[Updated April 28] AHIMA and AHA FAQ: ICD-10-CM Coding for COVID-19

https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

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The following FAQ on ICD-10-CM coding for COVID-19 was jointly developed and approved by the American Hospital Association's Central Office on ICD-10-CM/PCS and AHIMA.

Question: What is the ICD-10-CM code for COVID-19? (*rev. 4/1/2020*)

Answer: ICD-10-CM code U07.1, COVID-19, may be used for discharges/date of service on or after April 1, 2020. For more information on this code, click here. The code was developed by the World Health Organization (WHO) and is intended to be sequenced first followed by the appropriate codes for associated manifestations when COVID-19 meets the definition of principal or first-listed diagnosis. Specific guidelines for usage are available here. For guidance prior to April 1, 2020, please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak.

Question: Is the new ICD-10-CM code U07.1, COVID-19, a secondary code? (*rev. 4/1/2020*)

Answer: When COVID-19 meets the definition of principal or first-listed diagnosis, code U07.1, COVID-19, should be sequenced first, and followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients. However, if COVID-19 does not meet the definition of principal or first-listed diagnosis (e.g. when it develops after admission), then code U07.1 should be used as a secondary diagnosis.

Question: Are there additional new codes to identify other situations specific to COVID- 19? For example, codes for exposure to COVID-19, or observation for suspected COVID-19 but where the tests are negative? (*rev. 3/20/2020*)

Answer: No, at the present time, there are no other COVID-19-related ICD-10-CM codes. However, the Centers for Disease Control and Prevention's National Center for Health Statistics, the US agency responsible for maintaining ICD-10-CM in the US, is monitoring the situation. The off-cycle release of code U07.1, COVID-19, is unprecedented and is an exception to the code set updating process established under the Health Insurance Portability and Accountability Act (HIPAA).

Question: We have been told that the World Health Organization (WHO) has approved an emergency ICD-10 code of "U07.2 COVID-19, virus not identified." Is code U07.2 to be implemented in the US too? (*rev. 3/26/2020*)

Answer: The HIPAA code set standard for diagnosis coding in the US is ICD-10- CM, not ICD-10. As shown in the April 1, 2020 Addenda on the CDC website, the only new code being implemented in the US for COVID-19 is U07.1.

Question: How should we code cases related to COVID-19 prior to April 1, 2020, the effective date of ICD-10-CM code U07.1, COVID-19? (*rev. 4/1/2020*)

Answer: Please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak. After April 1, 2020, refer to the Official Guidelines for Coding and Reporting found here.

Question: Is the ICD-10-CM code U07.1, COVID-19 retroactive to cases diagnosed before the April 1, 2020 date? (*rev. 3/20/2020*)

Answer: No, the code is not retroactive. Please refer to the supplement to the ICD- 10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak for guidance for coding of discharges/services provided before April 1, 2020.

Question: Is code B97.29, Other coronavirus as the cause of diseases classified elsewhere, limited to the COVID-19 virus? (*rev. 3/20/2020*)

Answer: No, code B97.29 is not exclusive to the SARS-CoV-2/2019-nCoV virus responsible for the COVID-19 pandemic. The code does not distinguish the more than 30 varieties of coronaviruses, some of which are responsible for the common cold. Due to the heightened need to uniquely identify COVID-19 until the unique ICD-10-CM code is effective April 1, providers are urged to consider developing facility-specific coding guidelines that limit the assignment of code B97.29 to confirmed COVID-19 cases and preclude the assignment of codes for any other coronaviruses.

Question: What is the difference between ICD-10-CM codes B34.2 vs. B97.29? (*rev. 3/20/2020*)

Answer: Diagnosis code B34.2, Coronavirus infection, unspecified, would generally not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site of infection would not be “unspecified.” Code B97.29, Other coronavirus as the cause of diseases classified elsewhere, has been designated as interim code to report confirmed cases of COVID-19. Please refer to the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak for additional information. Because code B97.29 is not exclusive to the SARS-CoV-2/2019-nCoV virus responsible for the COVID-19 pandemic, we are urging providers to consider developing facility-specific coding guidelines that limit the assignment of code B97.29 to confirmed COVID-19 cases and preclude the assignment of codes for any other coronaviruses.

Question: Does the supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak apply to all patient encounter types, i.e., inpatient and outpatient, specifically in relation to the coding of “suspected”, “possible” or “probable” COVID-19? (*rev. 3/20/2020*)

Answer: Yes, the supplement applies to all patient types. As stated in the supplement guidelines, “If the provider documents “suspected”, “possible” or “probable” COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828, Contact with and (suspected) exposure to other viral and communicable diseases.”

Question: The supplement to the ICD-10-CM Official Guidelines for coding encounters related to the COVID-19 coronavirus outbreak refers to coding confirmed cases in a couple of instances, but it does not specify what "confirmation" means similar to language in guidelines found for reporting of HIV, Zika and H1N1. Can you clarify whether the record needs to have a copy of the lab results or what lab tests are approved for confirmation? (*rev. 3/20/2020*)

Answer: The intent of the guideline is to code only confirmed cases of COVID-19. It is not required that a copy of the confirmatory test be available in the record or documentation of the test result. The provider's diagnostic statement that the patient has the condition would suffice.

Question: Should presumptive positive COVID-19 test results be coded as confirmed? (*rev. 3/24/2020*)

Answer: Yes, Presumptive positive COVID-19 test results should be coded as confirmed. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC). CDC confirmation of local and state tests for the COVID-19 virus is no longer required.

Question: How should we handle cases related to COVID-19 when the test results aren't back yet? The supplementary guidance and FAQs are confusing since sometimes COVID-19 is not "ruled out" during the encounter, since the test results aren't back yet. (*rev. 3/24/2020*)

Answer: Due to the heightened need to capture accurate data on positive COVID-19 cases, we recommend that providers consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19.

Question: Based on the recently released guidelines for COVID-19 infections, does a provider need to explicitly link the results of the COVID-19 test to the respiratory condition as the cause of the respiratory illness to code it as a confirmed diagnosis of COVID-19? Patients are being seeing in our emergency department and if results are not available at the time of discharge, we are reluctant to query the physicians to go back and document the linkage when the results come back several days later. (*rev. 4/1/2020*)

Answer: No, the provider does not need to explicitly link the test result to the respiratory condition, the positive test results can be coded as confirmed COVID-19 cases as long as the test result itself is part of the medical record. As stated in the coding guidelines for COVID-19 infections that went into effect on April 1, code U07.1 may be assigned based on results of a positive test as well as when COVID- 19 is documented by the provider. Please note that this advice is limited to cases related to COVID-19 and not the coding of other laboratory tests. Due to the heightened need to uniquely identify COVID-19 patients, we recommend that providers consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available.

Question: We are unsure about how to interpret the newly released COVID-19 guidelines in relation to the uncertain diagnosis guideline which refers to diagnoses "documented at the time of discharge" stated as possible, probable, etc. Can we code these cases as confirmed COVID-19 if the test

results don’t come back until a few days later and the patient has already been discharged? (*rev. 4/1/2020*)

Answer: Yes, if a test is performed during the visit or hospitalization, but results come back after discharge positive for COVID-19, then it should be coded as confirmed COVID-19.

Question: Since the new guidelines for COVID regarding sepsis just say to refer to the sepsis guideline, is that then saying that sepsis would be sequenced first and then U07.1 for a patient presenting with sepsis due to COVID-19? (*rev. 4/1/2020*)

Answer: Whether or not sepsis or U07.1 is assigned as the principal diagnosis depends on the circumstances of admission and whether sepsis meets the definition of principal diagnosis. For example, if a patient is admitted with pneumonia due to COVID-19 which then progresses to viral sepsis (not present on admission), the principal diagnosis is U07.1, COVID-19, followed by the codes for the viral sepsis and viral pneumonia. On the other hand, if a patient is admitted with sepsis due to COVID-19 pneumonia and the sepsis meets the definition of principal diagnosis, then the code for viral sepsis (A41.89) should be assigned as principal diagnosis followed by codes U07.1 and J12.89, as secondary diagnoses.

Question: What is the difference between code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out, and code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, in relation to COVID-19? Can you provide examples on how to apply the codes? (*rev. 4/16/2020*)

Answer: Code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out, should be used if a patient is asymptomatic and there is a possible exposure to COVID-19 and the patient tests negative for COVID-19. Per the instructional note under category Z03, codes in this category may only be used if a patient has no signs or symptoms.

Code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, should be used if a patient has a known or suspected exposure to COVID- 19, is exhibiting signs/symptoms associated with COVID-19, and the test results are negative, inconclusive, or unknown. According to guideline I.C.21.c.1 Contact/Exposure, Z20 codes may be used for patients who are in an area where a disease is epidemic. Therefore, due to the current COVID-19 pandemic, when a patient presents with signs/symptoms associated with COVID-19 and is tested for the virus because the provider suspects the patient may have COVID-19, code Z20.828 may be assigned without explicit documentation of exposure or suspected exposure to COVID-19.

If the test results are positive, code U07.1 should be assigned instead of either code Z03.818 or Z20.828. An example of the application of code Z20.828 is a patient with respiratory signs or symptoms, testing for COVID-19 is negative, and the patient is determined to have another condition (e.g. flu, pneumonia). Codes should be assigned for the condition (e.g., flu, pneumonia) and code Z20.828 should be assigned as an additional diagnosis.

Question: Please provide guidance on correct coding when the provider has documented COVID-19 as a definitive diagnosis before the test results are available, and the test results come back negative. (*rev. 4/16/2020*)

Answer: Coding professionals should query the provider if the provider documented COVID-19 before the test results were back and the test results come back negative. Providers should be given the opportunity to reconsider the diagnosis based on the new information.

Question: Please provide guidance on correct coding when the provider has confirmed the documented COVID-19 after the test results come back negative. How should this be coded? (*rev. 4/16/2020*)

Answer: If the provider still documents and confirms COVID-19 even though the test results are negative, or if the provider documented disagreement with the test results, assign code U07.1, COVID-19. As stated in the Official Guidelines for Coding and Reporting for COVID-19, "Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider… the provider's documentation that the individual has COVID-19 is sufficient."

Question: When a patient who previously had COVID-19 is seen for a follow-up exam and the COVID-19 test is negative, what is best code(s) to capture this scenario? (*rev. 4/16/2020*)

Answer: Assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.19, Personal history of other infectious and parasitic diseases.

Question: How should an encounter for COVID-19 antibody testing be coded? (*rev. 4/28/2020*)

Answer: For an encounter for antibody testing that is not being performed to confirm a current COVID-19 infection, nor is being performed as a follow-up test after resolution of COVID-19, assign Z01.84, Encounter for antibody response examination.

Question: If a patient has both aspiration pneumonia and pneumonia due to COVID-19, may code J12.89, Other viral pneumonia, be assigned with code J69.0, Pneumonitis due to inhalation of food and vomit? There is an Excludes1 note at category J12, Viral pneumonia, not elsewhere classified, that excludes pneumonia not otherwise specified (J69.0). (*rev. 4/28/2020*)

Answer: Yes, both codes may be assigned, as aspiration pneumonia and pneumonia due to COVID-19 are two separate unrelated conditions with different underlying causes. This meets the exception to the Excludes1 guideline as a circumstance when the two conditions are unrelated to each other.

Question: For a patient who has HIV/AIDS and is diagnosed with COVID-19, the guidelines don't assume a relationship between COVID-19 and HIV, so does the provider need to link the two conditions for coding? (*rev. 4/28/2020*)

Answer: Any immunocompromised patient (which would include HIV patients) is at higher risk for becoming infected with COVID-19, but HIV does not cause COVID-19. Code both conditions separately, with sequencing depending on the circumstances of admission – just like a patient suffering from diabetes or any other chronic condition that puts them at higher risk for the COVID-19 infection.

Question: Is there a timeframe for considering the COVID-19 as history of, or current? For example, if a patient is documented as having had COVID-19 four weeks ago and during the current encounter the patient no longer has COVID-19, do we use the personal history code? (*rev. 4/28/2020*)

Answer: There is no specific timeframe for when a personal history code is assigned. If the provider documents that the patient no longer has COVID-19, assign code Z86.19, Personal history of other infectious and parasitic diseases.

Question: When a patient is diagnosed with COVID-19, we understand that signs and symptoms are not manifestations and would not be separately coded. We also understand that Guideline I.C.18.b. states that "signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification." When a patient diagnosed with COVID-19 presents with both respiratory signs/symptoms (e.g. shortness of breath, cough) and non-respiratory signs/symptoms (e.g. gastrointestinal problems, dermatologic or venous sufficiency issues), may the non-respiratory signs/symptoms/conditions be coded separately since they are not routinely associated with COVID-19? (*rev. 4/28/2020*)

Answer: Because COVID-19 is primarily a respiratory condition, any other signs/symptoms would be coded separately unless another definitive diagnosis has been established for the other signs or symptoms. This is supported by Guideline IC.18.b, "Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis."