDC issued a new ICD-10-CM diagnosis code (U07.1) to account for the reporting of a coronavirus diagnosis. It is imperative ICD-10 CM code U07.1 only be used for confirmed cases of COVID-19 with positive or presumptive-positive test results and sequenced first followed by appropriate codes based on chapter guidelines.

If COVID-19 is not confirmed or testing is negative, the following encounter codes may be used:

Z11.59: Encounter for screening for other viral diseases

- o Patient is asymptomatic with no known exposure, and results are unknown or negative.

Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out

- o Patient is possibly exposed to COVID-19, but infection has been ruled out.

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

- o Patient has been in contact with COVID-19, and there is suspicion of exposure.

The CDC has released detailed guidance for sequencing of diagnosis codes as well as additional codes to report conditions relating to COVID-19 (e.g., signs and symptoms, screening and exposure). This guidance includes common symptoms, such as:

R50.9: Fever, unspecified

R05: Cough

R06.02: Shortness of breath

PRACTICE EXPENSES ASSOCIATED WITH PPE

The COVID-19 pandemic has left OMS offices experiencing a financial challenge with the significant increase in all costs of infection control supplies, including PPE. The appropriate use of PPE is necessary in an OMS practice for safeguarding the patient, provider and staff and protecting against exposure to hazardous or infectious substances.

As healthcare facilities begin to relax restrictions on medical and dental services and the CDC implements stricter guidelines, additional requirements are

Coding Paper

necessary for extra PPE. The CDC continues to update a comprehensive listing of COVID-19 resources and recommendation for PPE. It is imperative to follow these guidelines and emphasize the importance of compliance in the practice.

Dental PPE

In an effort to relieve some of the financial burden PPE has added to dental practices, the ADA is urging third-party payers to increase the maximum allowable fees for all procedures or reimburse a standard fee per date of service to help with these additional costs.

Providers also may consider contacting third-party payers directly to renegotiate their contracts. The ADA developed a guide for Dental Benefits: Handling Contract Negotiations and issued a Statement on Third Party Payer Reimbursement for Costs Associated with Increased Standards for PPE in support of these efforts. Services are available to assist AAOMS members with contract negotiations and fee schedule increases (including Practice Quotient, an AAOMS Advantage Partner).

In the meantime, providers may consider reporting CDT code D1999-unspecified preventive procedure, by report to account for cost and use of additional PPE. The ADA recommends documenting the additional PPE used for the procedure and the cost involved per patient on the claim form for each date of service. The ADA offers interim guidance for COVID-19 coding and billing for PPE along with FAQs and a listing of third-party payers providing financial assistance to recognize the additional PPE expense. The ADA maintains an inventory list of Financial Assistance for Dental Practices from Third Party Payers as a reference for offices to learn more about financial resources available as several payers have instituted automatic PPE allowance per claim submitted.

It is important to check payer contracts and state consumer laws before passing along PPE expenses to patients as such acts may be prohibited by the state or may be considered a violation or a breach of contract.

Medical PPE

At this time, neither CMS nor the AMA has released guidance for coding and billing for PPE to medical insurance, nor is AAOMS aware of any medical plans reimbursing for extra PPE.

On the medical side, reimbursement is associated with three components: physician work, practice expense and physician liability. Typical physician and staff protective coverings and other infection control measures are considered practice overhead and already included in the practice expense component of the medical reimbursement. OMSs may want to ask payers for the best approach prior to submitting claims or billing their patients for extra PPE as some contracts and even state consumer laws may prohibit charging patients for infection control measures or costs not covered by insurance.

As stated, renegotiating the fee schedule to cover these costs going forward may be the best option. In the meantime, AAOMS continues to monitor CMS, AMA and other medical directives in relation to this issue.

ADDITIONAL RESOURCES

The COVID-19 pandemic has placed an enormous burden on healthcare communities. The information related to COVID-19 is fluid. Therefore, AAOMS has made numerous resources available to members on its COVID-19 Updates webpage ([AAOMS.org/COVID](https://www.aaoms.org/COVID)). The webpage contains practice guidance and protocols for reopening practices; infection control protocols; PPE recommendations; and guidance for what to do if an employee or patient tests positive. (See the [Interim Reopening Protocol for the OMS Office](#) and [COVID-19 Guidance FAQs](#).)

Coding Paper

Note: This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

CDT only copyright 2020 American Dental Association.
All rights reserved. CDT is a registered trademark of the American Dental Association

CPT only copyright 2020 American Medical Association.
All rights reserved. CPT is a registered trademark of the American Medical Association

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper discusses procedural coding guidelines utilizing CPT, HCPCS and CDT. When indicated, reference the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

© 2020 American Association of Oral and Maxillofacial Surgeons. No portion of this publication may be used or reproduced without the express written consent of the American Association of Oral and Maxillofacial Surgeons.