UPDATED: July 6, 2020

COVID-19 Coding Tips & FAQs

Intellis IQ coding guidance related to the 2019 novel coronavirus (COVID-19)

For a quick reference, we have updated the following information to provide official diagnosis coding guidance for health care encounters and death related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV. This coding guidance has been developed by the CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

Code for COVID-19: U07.1

Effective April 1, 2020 (not to be used retroactively)
Intended to be used for all patient types (IP and OP) as the principal or first-listed diagnosis.

Use additional code to identify pneumonia or other manifestations

Excludes1:

B34.2	Coronavirus infection, unspecified site
B97.2-	Coronavirus as the cause of diseases classified to other chapters
J12.81	Severe acute respiratory syndrome [SARS], unsp

Intended to be used for all patient types (IP and OP) as the principal or first-listed diagnosis

Presumptive Cases of COVID-19

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 CDC

Documentation that states: "suspected", "possible" or "probable" COVID-19

Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

Exposure to COVID-19

Possible exposure
to COVID-19, but this is ruled out after evaluation

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

Actual exposure
to someone who is confirmed to have COVID-19

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

Signs and Symptoms of COVID-19

Where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

R05	Cough
R06.02	Shortness of breath
R50.9	Fever, unspecified

Visit intellisIQ.com/covid-19 to find updates from AHIMA, the AMA, CDC, and CMS.

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COVID-19 Coding Scenarios

- **Patient is asymptomatic but testing Positive for COVID-19**
  Use U07.1- Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection. Use additional codes for 'exposure' if applicable

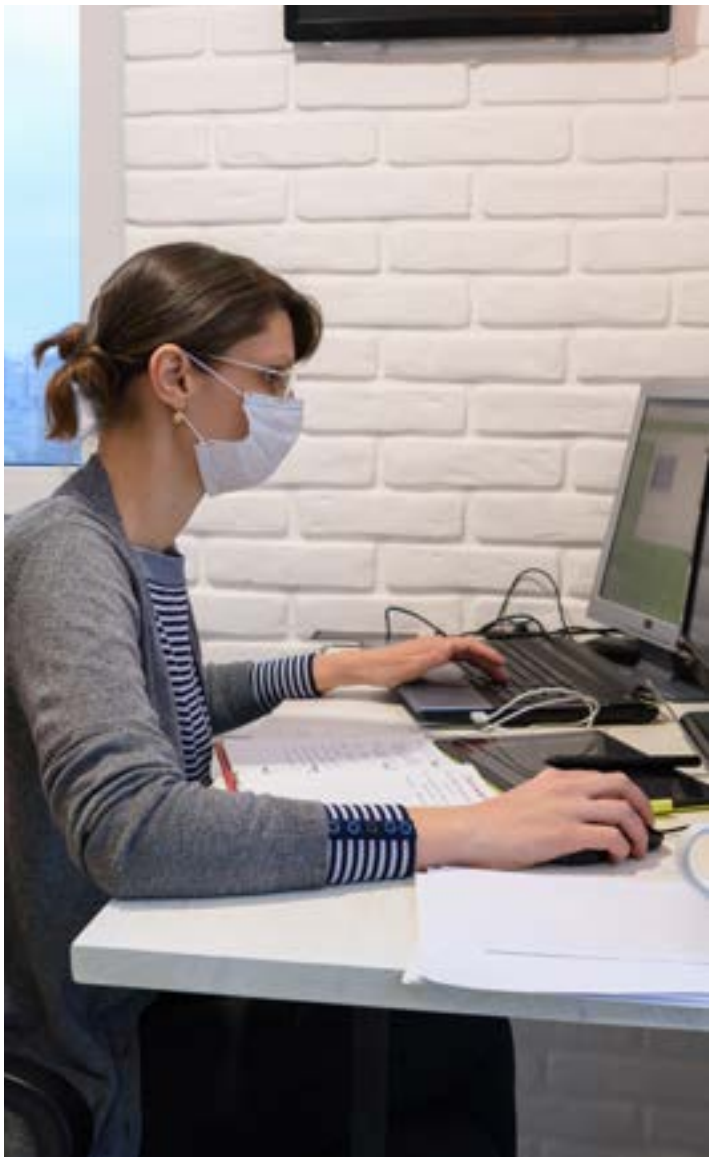
- **Asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative.**
  Use Z11.59, Encounter for screening for other viral diseases

- **A patient is tested for COVID-19 and the test comes back negative, but positive for pneumonia and the flu.**
  Assign codes for the flu and pneumonia
  Use additional code for 'exposure' if applicable.

- **Patient was admitted for liver transplant rejection and 10 days into the admission the patient develops new onset cough, runny nose and tests positive for coronavirus.** Documentation shows COVID-19 with very mild symptoms.
  Principal diagnosis: T86.41, Liver transplant rejection
  Secondary diagnosis: U07.1, COVID-1 (Not POA)

- **Patient is admitted with pneumonia due to COVID-19 which then progresses to viral sepsis.**
  Principal diagnosis: U07.1, COVID-19
  Secondary diagnosis: A41.89, Other specified sepsis (Not POA) AND **J12.89**, Other viral pneumonia

- **A patient is admitted with sepsis due to COVID-19 pneumonia.**
  Principal diagnosis: A41.89, Other specified sepsis
  Secondary diagnosis: U07.1, COVID-19 AND **J12.89**, Other viral pneumonia



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Questions & Answers

Q 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? Patients are being seen in our ED, and if results are not available, we are reluctant to query the physicians to go back and document the linkage when the results come back.

A The provider does NOT need to explicitly link the test result to the respiratory condition, as long as there is documentation of a positive COVID-19 test result in the record. It is recommended 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.

Q When a patient who previously had COVID-19 is seen for a follow-up exam and the COVID-19 test is negative, what is/are the best code(s) to capture for this scenario?

A 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.

Q 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?

A 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."

Q How should an encounter for COVID-19 antibody testing be coded?

A 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.

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Q For a patient who has HIV/AIDS and is diagnosed with COVID-19, does the provider need to link the two conditions for coding?

A 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.

Q How should we code neonates/newborns that test positive for COVID-19?

A When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants, should be assigned as the principal diagnosis. For a newborn that tests positive for COVID-19, assign code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) in neonates/newborns in the absence of documentation indicating a specific type of transmission. For a newborn that tests positive for COVID-19 and the provider documents the condition was contracted in utero or during the birth process, assign codes P35.8, Other congenital viral diseases, and U07.1, COVID-19.

Q Is there a timeframe for considering the COVID-19 as 'history of' or 'current'. 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?

A 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.

Q What is the correct sequencing for a patient who is S/P lung transplant admitted for management of respiratory manifestations of COVID-19?

A Assign code T86.812, Lung transplant infection, as the principal or first-listed diagnosis, followed by code U07.1, COVID-19. This sequencing is supported by the Tabular List note at code T86.812 to "use additional code to specify infection." The Official Guidelines for Coding and Reporting state that "a transplant complication code is only assigned if the complication affects the function of the transplanted organ." The COVID-19 infection has affected the function of the transplanted lung.

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Kim Felix RHIA, CCS, **Vice President of Education**

Kim has more than twenty-five years of HIM coding experience, including coding, auditing, and management at academic medical centers as well as community hospitals. She was a project manager for a Big Four RADV audit and ICD-10 conversion for analytics software.

Kim is a distinguished member and presenter for various national and local associations. She is a recognized leader in the HIM education field. Her education experience includes adjunct faculty appointments at Temple University, Gwynedd-Mercy College, Pierce College, Thomas Jefferson University as well as acting as a study mentor at Western Governors University.

Jeanie Heck BBA, CCS, CPC, CRC, **Director of Education**

Jeanie has built a career in the HIM field for more than twenty-five years. Her work has focused on the outpatient practice arena. She has extensive experience as both a business and a practice manager.

Jeanie is an approved AHIMA ICD-10-CM trainer and has extensive teaching experience in CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS, medical coding practicum, healthcare reimbursement, and medical terminology. She serves as an adjunct instructor at Camden County College and Santa Barbara City College. She currently serves as a lead auditor for a Big Four RADV audit.

Allison Van Doren RN, BSN, CCDS, CDIP, CRC,
Vice President of Clinical and Quality Services

Allison is a national leader for CDI and Quality initiatives. She possesses extensive experience in creating and managing CDI programs, PSI and Mortality committees leading academic medical centers to best documentation practices. Her approach profoundly impacts patient care, patient safety, denials, and reimbursement. Additionally, she has 15+ years of cardiac and surgical care nursing experience.

Allison's passion for CDI focuses on both education and quality. She understands clients' complex needs and provides knowledge-based training, support solutions, and excellent service.

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