COVID-19 Coding Updates

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Since April of 2020, there have been many updates to coding guidelines and codes for COVID-19 related services. This article will serve as a summary of these updates as of December 2020.

OFFICIAL GUIDELINES FY 2021

Coronavirus Infections

ICD-10-CM Official Guidelines for Coding and Reporting (effective October 1, 2020 - September 30, 2021)

The Official Guidelines for 1CD-10-CM coding were updated for FY 2021. The sections with revisions are included in C:

Chapter Specific Guidelines sections:

- Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, g. Coronavirus Infections
- Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)
- Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)
- Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99) c. Categories of Z Codes 6) Observation

- Chapter 22: Codes for special purposes (U00-U85)

New ICD-10-CM COVID-19 Codes
Effective January 1, 2021

- J12.82, Pneumonia due to COVID-19
- M35.81, Multisystem inflammatory syndrome
- M35.89, Other specified systemic involvement of connective tissue
- Z11.52, Encounter for screening for COVID-19
- Z20.822, Contact with and (suspected) exposure to COVID-19
- Z86.16, Personal history of COVID-19

MS-DRG Grouper V.38.1
The ICD-10 MS-DRG Grouper will be updated to V38.1 effective for discharges on or after January 1, 2021. The CMS MS-DRG page shows the new ICD-10-CM codes with the grouping information. Also listed on this page are the new technology codes, including COVID-19 vaccine and monoclonal antibody substances.

CODING CLINIC ARTICLES

Frequently Asked Questions Regarding ICD-10-CM Coding for COVID-19 Revised September 1, 2020
Coding Clinic updated the FAQs on September 1, 2020, adding questions and responses regarding the reporting of Remdesvir, Sarilmab and Tocilizumab and Dexamethasone.

New ICD-10-PCS Codes Effective August 01, 2020
Coding Clinic for ICD-10-CM/PCS, Third Quarter 2020: Page 17

Coding Clinic presented 12 new procedure codes for the introduction or infusion of therapeutics in treating COVID-19. These treatments include Remdesivir, Kevzara (Sarilumab), Tocilizumab and convalescent plasma. Plus, many questions and answers were included regarding these new codes.

Frequently Asked Questions Regarding ICD-10-CM Coding for COVID-19 Revised August 5, 2020
Coding Clinic for ICD-10-CM/PCS, Third Quarter 2020: Page 9

The FAQs for COVID-19 ICD-10-CM coding was revised and updated from previous versions. These FAQs are from both the American Health Information Association (AHIMA) and the American Hospital Association (AHA) and are approved by the cooperating parties.

Frequently Asked Questions Regarding ICD-10-PCS Coding for COVID-19
Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2020: Page 95

The FAQs for COVID-19 ICD-10-PCS coding was revised and updated from previous versions. These FAQs are from both AHIMA and AHA and are approved by the cooperating parties. Additionally, there is clarification in an additional article regarding reporting infusions and therapeutics once per visit.

COVID-19 with Presumptive Test Results
Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2020: Page 99

This reference answers the question as to why "presumptive" was removed from FY 2021 Official Coding and Reporting Guidelines.

NEW COVID REPORTING POLICY FOR FY 2021

Per the CARES Act, healthcare facilities may receive a 20% increase in the relative weight of a COVID MS-DRG. Effective with admissions occurring on or after September 1, 2020, to qualify for the increase, a copy of the positive COVID-19 laboratory test must be filed in the medical record. The type of approved testing noted in the regulation requires viral testing, meaning molecular or antigen, consistent with CDC guidelines. State or local COVID-19 test results will not be allowed. If the test was performed by another entity, that outside test must be filed in the medical record. CMS will consider cases where the positive test was performed more than 14 days prior to admission for special or complex circumstances.

As stated in Official Guidelines, Section I.C.1.g.1) a) 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."

The CMS article describing the new reporting policy (SE20015) was revised on September 11, 2020 and includes instructions on how facilities notify their Medicare Administrative Contractor when there is no evidence of a positive laboratory test in the medical record. This step is performed during the billing process (not by HIM coding).

The AHA has requested that CMS reconsider the new requirement. The AHA cites not only the administrative burden on hospitals as a reason for reconsideration, but the coding guidelines (noted above).

ICD-10-CM COORDINATION AND MAINTENANCE COMMITTEE

New ICD-10-CM code proposals were presented at the during the September 8-9, 2020 meeting. These new codes are expected to be implemented in January 2021.

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of years ago. Under it, a patient or representative was entitled to receive at no charge, a copy of records or of information needed to support a claim or appeal regarding eligibility for a public benefit program. The provider had to transmit the copies within 30 days after receiving a written request. The public benefits programs listed were Medi-Cal, In-Home Supportive Services, CalWORKS, SSI/SSP, CalFresh, and federal veteran's service-connected compensation and nonservice connected pension disability benefits. There were exceptions for situations where the patient was represented by a private attorney not employed by a nonprofit legal services entity, where more than one request was being made for the same information, or where the patient's appeal was ultimately successful [Cal. Health & Safety Code §123110(d),(e),(f)].

A.B. 2520 removes the exception that allowed a provider to collect fees if the patient's appeal was successful. Accordingly, a provider will be unable to collect fees whether or not the appeal was successful. In addition, it stated that a provider cannot charge a fee to a patient for filling out forms or for providing information responsive to forms that support a claim or appeal regarding eligibility for a public benefit program [Cal. Health & Safety Code §123114(a)]. As a result, a provider called upon to fill out such forms or to give responsive information to the patient is not allowed to charge for the service. In addition, A.B. 2520 requires the provider to furnish information necessary to present a medical opinion. If it does not have such information, the provider may inform the patient if an examination is necessary in order for it to obtain the information [Cal. Health & Safety Code §123114(b),(c)]. Finally, A.B. 2520 expanded the number of public benefit programs covered by it to include programs for the discharge of federal student loans based on disability, the Cash Assistance Program for Aged, Blind, and Disabled Legal Immigrants, and government-funded housing subsidies or tenet-based housing assistance [Cal. Health & Safety Code §123114(d)].

WITH NO SPECIFIC INDICATION IN EITHER HIPAA OR CMIA THAT ELECTRONIC SIGNATURES ARE PRECLUDED, IT FOLLOWED THAT ELECTRONIC SIGNATURES ARE GENERALLY ACCEPTABLE IF THE PROPER STEPS ARE TAKEN TO ENSURE THEIR RELIABILITY

Conclusion

A.B. 2520 makes what ultimately amount to minor changes in California's patient access law. All of them permit greater access than the HIPAA equivalent. Accordingly, they prevail over the comparable HIPAA rule under HIPAA's so-called "stringency" test, which favors the law that gives expanded rights of access. Health information managers should be aware of the modifications and should comply with them when responding to patient access requests.

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Coding *from Page 19*

Three new codes in the Z category were proposed:

- ZS20.822: Contact with and (suspected) exposure to COVID-19
- Z11.52: Encounter for screening for COVID-19
- Z86.16: Personal history of COVID-19

Another proposed new code is M35.81, Multisystem inflammatory syndrome. This code would include MIS-C, Multisystem inflammatory syndrome in children, Pediatric Multisystem inflammatory syndrome and PIMS. The "code first, if applicable, COVID-19 (U07.1)" would still stand with "use additional code(s)" instruction to code additional complications. Code M35.89 would be added to retain Other specified systemic involvement of connective tissue in the M35.8x category.

A new code for Pneumonia due to coronavirus disease 2019, J12.82, was proposed. It will include Pneumonia due to COVID-19 and Pneumonia due to 2019 novel coronavirus (SARS-CoV-2).

A FINAL NOTE ON CPT CODING

The AMA has gathered all of the COVID-19 CPT coding guidance on one web page with updates as current as October 6, 2020. The URL for this reference is: ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance

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