



AAPM&R Multi-Disciplinary PASC Collaborative

Post-Acute Sequelae of SARS-CoV-2 Infection (PASC or Long COVID)

Clinician Note Templates

Overview

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) has undertaken comprehensive efforts to support its call for a national plan to address Post-Acute Sequelae of SARS-CoV-2 infection (PASC or Long COVID) and the 3 to 10 million Americans it is affecting. AAPM&R understands the need for focused, meaningful, and ongoing clinical exchange between the medical community to assess and implement appropriate clinical practice for treating and following all long-term COVID issues, not just those issues requiring PM&R intervention, is necessary. AAPM&R developed a Multi-Disciplinary PASC Collaborative of close to 40 PASC Clinics from across the U.S. The Collaborative aims to foster engagement and share experiences to propel the health system towards defining standards of care for persons experiencing Long COVID-19/PASC.

The Collaborative has been working together since March 2021 developing clinical consensus guidance for the assessment and treatment of the most common symptoms of Post-Acute Sequelae of SARS-CoV-2 infection (PASC or Long COVID). To help primary care physicians who are and will see individuals experiencing symptoms of PASC or Long COVID, the Collaborative created clinician note templates. These templates are intended to provide primary care physicians with a summary of how a PASC visit note might be documented.

The Collaborative is developing simple note templates for each PASC symptom area it is developing detailed consensus guidance. Each note template is derived from the Collaborative's published manuscript. These templates are meant to only serve as a guide and are not intended to replace clinical judgement. Please refer to the full published manuscripts for more context in each area. These templates will be updated as the Collaborative publishes more guidance. The areas templates will be developed for include:

- PASC Fatigue
- PASC Cognitive Symptoms
- PASC Breathing Discomfort
- Chronic Anosmia following COVID-19 Infection
- PASC Cardiovascular Complications (TBD)
- PASC Autonomic Dysfunction (TBD)
- PASC Neurological Sequelae (TBD)

General Statement/Overview of PASC:

Millions of individuals who have been infected with SARS-CoV-2 continue to experience a collection of symptoms after they have recovered from the acute stages of their illness. Often referred to as "long COVID", "post-COVID" or Post-Acute Sequelae of COVID-19 (PASC) these symptoms, which can include fatigue, shortness of breath, palpitations, cognitive dysfunction ("brain fog"), sleep disorders, headaches, fevers, menstrual changes, gastrointestinal symptoms, post exertional malaise, primary mood disorders and those secondary to new medical conditions and others. These symptoms can persist for months, range from mild to incapacitating and wax and wane over time. Currently, there is no identifiable pathophysiologic cause for this disease but there are several hypotheses including residual organ damage, remaining virus in the body, autoimmune process, or an exaggerated immune response.

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PASC ICD-10 Coding Information

Clinicians should utilize the ICD-10 code U09.9 for visit diagnosis and related order associations for patients with Post-Acute Sequelae of SARS-CoV-2 Infection to facilitate long term patient care, tracking and outcomes measures. However, the specific condition related to the COVID-19 infection should be coded as the primary diagnosis followed by the U 09.9 code, if the covid-related condition is identifiable.

ICD-10 Code U09.9 includes “code first” instructions. This means the following:

- The specific condition(s) related to COVID should be coded as the primary (first) diagnosis/es followed by U09.9. This should be done if the COVID-related condition(s) is/are known.
- If the COVID-related specific condition(s) is/are unknown, U09.9 could be used as the primary (first) diagnosis.

For example, if a patient is being evaluated for PASC related fatigue the visit diagnoses could be coded as follows:

- Primary (Post Viral Fatigue Syndrome): ICD G93.3
- Secondary (Post-Acute Sequelae of SARS-CoV-2 Infection) U09.9

Other examples may include if a patient is experiencing COVID-related specific condition(s) such as loss of smell and/or taste. If so, the visit diagnoses could be coded as follows:

- Primary (loss of smell): R43.8 AND/OR Primary (loss of taste): (R43.8)
- Secondary (Post-Acute Sequelae of SARS-CoV-2 Infection) U09.9

In the clinical note templates below, an example primary condition code is included with the Long COVID ICD-10 code U09.9 as the secondary diagnosis code.

Clinician Note Templates

PASC Fatigue (ICD G93.3, U09.9)

*Refer to [Multidisciplinary collaborative consensus guidance statement on the assessment and treatment of fatigue in postacute sequelae of SARS-CoV-2 infection \(PASC\) patients](#)

- Discussed that this is the most common symptom of PASC, reviewed pertinent labs and imaging with no evidence of end-organ damage (e.g. heart failure, pulmonary fibrosis, anemia) or medications contributing to these symptoms.
- Obtain basic lab workup for conditions that may contribute to fatigue: CBC w/diff, CMP, TSH, CRP, ESR, and CK
- Recommend an individualized and structured, titrated return to activity as tolerated. Counseled patient that post-exertional malaise is common and energy conservation strategies using 4P Strategy (Planning, Pacing, Prioritizing, and Positioning)
- Counseled on sleep hygiene, healthy dietary pattern and hydration to promote wellness and reduce inflammation

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- Discussed prescription medications that are used for fatigue in other chronic illnesses, including amantadine, activating antidepressants like or bupropion, or stimulants like methylphenidate and modafinil. Counseled that there is limited evidence for these medications in the PASC population. Currently, the patient does not elect to start pharmacologic therapy.

PASC Cognitive Symptoms (ICD R41.9, U09.9)

*Refer to [Multi-Disciplinary Collaborative Consensus Guidance Statement on the Assessment and Treatment of Cognitive Symptoms in Patients with Post-Acute Sequelae of SARS-CoV-2 infection \(PASC\)](#)

- We discussed that neurologic and cognitive symptoms are common in PASC, including deficits in attention, word retrieval, working memory, and executive function. Patient has normal neurological evaluation without any focal deficit, so do not recommend neuroimaging at this time.
- A complete medication reconciliation was performed. Patient is not taking antihistamine, anticholinergic, benzodiazepine or other antidepressant medications that could be contributing to cognitive symptoms
- Obtain basic lab workup for reversible factors contributing to symptoms: CBC w/diff, CMP, Vitamin B12, Thiamine, Folate, Homocysteine, Vitamin D 1,25, Magnesium, TSH w/reflex FT4. In high-risk patients obtain HIV and treponemal testing
- Counseled on sleep hygiene and recommend treatment of concomitant mood disorders that can contribute to symptoms
- Discussed that cognitive symptoms are closely associated with fatigue, and recommend an individualized and structured, titrated return to activity with aerobic exercise as tolerated. Counseled on energy management strategies, avoidance of over-exertion with cognitive tasks as this may cause post-exertional malaise in some patients
- Refer to specialist for rehab and accommodation strategies (speech language pathologist, occupational therapist, or neuropsychologist)

PASC Breathing Discomfort (ICD R06.00, U09.9)

*Refer to [Multi-Disciplinary Collaborative Consensus Guidance Statement on the Assessment and Treatment of Breathing Discomfort and Respiratory Sequelae in Patients with Post-Acute Sequelae of SARS-CoV-2 Infection \(PASC\)](#)

- Patient had mild-moderate illness without hypoxemia, with SpO₂ > 92% with ambulation in the office today. Discussed that at this time development of lung disease appears to be associated with severity of acute COVID-19 with high rates of abnormalities in patients who had critical illness. For patients who did not require hospitalization, dyspnea is common with unclear cause, but may be associated with fatigue and dysautonomia.
- Given normal SpO₂, no contraindications for supervised rehabilitation (PT/OT or pulmonary rehab if patient qualifies)
- Obtain PFTs (including DLCO) given persistent dyspnea not improving after 8 weeks from acute COVID-19 illness and consider CT Chest ILD protocol. Will consult pulmonology if new or progressive abnormality
- Low concern for cardiac dyspnea based on history and physical, so no indication for TTE or stress testing at this time

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- Counseled patient that pharmacologic therapies (inhaled bronchodilators or corticosteroids) are not routinely recommended for dyspnea in absence of objective pulmonary dysfunction
- Provided breathing exercises through self-directed educational resources (examples: [Stasis App](#), [COVID Bootcamp](#), Coronavirus Recovery [Breathing Exercises](#)).

PASC Cardiovascular Symptoms (ICD R00.2, U09.9)

*Refer to [Multi-disciplinary collaborative consensus guidance statement on the assessment and treatment of cardiovascular complications in patients with post-acute sequelae of SARS-CoV-2 infection \(PASC\)](#)

- Discussed that cardiovascular symptoms in PASC are highly variable and potentially multifactorial including the heart, peripheral/central vasculature, and autonomic nervous system. Counseled that severe initial COVID-19 infections requiring hospitalization have high rates of cardiac complication like MI or RV dysfunction, but patient had mild to moderate outpatient illness, so is at low risk for structural cardiac abnormality
- Cardiac exam is normal, therefore will obtain 10-minute stand test to rule out coexistent POTS/dysautonomia
- Obtain basic lab workup for cardiac complications: CBC w/diff, BMP, Troponin, BNP/NT-BNP, D-dimer, CRP, ESR and lipid panel. Order baseline EKG, will consider Holter vs. extended event monitoring if it is normal and symptoms are intermittent
- If workup above is abnormal will order TTE and consider referral to cardiology
- Counseled patient on healthy lifestyles and addressing modifiable risk factors such as HTN, diabetes, dyslipidemia, tobacco use, and maintaining healthy weight
- Patient has no contraindications for participation in rehabilitation activities such as cardiac rehab or PT. Recommend a staged and titrated return to activity and exercise as tolerated

Chronic Anosmia following COVID-19 Infection (ICD R43.9, U09.9)

*No manuscript reference for this template.

- Counseled patient that current research suggests that chronic anosmia is not caused by viral destruction of olfactory neurons, that instead there is injury to supporting neuroepithelial structures and olfactory microvasculature. Discussed excellent prognosis described in literature where > 95% of patients have recovered sense of smell/taste at 1yr.
- No imaging or further workup necessary
- Recommend self-directed olfactory training using a smell kit and 20 min daily of intentionally smelling/focusing unique fragrances in 4 different categories (citrus, floral, resinous, spicy) . Patient was given information for website Abscent.org where directions on smell training and creating a smell kit can be found
- Nasal corticosteroids may be helpful in severe cases in addition to olfactory training, so will prescribe mometasone furoate 100mcg BID x 4 wks (this is the best studied regimen, but patient counseled they can substitute fluticasone/beclomethasone if that is a cheaper OTC alternative)
- Patient counseled on home and personal safety: ensuring smoke and carbon monoxide alarms are working and to have others smell food if there is concern that it may be spoiled

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