WELCOME TO CODING ROUND TABLE WEBINAR 145: COVID Revisited

The webinar will begin shortly

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Round Table 145

COVID Revisited

April 12, 2022

Agenda

- April 1, 2022 COVID Updates
- Symptoms Integral to COVID
- General Guideline Refresher
- Coding Scenarios
- Hx of COVID / Post COVID condition

APRIL 1, 2022 CODE UPDATE

In the fiscal year 2022 Hospital Inpatient Prospective Payment System final rule published on August 2, 2021, the Centers for Medicare & Medicaid Services (CMS) announced its adoption of an April 1 implementation date for ICD-10-CM and ICD-10-PCS code updates, in addition to the annual October 1 update, beginning with April 1, 2022. Please refer to *Coding Clinic* Fourth Quarter 2021, page 100, for additional information regarding the addition of April 1, 2022 maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems.

NEW ICD-10-CM CODES

Summary explanations of the ICD-10-CM changes effective April 1, 2022 are provided below. Addenda changes demonstrating the specific revisions to the code titles or instructional notes are not included in the explanations below. Please note that a few addenda changes have been made in the Alphabetical Index and Tabular List unrelated to the new codes described below. The official ICD-10-CM addenda has been posted on the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics website at: https://www.cdc.gov/nchs/icd/icd10cm.htm.

Underimmunization for COVID-19 Status

Code Z28.3, Underimmunization status, has been expanded and three new codes are created to identify:

- **Z28.310, Unvaccinated for COVID-19**
- **Z28.311, Partially vaccinated for COVID-19**
- **Z28.39, Other underimmunization status**

Reference: 1 Q 2022, issue effective with discharges March 18,2022

Question:
A patient presents to the physician's office for an annual check-up and is noted to have received the first dose of a two-dose regimen (e.g., Moderna) COVID-19 vaccine, but has not received the second dose yet. How should the patient's underimmunization status for COVID-19 be reported?

Answer:
Assign code Z28.311, Partially vaccinated for COVID-19, since the patient received the first dose of a two-dose regimen.

Reference: Q1 CC 2022

Current advice (On or after April 1, 2022 Discharges) for coding Underimmunization status

CHANGES TO THE *ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING* FY 2022 -- UPDATED APRIL 1, 2022 (OCTOBER 1, 2021 - SEPTEMBER 30, 2022)

Updates to the ICD-10-CM Official Guidelines for Coding and Reporting the new diagnosis codes that describe immunization status for COVID-19 are included below. The complete guidelines may be downloaded by visiting the following website: https://www.cdc.gov/nchs/icd/icd10cm.htm

Section I. Conventions, general coding guidelines and chapter specific guidelines

C. Chapter Specific Coding Guidelines . . .

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, U09.9 . . .

g. Coronavirus infections . . .

1) COVID-19 infection (infection due to SARS-CoV-2) . . .

(n) Underimmunization for COVID-19 Status

Code Z28.310, Unvaccinated for COVID-19, may be assigned when the patient has not received at least one dose of any COVID-19 vaccine. Code Z28.311, Partially vaccinated for COVID-19, may be assigned when the patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the Centers for Disease Control and Prevention (CDC) definition of "fully vaccinated" in place at the time of the encounter. For information, visit the CDC's website https://www.cdc.gov/coronavirus/2019-ncov/vaccines/.

Question:
Is it appropriate to report code Z28.3, Underimmunization status, for encounters where the provider documents the patient has not been immunized against COVID-19?? (8/27/21).

Answer:
No, code Z28.3, Underimmunization status, is not appropriate for this purpose. There is currently no ICD-10-CM code available to identify lack of immunization against COVID-19.

Previous Advice (Prior to April 1, 2022) for coding Underimmunization status

Reference: Fourth Quarter 2021, issue effective with discharges October 1, 2021

COVID PHE PCS CODES, APRIL 1 2022 UPDATES

The Code Tables, Index and related Addenda files are available on the Centers for Medicare & Medicaid Services (CMS) website at https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs.

Nine new procedure codes are created to describe the introduction or infusion of therapeutics, including vaccines, monoclonal antibodies and a drug for COVID-19 treatment.

https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

COVID-19 VACCINE ADMINISTRATION

Four new procedure codes are created for COVID-19 vaccines as shown below. Two codes were created for vaccines described as a third dose, and two codes were created for vaccines described as boosters.

XW013V7 Introduction of COVID-19 vaccine dose 3 intosubcutaneous tissue, percutaneous approach, new technology group 7

XW013W7 Introduction of COVID-19 vaccine booster into subcutaneous tissue, percutaneous approach, new technology group 7

XW023V7 Introduction of COVID-19 vaccine dose 3 into muscle,
percutaneous approach, new technology group 7

XW023W7 Introduction of COVID-19 vaccine booster into muscle, percutaneous approach, new technology group 7

A COVID-19 vaccine booster shot is an additional dose of a vaccine given after the protection provided by the original shot(s) has begun to decrease over time. The CDC recommendations for a COVID-19 booster vary based on the vaccine received (e.g., Pfizer-BioNTech, Moderna, or Janssen/Johnson& Johnson), the patient's age, and the
time after completion of the primary COVID-19 vaccination series. For example, at press time, the CDC recommended boosters for all patients 12 years and older who received the Pfizer-BioNTech vaccine at least 5 months after completing their primary COVID-19 vaccination series. Please refer to the CDC's website at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html for the current recommendations for COVID-19 boosters as the guidance is evolving.

A COVID-19 third dose refers to an additional vaccine dose administered to people with moderately or severely compromised immune systems to improve the response to the initial vaccine series.
The term "third dose" can be used to refer to an additional dose of the two-dose vaccine regimens (e.g., Moderna or Pfizer-BioNTech), but the term "additional dose" may be used to describe doses given to individuals who received the Janssen/Johnson & Johnson single dose vaccine regimen that may also be eligible for another dose based on their immune systems.

Code assignment should be based on the documentation. Assign the code for dose 2 if it's documented as the second dose, the code for
dose 3 if it's documented as the third dose, and the booster code if it's documented as a booster.

INTRODUCTION OF NEW THERAPEUTIC SUBSTANCES

New Substance values were added to code Table XW0, Anatomical Regions, Introduction, for the three substances listed below. Please note that all of the substances below have a qualifier of 7, New Technology Group 7.

Device/Substance/Technology
R Fostamatinib
X Tixagevimab and Cilgavimab Monoclonal Antibody
Y Other Monoclonal Antibody

Fostamatinib

Three new codes have been created for the administration of fostamatinib (Tavalisse®). The drug may be administered orally or enterally. Fostamatinib is approved in the United States, Europe, and Canada as a treatment for adult **chronic immune thrombocytopenia.**

A request for Emergency Use Authorization (EUA) for fostamatinib is under review by the U.S. Food and Drug Administration (FDA) for the treatment of hospitalized adult COVID-19 patients. The new ICD-10- PCS codes are listed below:

XW0DXR7 Introduction of fostamatinib into mouth and pharynx, external approach, new technology group 7

XW0G7R7 Introduction of fostamatinib into upper GI, via natural or artificial opening, new technology group 7

XW0H7R7 Introduction of fostamatinib into lower GI, via natural or artificial opening, new technology group 7

INTRODUCTION OF NEW THERAPEUTIC SUBSTANCES

New Substance values were added to code Table XW0, Anatomical Regions, Introduction, for the three substances listed below. Please note that all of the substances below have a qualifier of 7, New Technology Group 7.

Device/Substance/Technology
R Fostamatinib
X Tixagevimab and Cilgavimab Monoclonal Antibody
Y Other Monoclonal Antibody

Tixagevimab and Cilgavimab

One new code has been created for the administration of tixagevimab and cilgavimab monoclonal antibody. (Evusheld™). The FDA granted Evusheld™ EUA for the **pre-exposure prophylaxis of COVID-19** in adults and pediatric individuals:

• who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual infected with SARS-CoV-2 and who have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination or

• for whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/ or COVID-19 vaccine component(s).

One dose is administered as two separate, consecutive intramuscular injections. A single code would be reported for the full dose.

The new ICD-10-PCS code is as follows:

XW023X7 Introduction of tixagevimab and cilgavimab monoclonal antibody into muscle, percutaneous approach, new technology group 7

INTRODUCTION OF NEW THERAPEUTIC SUBSTANCES

New Substance values were added to code Table XW0, Anatomical Regions, Introduction, for the three substances listed below. Please note that all of the substances below have a qualifier of 7, New Technology Group 7.

Device/Substance/Technology
R Fostamatinib
X Tixagevimab and Cilgavimab Monoclonal Antibody
Y Other Monoclonal Antibody

Other Monoclonal Antibody

One new code has been created for other new monoclonal antibody **COVID-19 treatments that are administered intramuscularly that may become available and do not yet have a unique code**. The ICD-10- PCS code is as follows:

XW023Y7 Introduction of other new technology monoclonal antibody into muscle, percutaneous approach, new technology group 7

For administration of “other monoclonal antibodies” used to treat neoplastic conditions rather than COVID-19, see ICD-10-PCS table 3E0. For example, code 3E0230M describes “Introduction of antineoplastic, monoclonal antibody, into muscle, percutaneous approach.”

Symptoms integral to COVID

What are signs and symptoms of COVID vs. Manifestations of COVID?

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Revised August 27, 2021

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 routinely associated 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 nonrespiratory signs/symptoms/conditions be coded separately since they are not routinely associated with COVID-19? (4/28/2020; revised 8/25/21)

Answer:

People infected with COVID-19 may vary from being asymptomatic to having a range of symptoms and severity. Therefore, for coding purposes, signs and symptoms associated with COVID-19 may be coded separately, unless the signs or symptoms are routinely associated with a manifestation. For example, cough would not be coded separately if the patient has pneumonia due to COVID-19, as cough is a symptom of pneumonia. **The additional coding of signs or symptoms not explained by the manifestations would provide additional information on the severity of the disease.**

SYMPTOMS INTEGRAL OR NOT INTEGRAL TO DISEASE PROCESS

Conditions that are an integral part of a disease process
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the Classification

Conditions that are not an integral part of a disease process
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present

Use of symptom codes
Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider

Use of a symptom code with a definitive diagnosis code
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, such as the various signs and symptoms associated with complex syndromes. **The definitive diagnosis code should be sequenced before the symptom code. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.**

General Guidelines

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022 –

Issue	Comments
Exposure to COVID-19	For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. See guideline I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes. If COVID-19 is confirmed, see guideline I.C.1.g.1.a.
Screening for COVID-19	During the COVID-19 pandemic, a screening code is generally not appropriate. Do not assign code Z11.52, Encounter for screening for COVID-19. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (guideline I.C.1.g.1.e). **Coding guidance will be updated as new information concerning any changes in the pandemic status becomes available**.
Signs and symptoms without definitive diagnosis of COVID-19	Signs and symptoms without definitive diagnosis of COVID-19 For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as: • R05.1, Acute cough, or R05.9, Cough, unspecified • R06.02 Shortness of breath • R50.9 Fever, unspecified If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822, Contact with and (suspected) exposure to COVID-19, as an additional code.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022 –

Issue	Comments
Asymptomatic individuals who test positive for COVID-19	For asymptomatic individuals who test positive for COVID-19, see guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.
Personal history of COVID-19	For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.
Follow-up visits after COVID-19 infection has resolved	For individuals who previously had COVID-19, without residual symptom(s) or condition(s), and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19. For follow-up visits for individuals with symptom(s) or condition(s) related to a previous COVID-19 infection, see guideline I.C.1.g.1.m. See Section I.C.21.c.8, Factors influencing health states and contact with health services, Follow-up
Encounter for antibody testing	For an encounter for antibody testing that is not being performed to confirm a current COVID-19 infection, nor is a follow-up test after resolution of COVID-19, assign Z01.84, Encounter for antibody response examination. Follow the applicable guidelines above if the individual is being tested to confirm a current COVID-19 infection. For follow-up testing after a COVID-19 infection, see guideline I.C.1.g.1.j.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Issue	Comments
Code only confirmed cases	Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID- 19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of a positive test result for COVID-19; the provider’s documentation that the individual has COVID-19 is sufficient. If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.
Sequencing of codes	When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications. ***For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock*** ***See Section I.C.15.s. for COVID-19 infection in pregnancy, childbirth, and the puerperium*** ***See Section I.C.16.h. for COVID-19 infection in newborn*** ***For a COVID-19 infection in a lung transplant patient, see Section I.C.19.g.3.a. Transplant complications other than kidney.***

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Issue	Comments
Acute respiratory manifestations of COVID-19	When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.
Pneumonia	For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.82, Pneumonia due to coronavirus disease 2019 .
Acute bronchitis	For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms. Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.
Lower respiratory infection	If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned. If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.
Acute respiratory distress syndrome	For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Issue	Comments
Acute respiratory failure	For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.
Non-respiratory manifestations of COVID-19	When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Issue	Comments
Multisystem Inflammatory Syndrome	Multisystem Inflammatory Syndrome For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis. If an individual with a history of COVID-19 develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and U09.9, Post COVID-19 condition, unspecified. If an individual with a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19. Additional codes should be assigned for any associated complications of MIS.
Post COVID-19 Condition	For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified. Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection. If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Issue	Comments
Underimmunization for COVID-19 Status	Code Z28.310, Unvaccinated for COVID-19, may be assigned when the patient has not received at least one dose of any COVID-19 vaccine. Code Z28.311, Partially vaccinated for COVID-19, may be assigned when the patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the Centers for Disease Control and Prevention (CDC) definition of “fully vaccinated” in place at the time of the encounter. For information, visit the CDC’s website https://www.cdc.gov/coronavirus/2019-ncov/vaccines/.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022

Issue	Comments
COVID-19 infection in pregnancy, childbirth, and the puerperium	During pregnancy, childbirth or the puerperium, when COVID-19 is the reason for admission/encounter , code O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, should be sequenced as the principal/first-listed diagnosis, and code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) should be assigned as additional diagnoses. Codes from Chapter 15 always take sequencing priority. If the reason for admission/encounter is unrelated to COVID-19 but the patient tests positive for COVID-19 during the admission/encounter, the appropriate code for the reason for admission/encounter should be sequenced as the principal/first- listed diagnosis, and codes O98.5- and U07.1, as well as the appropriate codes for associated COVID-19 manifestations, should be assigned as additional diagnoses.
Birth process or community acquired conditions	If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used. If the condition is community-acquired, a code from Chapter 16 should not be assigned. **For COVID-19 infection in a newborn, see guideline I.C.16.h.**
COVID-19 Infection in Newborn	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. When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants according to place of birth and type of delivery, should be assigned as the principal diagnosis.

CODING COVID SYMPTOMS VS. MANIFESTATIONS

Scenario	Codes?
Asymptomatic COVID	
Patient was diagnosed with acute cough due to COVID	
Patient has a loss of taste and smell. Final Dx: COVID +	
Patient presents with diarrhea due COVID	
Patient presents with cough and found to have acute bronchitis due to COVID	
Patient admitted with COVID pneumonia. Patient thought to have elevated liver function tests due to COVID	
Patient admitted with sepsis due COVID pneumonia. Found to have elevated lefts due to acute hepatitis due to COVID	
Patient has COVID with elevated liver enzymes	

CODING COVID SYMPTOMS VS. MANIFESTATIONS

Scenario	Codes?
Asymptomatic COVID	U07.1 (COVID-19)
Patient was diagnosed with acute cough due to COVID	U07.1 (COVID-19), R05.1 (Acute cough)
Patient has a loss of taste and smell. Final Dx: COVID +	U07.1 (COVID-19), R43.8 (Other disturbances of smell and taste)
Patient presents with diarrhea due COVID	U07.1 (COVID-19), A08.39 (Other viral enteritis)
Patient presents with cough and found to have acute bronchitis due to COVID	U07.1 (COVID-19), J20.8 (Acute bronchitis due to other specified organisms)
Patient admitted with COVID pneumonia. Patient thought to have elevated liver function tests due to COVID	U07.1 (COVID-19), J12.82 (Pneumonia due to coronavirus disease 2019). R74.8 (Abnormal levels of other serum enzymes)
Patient admitted with sepsis due COVID pneumonia. Found to have elevated lefts due to acute hepatitis due to COVID	A41.89 (Other specified sepsis), U07.1 (COVID-19), J12.82 (Pneumonia due to coronavirus disease 2019) B17.8 (Other specified acute viral hepatitis)
Patient has COVID with elevated liver enzymes	U07.1 (COVID-19), R74.8 (Abnormal levels of other serum enzymes)

COVID Scenarios

SCENARIO 1: CODING QUESTION

Admitted 1/18-1/26/22

ED: Upon arrival to ED, patient found to have bilateral feet myoclonus and sudden involuntary movements/jerking of upper bilateral limbs hence neurology consultation

Chief Complaint
Patient presents with
• Weakness - Generalized
Pt. More lethargic and weakness. Also has jerk movements and family curious of parkinson's .

presenting to the ED with increased weakness and fatigue for the last 4 days. She also notes decreased appetite and tremors to her hands and feet. She was hospitalized 3 weeks ago with encephalopathy. She takes abilify for her depression. She just stopped taking her lunesta. Denies fever, headaches, cough, and other acute symptoms. No other known modifying factors

1/19/2022-> Hospital course complicated by bilateral PE. Patient was initiated on heparin drip. EEG abnormal due to triphasic waves which can be seen in neuronal dysfunction from toxic metabolic cause. Patient is COVID-19 positive which most likely is the etiology of her myoclonus

admit 1/18 to / 1/26
Pt with Covid positive test results
Pt does not require oxygen supplementation, therefore not a candidate for remdesivir or dexamethasone.
Patient was afebrile without any chest pain, shortness of breath, headache, or fever
Work-up: URP: Positive for SARS COV 2.
Patient is COVID-19 positive which most likely is the etiology of her myoclonus
CTA chest with incidental finding of BL PE
1/19/2022-> Hospital course complicated by bilateral Acute PE. Patient was initiated on heparin drip

Should PE or Myoclonus be our PDx for this encounter because covid is without respiratory manifestations?

SCENARIO 2: CODING QUESTION

Request PDx opinion.
Pt was dx w/ hyponatremia, AKI, w/ positive COVID test. No respiratory symptoms/signs were found. Pt underwent one treatment of Remdesivir and was discontinued d/t increased Cr level. Pt dx w/ ARF w/ acute cortical necrosis and COVID associated nephropathy. Pt then underwent tunneled VAD and multiple dialysis sessions. Renal and infectious disease consultations were done. Pt was treated w/ Dexamethasone for COVID infection.

Would you still code U07.1 as PDx? If so, DRG is mapped to 177 (Resp infxn & inflame w/ MCC), even though there is no resp symptomology

PDX	PPX	DRG	Weight	ALOS	GLOS	Reimb $	PDX Description
U071		177	1.8491	6.80	5.40	$8020.59	COVID-19
N171		682	1.4727	5.70	4.30	$6403.06	Acute kidney failure with acute cortical necrosis
E871		640	1.2308	4.50	3.30	$5363.50	Hypo-osmolality and hyponatremia
N08		698	1.6106	6.00	4.70	$6995.67	Glomerular disorders in diseases classified elsewhere (manifestation)

N08 **Glomerular disorders in diseases classified elsewhere**

Glomerulonephritis
Nephritis
Nephropathy

CODE FIRST
Code first underlying disease, such as:
amyloidosis (E85.-)
congenital syphilis (A50.5)
cryoglobulinemia (D89.1)
disseminated intravascular coagulation (D65)
gout (M1A.-, M10.-)
microscopic polyangiitis (M31.7)
multiple myeloma (C90.0-)
sepsis (A40.0-A41.9)
sickle-cell disease (D57.0-D57.8)

U07.1 **COVID-19**

USE ADDITIONAL
Use additional code to identify pneumonia or other manifestations, such as:
pneumonia due to COVID-19 (J12.82)

EXCLUDES 2
coronavirus as the cause of diseases classified elsewhere (B97.2-)
coronavirus infection, unspecified (B34.2)
pneumonia due to SARS-associated coronavirus (J12.81)

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Skin failure due to underlying coagulopathy due to COVID-19

ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Pages: 39-40
Effective with discharges: March 10, 2021

Question:
What are the appropriate ICD-10-CM code(s) for skin failure due to underlying coagulopathy and microvascular changes due to COVID-19? (12/11/2020)

Answer:
Assign codes U07.1, COVID-19, D68.8, Other specified coagulation defects, and L99, Other disorders of skin and subcutaneous tissue in diseases classified elsewhere.

Thrombo-inflammation of COVID-19 associated coagulopathy

ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Page: 39 Effective with discharges: March 10, 2021

Question:
What are the appropriate ICD-10-CM code(s) for thrombo-inflammation of COVID-19 associated coagulopathy? (12/11/2020)

Answer:
Assign codes U07.1, COVID-19, and D68.8, Other specified coagulation defects.

If disseminated intravascular coagulation (DIC) is documented, assign code D65, Disseminated intravascular coagulation [defibrination syndrome], instead of code D68.8. Not all COVID-19 associated coagulopathy progresses to DIC.

SCENARIO 3: CODING QUESTION

Patient that presented to the ED due to abdominal pain found to have PD cath related peritonitis with adhesions. Treated with OR visit for lysis of adheshions

The patient also tested positive for COVID-19. Documentation also states **asymptomatic** COVID-19 infection.

My question is would COVID-91 be PDX based on CC Sequencing of COVID-19 code?

ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Page: 32 Effective with discharges: March 10, 2021
Question:
Is the new ICD-10-CM code U07.1, COVID-19, a secondary code? (4/1/2020; revised 12/11/2020)
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 when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications. However, if COVID-19 does not meet the definition of principal or firstlisted diagnosis (e.g. when it develops after admission), then code U07.1 should be used as a secondary diagnosis.

Would you link the AKI to COVID in this account with the d/s saying "came to ER
with symptoms from Covid infection, and blood test showed acute worsening of renal function."? Nephrology documents it's **"likely associated with some hypovolemia from his recent illness. Possibility of further progression of his underlying disease cannot be ruled out"**
The patient had a tunneled cath so my DRG options are 177 and 673

HP:
ASSESSMENT AND PLAN:
** is a 56 y.o. year old male admitted with AKI (acute kidney injury) (HCC)

*AKI (acute kidney injury)
Chronic kidney disease, stage 4 (severe)
Benign hypertensive renal disease
IgA nephropathy
- in the process of trying to get evaluated for kidney transplant.
- Dr. ** consulted
- Recommends IVF with bicarb.
- trend Cr. and urine output.
- avoid nephrotoxins.
- hold lisinopril.

COVID-19
- airborne isolation.
- supportive care with anti-tussives.
- No pneumonia on CXR and saturating well on RA.
- Does not qualify for any treatment at this time.

Nephrology progress notes 02/6/22 - 02/10/22:

Chronic kidney disease stage V with acute on chronic kidney injury.
1/11/2022: BUN 70, creatinine 5.6, GFR 11
2/6/2022: BUN 78, creatinine 7.2.eGFR 8
2/7/2022: BUN 79, creatinine 7.2 eGFR 8
2/8/2022: BUN 76, creatinine 6.4 eGFR 10 Started hemodialysis
2/9/2022: BUN 60, creatinine 5.4, eGFR 12 HD
2/10/2022 BUN 48, creatinine 4.6, eGFR 14
Acute deterioration is most likely associated with some hypovolemia from his recent illness. Possibility of further progression of his underlying disease cannot be ruled out. Discussed with the patient that he needed renal support with dialysis initiated during this hospitalization. He consented. TDC placed 2/8/2022.First hemodialysis was 2/8/2022.
IgA nephropathy biopsy proven 2/5/2010
Hyperkalemia.
Treated medically in the emergency department.Received D50, insulin, calcium, albuterol. Potassium normal this morning at 4.6 mmol/L.

Metabolic acidosis.
Discontinue sodium bicarbonate oral supplement.

Dialysis Access is TDC placed 2/8/2022 by HHI IR. Routine access care.

COVID-19 infection. No pneumonia on chest x-ray. He has received COVID-19 vaccine but has not received the booster yet
Worst symptoms are dry and sore throat; not relieved by Cepacol

SCENARIO 4: CODING QUESTION

Discharge Summary 02/10/22:

Primary Discharge Diagnoses:
AKI (acute kidney injury) (HCC)
COVID-19 infection

Secondary Discharge Diagnoses:
Active Hospital Problems:
Diagnosis
- AKI (acute kidney injury)
- Anemia due to stage 5 chronic kidney disease
- Thrombocytopenia
- Chronic kidney disease (CKD), stage V
- Metabolic acidosis
- Hyperkalemia
- COVID-19
- Benign hypertensive renal disease
- IgA nephropathy
- Mixed hyperlipidemia
- Secondary hyperparathyroidism of renal origin

Reason for Admission:
** is a 56 y.o. year old male admitted with AKI (acute kidney injury) (HCC)

History of Present Illness (from Dr. ** H&P):
Is a 59-year-old male history of CKD 4 secondary to IgA nephropathy, hypertension, GERD, and migraines who presents with complaint of 5-day history of dry cough, chills, fatigue, nausea, anorexia, nausea, sore throat, and dizziness.Patient states that he is vaccinated x2 with Pfizer but has not gotten his booster yet.Patient was seen at ** urgent care yesterday and had a negative strep, negative influenza A/P, and negative rapid PCR for Covid.

Patient also complains of decreased urine output over the past few days.Due to the persistent symptoms, the patient presented to the ED for further evaluation. He has underlying IgA nephropathy, biopsy proven from 2010.He has developed progressive deterioration in kidney function and now has chronic kidney disease stage V. His most recent outpatient labs from 1/11/2022 showed a BUN of 70 with a creatinine of 5.6.He has been discussing dialysis therapy with Dr. ** but has not decided on HD or PD.

Hospital Course:
*AKI (acute kidney injury) on Chronic kidney disease (CKD), stage V due to IgA nephropathy
-This patient with advanced kidney disease due to IgA nephropathy came to ER with symptoms from Covid infection, and blood test showed acute worsening of renal function.Prior to this admission, he was in the process of trying to get evaluated for kidney transplant.
-Nephrology was consulted and recommended tunneled dialysis catheter and starting dialysis.Patient started dialysis in the hospital, and outpatient dialysis was arranged.He was discharged home in stable condition and will follow up with his outpatient nephrologist, Dr. **.

Hyperkalemia
-5.8 on admission.After treatment, it improved and remained stable.His lisinopril was discontinued.

COVID-19
-He had no evidence of pneumonia on x-ray and respiratory status remained stable.He did not require any treatment specific for COVID-19.He remained in Covid isolation.

Thrombocytopenia
-Possibly due to acute Covid infection.Mild and stable.Monitor as outpatient

SCENARIO 5: CODING QUESTION

If COVID is still considered current would be the only MCC. Per below I'm reading as Hx of COVID or should I query to confirm since original quarantine was for 14 days?

Per the H&P

tested positive for Covid approximately 10 days ago in 14-day quarantine at a hotel.

had a significant clot burden throughout that SVG that we are not able to completely clear.

I wonder if this is due to recent COVID infection.

PN

COVID-19 virus infection Tested positive 10 days ago

has been without symptoms for greater than 5 days. Therefore, contact precautions are not needed.

DISCHARGE DIAGNOSIS:
Acute MI, left heart cath with findings of thrombotic occlusion of SVG to the OM and then onto the posterior lateral branch. Possibly also with a small segment to the PDA. Status post angioplasty, thrombectomy and TPA

COVID-19 virus infection
Tested positive 10 days ago.- Out of the 5-10 day quarantine period.

Hx of COVID and Post COVID condition

Chapter Specific Guidelines

Chapter	Description
Chapter 1: Certain Infectious and Parasitic Diseases	(l) **Multisystem Inflammatory Syndrome** For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis. If an individual with a history of COVID-19 develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and **U09.9, Post COVID-19 condition, unspecified**. If an individual with a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19. Additional codes should be assigned for any associated complications of MIS. (m)**Post COVID-19 Condition** **For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified.** **Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection.** **If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.**

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Question:

The patient presents to the facility with symptoms such as generalized weakness and lack of appetite, and the provider documents a diagnosis of "post COVID-19 syndrome." How should this be coded? (12/11/2020; revised 8/25/21)

Answer:

[Effective 10/1/21:]
For discharges/encounters on or after October 1, 2021, assign codes R53.1, Weakness, R63.0, Anorexia, and U09.9, Post COVID-19 condition, unspecified, for a diagnosis of post COVID-19 syndrome with generalized weakness and lack of appetite This is supported by the instructional note at code U09.9 to "code first the specific condition related to COVID-19 if known."

[Prior to 10/1/21:]
For discharges/encounters prior to October 1, 2021, unless the provider specifically documents that the symptoms are the result of COVID-19, assign code(s) for the specific symptom(s) and a code for personal history of COVID-19. "Post COVID-19 syndrome" indicates temporality, but not that the current symptom(s) or clinical condition(s) are a residual effect (sequelae) of COVID-19. As stated in the ICD-10-CM *Official Guidelines for Coding and Reporting,* in the absence of Alphabetic Index guidance for coding syndromes, assign codes for the documented manifestations of the syndrome.

The appropriate personal history code is Z86.19, Personal history of other infectious and parasitic diseases, for discharges/encounters prior to January 1, 2021 or code Z86.16, Personal history of COVID-19, for discharges/ encounters after January 1, 2021.

If the provider documents that the symptoms are the result (residual effect) of COVID-19, assign code(s) for the specific symptom(s) and code B94.8, Sequelae of other specified infectious and parasitic diseases. According to the ICD-10-CM *Official Guidelines for Coding and Reporting,* a sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated.

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Question:

A patient was COVID-19 positive at a short term acute care hospital where he was being cared for COVID-19 related respiratory problems and completed treatment with Remdesivir and Dexamethasone. After more than a two-month stay, the patient is now transferred to a long-term care hospital (LTCH) with acute respiratory failure for tracheostomy weaning. At the time of transfer, the patient had been weaned from ventilator to tracheostomy collar at 28%. Diagnosis on admission was history of COVID-19, acute respiratory failure, and tracheostomy dependence. When queried regarding the patient's COVID-19 status on admission to the LTCH, the provider indicated that the patient was no longer infectious and is being admitted only to treat the residual respiratory failure requiring oxygenation via tracheostomy. May we assign code J96.90 as a principal diagnosis, followed by code Z86.16, Personal history of COVID-19, since the patient no longer has a COVID-19 infection? (3/1/21; revised 8/25/21)

Answer:

Query the provider whether "residual respiratory failure" refers to acute on chronic, or chronic respiratory failure. Assign the appropriate respiratory failure code based on the response, followed by code B94.8, Sequelae of other specified infectious and parasitic diseases, for discharges/encounters prior to October 1, 2021, or code U09.9, Post COVID-19 condition, unspecified, for discharges/encounters on or after October 1, 2021, as a secondary diagnosis, for the sequelae of COVID-19 infection, since the patient has been documented as no longer infectious for COVID-19.

Although the provider referred to "history of COVID-19," a personal history code is inappropriate in this case. As defined in the ICD-10-CM *Official Guidelines for Coding and Reporting,* Section IB. "A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated." In addition, Section I. C.21,c,(4) states "Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring."

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Question:

A patient who tested negative for COVID-19 several times as an outpatient now presents to the Emergency Department because of worsening symptoms. The patient was admitted for treatment of possible pneumonia. He was retested for COVID-19, and the results were still negative; however, a COVID-19 antibody test was positive. The provider's final diagnostic statement lists, "Post COVID-19 organizing pneumonia." Would pneumonia be considered an acute manifestation of COVID-19, a late effect/sequela of COVID- 19, or is the COVID-19 coded as a personal history since the most recent COVID-19 test is negative? What is the principal diagnosis, COVID-19 or pneumonia? (3/1/21; revised 8/25/21)

Answer:

Based on the documentation provided, the patient has an organizing pneumonia due to previous COVID-19 infection. Assign code J84.89, Other specified interstitial pulmonary diseases, followed by code B94.8. Sequelae of other specified infectious and parasitic diseases, for discharges/encounters prior to October 1, 2021, or code U09.9, Post COVID-19 condition, unspecified, for discharges/encounters on or after October 1, 2021, for a diagnosis of post COVID-19 organizing pneumonia. Code J84.89 may be located by the following Index entry:

Pneumonia
organizing J84.89

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Question:

A patient with a history of COVID-19 infection was admitted for treatment of acute hyperkalemia and acute kidney injury with chronic kidney disease. Follow-up COVID-19 testing was positive. The provider documented, "COVID likely reflective of old noninfectious virus." How is the COVID-19 status captured for this patient? Does the *Official Coding and Reporting Guideline* I.C.1.g.1.a., "code only confirmed cases" apply when the provider documents the patient as "noninfectious" but has a positive COVID-19 test during the admission? (8/25/21)

Answer:

Assign code Z86.16, Personal history of COVID-19. While the patient had a positive COVID-19 test, the provider documented that the patient was not actively infectious during this admission. When the provider documents "noninfectious" or "not infectious" COVID-19 status, this indicates that the patient no longer has an active COVID-19 infection, therefore assign code Z86.16 instead of code U07.1, COVID-19.

Although guideline I.C.1.g.1.a., states: "Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID-19 test result," in this scenario the provider has clarified the patient no longer has an active COVID-19 infection.

Therefore, code U07.1, COVID-19, is not appropriate and the *Official Coding Guideline* I.C.1.g.1.a., regarding a positive COVID-19 test result would not apply.

If the documentation is unclear, as to whether the patient has an active COVID-19 infection or a personal history, query the provider for clarification.

New/revised frequently asked questions regarding ICD-10-CM/PCS coding for COVID-19
ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2021 Pages: 101-111 Effective with discharges: October 1, 2021

Question:

A patient presented to the hospital with acute respiratory failure and COPD exacerbation. It was noted that the patient tested positive for COVID-19 approximately 80 days prior to this admission. A repeat COVID-19 test was performed and came back positive but the provider documented she did not consider the patient's status to be a COVID-19 "reinfection." The discharge summary states: "history of COVID infection currently still testing positive for COVID." Is it appropriate to assign code Z86.16, Personal history of COVID-19, or code U07.1, COVID-19 since there is a positive test? (8/25/21)

Answer:

Although the patient is still testing positive for COVID-19, the provider has documented the patient's condition was a previous history of a COVID-19 infection and not a reinfection, therefore it would be appropriate to assign code Z86.16, Personal history of COVID-19.

Question:

A patient presented for treatment of bulbous pemphigoid bulla with surrounding cellulitis. During the admission, the patient was tested for COVID-19. Although the patient was completely vaccinated, the physician documented the COVID-19 test was positive. The patient was subsequently placed in isolation and instructed to complete 10 days of self-isolation following discharge. How is COVID-19 coded in this scenario? (8/25/21)

Answer:

Assign code U07.1, COVID-19. The provider's assessment stated "COVID-19 virus detected," and it is possible for a COVID-19 infection to occur despite vaccination. This is consistent with *Official Guidelines for Coding and Reporting,* Section I.C.1.g.1.a., which states: Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID-19 test result.

NEW/REVISED FREQUENTLY ASKED QUESTIONS REGARDING ICD-10-CM/PCS CODING FOR COVID-19

Question:

A patient was recently discharged from the hospital, admitted to a nursing home, and subsequently tested positive for COVID-19 via a rapid antigen test. The patient was readmitted to the hospital for COVID-19; however was asymptomatic. Repeat testing x2 including confirmatory testing of COVID PCR was negative. The provider consulted with infectious disease and hematology and it was documented the patient had a false positive that did not represent a true COVID-19 infection. How is COVID-19 coded in this scenario? (8/25/21)

Answer:

Assign code Z20.822, Contact with and (suspected) exposure to COVID-19, as principal diagnosis, for a patient admitted and found to have a false positive COVID-19 test. ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.1.g.1.e. states: For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19.

Although guideline I.C.1.g.1.a., allows coding of confirmed cases of COVID-19 on the basis of "documentation of a positive COVID-19 test result," in this scenario the provider clarified the COVID-19 test as being a false positive; therefore code U07.1, COVID-19, is not appropriate and the Official Coding Guideline I.C.1.g.1.a. regarding coding on the basis of a positive COVID-19 test result would not apply to this case.

However, it is always appropriate to query the provider for clarification whenever the coding professional finds the medical record documentation to be unclear regarding the patient's COVID-19 status.

Critical illness myopathy and peroneal palsy due to sequelae of COVID-19 infection

ICD-10-CM/PCS Coding Clinic, Third Quarter ICD-10 2020 Pages: 12-13 Effective with discharges: September 8, 2020

Question:

A patient was transferred from an acute care hospital to a rehab facility due to sequelae of a COVID-19 infection, including critical illness myopathy and peroneal palsy in the right lower extremity. The patient no longer has COVID-19. What codes should be assigned?

Answer:

Assign codes G72.81, Critical illness myopathy, and G57.31, Lesion of lateral popliteal nerve, right lower limb. Assign code B94.8, Sequelae of other specified infectious and parasitic diseases, as a secondary diagnosis for the sequelae of a COVID-19 infection.

Note: As of October 1, 2021, a code U09.9, Post COVID-19 condition, unspecified, has been created to identify health problems that can last for an extended time after the initial COVID-19 infection has resolved. See advice published in Coding Clinic, 4th Quarter 2021, pages 31-32.

POST COVID SYNDROME

New/revised frequently asked questions regarding ICD-10-CM/PCS coding for COVID-19
ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2021 Pages: 101-111 Effective with discharges: October 1, 2021

Question:
The patient presents to the facility with symptoms such as generalized weakness and lack of appetite, and the provider documents a diagnosis of "post COVID-19 syndrome." How should this be coded? (12/11/2020; revised 8/25/21)

Answer:

[Effective 10/1/21:]

For discharges/encounters on or after October 1, 2021, assign codes R53.1, Weakness, R63.0, Anorexia, and U09.9, Post COVID-19 condition, unspecified, for a diagnosis of post COVID-19 syndrome with generalized weakness and lack of appetite This is supported by the instructional note at code U09.9 to "code first the specific condition related to COVID-19 if known."

[Prior to 10/1/21:]

For discharges/encounters prior to October 1, 2021, unless the provider specifically documents that the symptoms are the result of COVID-19, assign code(s) for the specific symptom(s) and a code for personal history of COVID-19. "Post COVID-19 syndrome" indicates temporality, but not that the current symptom(s) or clinical condition(s) are a residual effect (sequelae) of COVID-19. As stated in the ICD-10-CM Official Guidelines for Coding and Reporting, in the absence of Alphabetic Index guidance for coding syndromes, assign codes for the documented manifestations of the syndrome.

The appropriate personal history code is Z86.19, Personal history of other infectious and parasitic diseases, for discharges/encounters prior to January 1, 2021 or code Z86.16, Personal history of COVID-19, for discharges/ encounters after January 1, 2021.

If the provider documents that the symptoms are the result (residual effect) of COVID-19, assign code(s) for the specific symptom(s) and code B94.8, Sequelae of other specified infectious and parasitic diseases. According to the ICD-10-CM Official Guidelines for Coding and Reporting, a sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated.

COVID-19 viral shedding

Answer: Viral shedding can mean either that the patient has an active (current) COVID-19 infection or a personal history of COVID-19. Therefore, the code assignment depends on the provider documentation.

For documentation of viral shedding in a patient with an active COVID-19 infection, assign code U07.1, COVID-19.

For documentation of viral shedding in a patient with a personal history of a COVID-19 infection rather than an active infection, assign code Z86.19, Personal history of other infectious and parasitic diseases, for discharges/encounters prior to January 1, 2021 or code Z86.16, Personal history of COVID-19, for discharges/encounters after January 1, 2021.

If the documentation is not clear as to whether the patient has an active COVID-19 infection or a personal history, query the provider.

42. Question: What are the appropriate ICD-10-CM code(s) for "COVID-19 viral shedding?" (12/11/2020)

COVID-19 viral shedding
ICD-10-CM/PCS Coding Clinic, First Quarter ICD-10 2021 Page: 40 Effective with discharges: January 1, 2021

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

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Thank You