E-BRIEF SERIES

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Your Guide to Proper Coding of COVID-19

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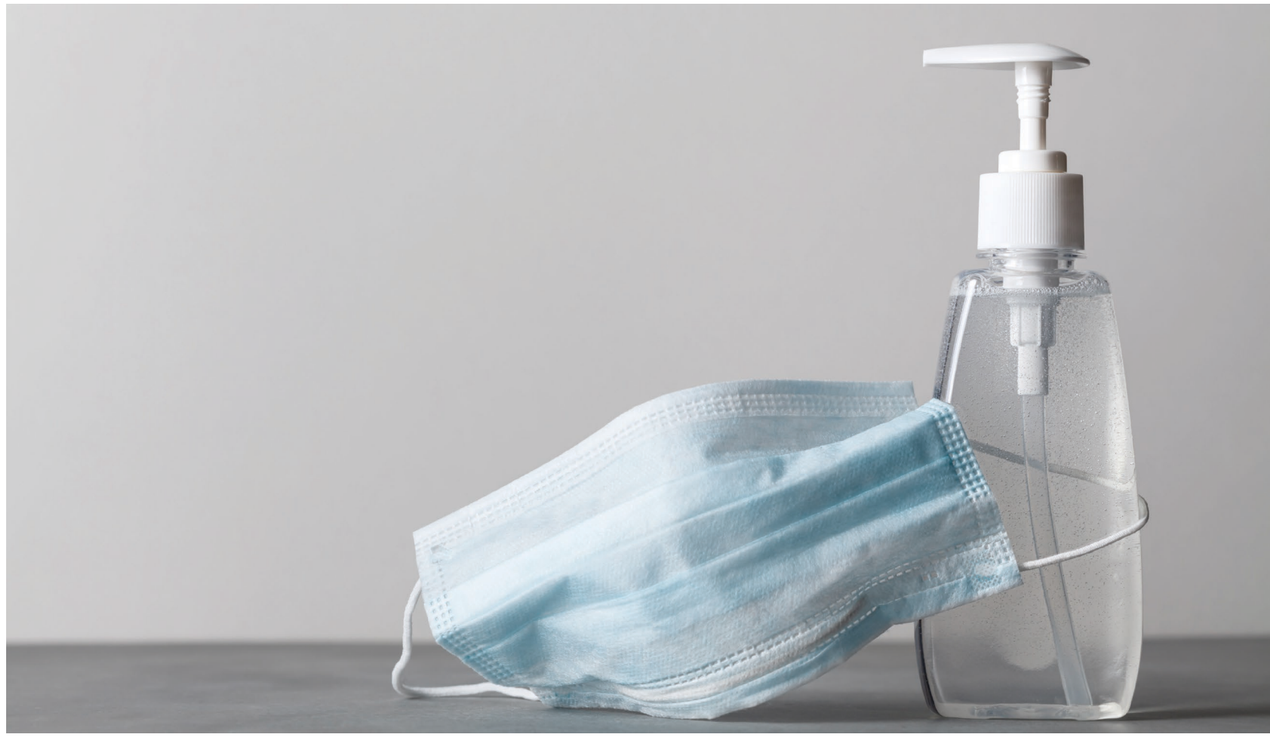
In the world of medical coding and auditing, change has always been a consistent aspect, as the demand for more specific clinical data and developments in treatment and technology continues to increase.



And 2020 brought more change than ever, with the novel Coronavirus requiring quick actions from the World Health Organization, The Centers for Medicare and Medicaid Services, and the National Center for Health Statistics. Medical professionals were responding rapidly to the public health emergency and many unseen demands were placed on our healthcare system. During this time, medical professionals quickly learned and applied the ICD-10-CM guidelines released on April 1, 2020, but not without some confusion and inconsistencies.

With new codes (effective January 1, 2021), updates to the guidelines, the strain placed on providers during the COVID-19 outbreak, coders and auditors face even greater accountability to provide accurate, precise, and consistent coding and advice to providers. As the pandemic and the reporting of COVID-19 continues to evolve, it will be vital for coding professionals to stay educated on all updates and guidelines — to best support both patients and providers.

Diagnosis Coding for COVID-19

Significant changes have been made to the ICD-10-CM guidelines related to the reporting of COVID-19, requiring coders to pay close attention to the date of service being reviewed to ensure the appropriate guidelines are followed for code assignment. For all dates of service on or after January 1, 2021, the new guidelines and six (6) new ICD-10-CM codes are to be reported. All dates of service prior to the effective date should follow the guidelines released on April 1, 2020. Let's take a look at what's changed, what hasn't, and what might be updated moving forward:

New codes effective beginning January 1, 2021:

- J12.82 Pneumonia due to coronavirus disease 2019
- M35.81 Multisystem inflammatory syndrome
- M35.89 Other specified systemic involvement of connective tissue
- Z20.822 Contact with and (suspected) exposure to COVID-19
- Z86.16 Personal history of COVID-19

Guideline Updates

- Additional clarification was given related to the sequencing of codes when COVID-19 meets the definition of principal diagnosis. COVID-19 should be sequenced first, along with any manifestations, except when directed otherwise by other guidelines. This guideline now encompasses more than just the sequencing of obstetric and sepsis cases as previously instructed.
- Acute respiratory failure due to COVID-19 has been added, directing coders to assign U07.1 and J96.0-.
- Non-respiratory manifestations that are the reason for the encounter are to be coded with U07.1 as the principal diagnosis or first listed with additional codes for the presenting manifestations.
- For exposure to COVID-19, we now have the new, more specific code Z20.822, Contact with and (suspected) exposure to COVID-19. Guidelines have been updated to include asymptomatic and symptomatic individuals with actual or suspected exposure, directing coders to assign Z20.822 if the diagnosis has been ruled out, or test results are inconclusive or unknown. If confirmed, guidelines for confirmed cases are followed. Due to the nature of the public health emergency, the probability of exposure is elevated and a statement of direct contact with a person(s) who have or are suspect to be infected does not need to be documented for reporting. According to guideline I.C.21.c.1 Contact/Exposure: "These codes are for patients who are suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic."

- Screening for COVID-19 during the pandemic is where we see big changes with likely more changes to come. Guidelines released April 1st direct coders to report Z11.59, Encounter for screening for other viral diseases, for asymptomatic individuals and to code for exposure to COVID-19 for patients with possible or actual exposure. Now we also have a more specific code, Z11.52 Encounter for screening for COVID-19. However, the updated guidelines released January 1st were revised and state that a screening code is generally not appropriate. So, what direction should coders take? Guidelines clarify that a code for exposure to COVID-19 should be reported for testing, including preoperative testing. This change correlates with the Z20 Contact/Exposure guideline stated above. There is a considerable probability that the patient could have been exposed to the virus due to the nature of a pandemic, so a screening code would not be appropriate as the testing is diagnostic in nature. Looking forward, as measures to control the spread of the virus continue to improve and the pandemic status changes, be on the lookout for revisions to these screening guidelines.

- A new code for antibody testing has been added, code Z01.84, Encounter for antibody response examination. This code should not be used for testing, to confirm an infection, nor used for follow-up testing. Follow-up testing for resolved cases should be reported with Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19.

- Guidelines for reporting M35.81, Multisystem inflammatory syndrome (MIS), have been added for correct assignment of cases if MIS due to a previous infection relating to a sequela stated as due to COVID-19, not stated as due to, and known or suspected exposure without a history of or current infection.

- Clarification related to the sequencing of Chapter 15 code advise coders that if the reason for the admission or encounter is unrelated to COVID-19 and the patient tests positive, the reason for the admission or encounter takes priority followed by O98.5-, U07.1 , and any associated manifestations. Guidelines released April 1st only addressed if the reason for the admission or encounter was due to COVID-19. If the reason for admission or encounter was for condition(s) other than COVID-19 with a positive test result during the stay, the selection of principal diagnosis does still apply.

- Coding for COVID-19 infections in newborns was not addressed previously, but now we have guidance for reporting. For the principal diagnosis, a code from category Z38-, Liveborn infants according to place of birth and type of delivery, will be assigned. For confirmed newborn cases of COVID-19, code to U07.1 along with any manifestations when there is no documentation of the type of transmission. Code to P35.8, Other congenital viral diseases, with U07.1 when documentation states the infection was contracted in utero or during the birthing process.

ICD 10-CM Code Changes

The following are additional code updates released in January:

- Pneumonia cases confirmed as due to COVID-19 will now be reported with U07.1 and the new J12.82 code. If documentation does not state that the pneumonia is due to the infection, this link should not be made according to section I.A.15.

- Signs and symptoms without a definitive diagnosis of COVID-19 should be reported using any signs and symptoms codes as well as Z20.822 contact with and (suspected) exposure to COVID-19 if related.

- Personal history of COVID-19 can now be reported with Z86.16 history of COVID-19.

Unaffected Guidelines

The following guidelines have not been revised:

- Code only confirmed cases of COVID-19: Documentation by the provider that the patient has COVID-19, or a positive test result is acceptable for reporting. Guidelines tell us this is an exception to the inpatient guidelines that states that uncertain diagnosis at the time of discharge are to be coded as if it existed or was established. Codes for signs and symptoms are to be reported for unconfirmed cases.

- Acute bronchitis, lower respiratory infection associated with COVID-19, acute respiratory distress syndrome, and asymptomatic individuals who test positive remain unchanged.

New CPT® Vaccination and Administration Codes

Now that we have vaccines available, new CPT® codes were released in November 2020. It's important to know which manufacturer the vaccine came from to ensure the correct code selection.
Pfizer-BioNTech:

- 91300 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use.
- 0001A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose.
- 0002A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose.

Moderna:

- 91301 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use

- 0011A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose

- 0012A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose

Together with the coding updates and changes related to COVID-19, coders and auditors must be vigilant with staying up to date on new releases through education, review, and audit processes. Take the time to review and become informed about the guidelines, codes, and their application. With so many resources to assist in bridging the gaps in expertise, including local chapter meetings and third-party vendors, staying informed in the ever-changing world of healthcare is easier than ever.

Resources:

file:///C:/Users/laura.brink.ASG/Downloads/icd10cm_guidelines_2021%20(20).pdf

file:///C:/Users/laura.brink.ASG/Downloads/COVID_19_Guidelines%20(6).pdf

https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance#:~:text=Accepted%20addition%20of%20codes%20addition,the%20Moderna%20COVID%2D19%20vaccine.

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Laura Brink, RHIT, CRC began her career as an outpatient medical coder and auditor. Following her work in outpatient services, she moved to specializing in HCC Risk Adjustment preforming provider and coder auditing with experience working in multiple models such as HCC, RxHCC, ACO, and QHP. Additionally, she assisted in provider education and training to ensure accurate risk scores utilizing query processes.

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