Frequently Asked Questions Regarding ICD-10-CM/PCS Coding for COVID-19

Revised September 1, 2020

The following questions and answers were jointly developed and approved by the American Hospital Association' Central Office on ICD-10-CM/PCS and the American Health Information Management Association.

ICD-10-CM Questions

1. *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/dates 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.

2. *Question: Is the new ICD-10-CM code U07.1, COVID-19, a secondary code? (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.

3. *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? (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).

4. *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? (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.

5. *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? (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.

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

7. *Question: Is code B97.29, Other coronavirus as the cause of diseases classified elsewhere, limited to the COVID-19 virus? (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.**

8. *Question: What is the difference between ICD-10-CM codes B34.2 vs. B97.29? (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.**

9. *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? (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."

10. *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? (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.

11. *Question: Should presumptive positive COVID-19 test results be coded as confirmed? (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.

12. *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 some times COVID-19 is not "ruled out" during the encounter, since the test results aren't back yet. (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.

13. *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. (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.**

14. *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? (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.

15. *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? (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.

16. ~~*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? (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 #16 was deleted on August 5, 2020. See Questions #38 and #39 for updated advice regarding the coding for encounters for testing for COVID-19 and COVID-19 has not been confirmed)

17. *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.* (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.

18. *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?* (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."

19. *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? (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.

20. *Question: How should an encounter for COVID-19 antibody testing be coded?* (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.

21. *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).* (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.

22. *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? (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.

23. *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? (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.

24. *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? (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."

25. *Question: How should we code neonates/newborns that test positive for COVID-19? (5/26/2020)*

> Answer: 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. 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.

26. *Question: What is the correct sequencing for a patient who is status post lung transplant admitted for management of respiratory manifestations of COVID-19? (6/4/2020)*

> Answer: 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 ICD-10-CM *Official Guidelines for Coding and Reporting*, Section I.C.19.g.3.a. 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.

27. *Question: A patient was treated for pneumonia and pneumothorax due to COVID-19 and discharged from the hospital. Later the same day, the patient presented to the emergency department with pneumothorax and was readmitted due to increasing shortness of breath and for pneumothorax evacuation. Chest tube was inserted, the patient improved and was discharged. How should the readmission be coded? (7/22/2020)*

> Answer: Assign code U07.1, COVID-19, as the principal diagnosis, and code J93.83, Other pneumothorax, as a secondary diagnosis. Since the pneumothorax due to COVID-19 present on the first admission has not resolved, this appears to be ongoing treatment for a COVID-19 manifestation.

> If the documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection vs. a residual

effect from a previous COVID-19 infection, query the provider. As stated in the *Official Guidelines for Coding and Reporting*, the provider's documentation that the individual has COVID-19 is sufficient for coding purposes.

28. *Question: A patient was hospitalized a few weeks ago for pneumonia due to COVID-19. The patient now presents to the emergency department with shortness of breath and is admitted. The discharge diagnosis for this admission is "pneumothorax due to a previous history of COVID-19." How should this admission be coded? (7/22/2020)*

   Answer: Assign code J93.83, Other pneumothorax, as the principal diagnosis, followed by code B94.8, Sequelae of other specified infectious and parasitic diseases. In this case, the patient no longer has COVID-19 and the pneumothorax is a residual effect (sequelae). A personal history code is not appropriate because as stated in guideline I.C.21.c.4), "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." The patient is clearly receiving treatment for the residual effect of COVID-19.

29. *Question: A patient was diagnosed with COVID-19 infection a week ago and is admitted after developing acute onset shortness of breath associated with upper back pain as well as dizziness without syncope. The patient continued to experience symptoms of COVID-19 infection. Patient was discharged with the diagnosis of pulmonary embolism (PE) and COVID-19. What are the appropriate codes? (7/22/2020)*

   Answer: Assign code U07.1, COVID-19, as the principal diagnosis, followed by code I26.99, Other pulmonary embolism without acute cor pulmonale, for a patient diagnosed with pulmonary embolism and COVID-19. The pulmonary embolism is a manifestation of the COVID-19 infection. Per the instructional note under code U07.1, COVID-19 should be sequenced as the principal diagnosis and additional codes should be assigned for the manifestations.

30. *Question: A patient is readmitted due to shortness of breath following a previous admission for COVID-19 and associated respiratory failure. The patient no longer has COVID-19. The final diagnosis is "pulmonary embolism due to previous COVID-19." What are the appropriate codes? (7/22/2020)*

Answer: Assign code I26.99, Other pulmonary embolism without acute cor pulmonale, as the principal diagnosis, followed by code B94.8, Sequelae of other specified infectious and parasitic diseases, as a secondary diagnosis.

31. *Question: A nursing home patient was hospitalized for COVID-19 and pneumonia. He has completed treatment, but he cannot go back to the nursing home until he tests negative for COVID-19, so he is admitted to the skilled nursing facility (SNF) unit at the hospital until he tests negative and can return to the nursing home where he resides. What code should be assigned for the hospital SNF unit stay? (7/22/2020)*

Answer: Assign code U07.1, COVID-19, as the patient still has COVID-19. Do not assign a code for the pneumonia as the condition has resolved.

32. *Question: A patient was diagnosed with "Guillian-Barre Syndrome which is likely a parainfectious complication of recent COVID-19 infection." The patient no longer has COVID-19. How should this be coded? (7/22/2020)*

Answer: Assign code G61.0, Guillain-Barre syndrome, as the principal diagnosis, followed by code B94.8, Sequelae of other specified infectious and parasitic diseases.

33. *Question: A patient was transferred from a short term acute care hospital to a long term acute care hospital (LTCH) for continued treatment of acute hypoxic respiratory failure due to COVID-19. What are the appropriate codes for the LTCH admission? (7/22/2020)*

Answer: Assign code U07.1, COVID-19, as the principal diagnosis, and code J96.01 Acute respiratory failure with hypoxia, as a secondary diagnosis. Per the instructional note under code U07.1, COVID-19 should be sequenced as the principal diagnosis and additional codes should be assigned for the manifestations.

34. *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? (7/22/2020)*

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.

35. *Question: A patient was transferred from an acute care hospital to a rehab facility for deconditioning for generalized debility due to prolonged hospitalization for COVID-19 which has now resolved. What codes should be assigned? (7/22/2020)*

Answer: Assign codes for the specific symptoms (such as generalized weakness, debility, etc). Assign code Z86.19, Personal history of other infectious and parasitic diseases, as a secondary diagnosis.

Do not assign code B94.8, Sequelae of other specified infectious and parasitic diseases, as the debility is due to the prolonged hospitalization rather than being a sequela of the COVID-19 infection.

36. *Question: What is the ICD-10-CM diagnosis code(s) for a child admitted due to documented multisystem inflammatory syndrome in children (MIS-C) due to COVID-19? (7/23/2020)*

Answer: Assign code U07.1, COVID-19, as the principal diagnosis, and code M35.8, Other specified systemic involvement of connective tissue, as a secondary diagnosis, for MIS-C due to COVID-19. The MIS-C is a manifestation of the COVID-19 infection. Per the instructional note under code U07.1, COVID-19 should be sequenced as the principal diagnosis and additional codes should be assigned for the manifestations.

If the documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection vs. a residual effect from a previous COVID-19 infection, query the provider. As stated in the Official Guidelines for Coding and Reporting, the provider's documentation that the individual has COVID-19 is sufficient for coding purposes.

37. *Question: A child diagnosed with COVID-19 several weeks ago is now admitted with multisystem inflammatory syndrome in children (MIS-C) due to COVID-19. The patient no longer has COVID-19. How should this be coded? (7/23/2020)*

Answer: Assign code M35.8, Other specified systemic involvement of connective tissue, as the principal diagnosis, for the MIS-C, and code B94.8, Sequelae of other specified infectious and parasitic diseases, as a secondary diagnosis for the sequelae of a COVID-19 infection.

If the documentation is not clear regarding whether the physician considers a condition to be an acute manifestation of a current COVID-19 infection vs. a residual effect from a previous COVID-19 infection, query the provider. As stated in the Official Guidelines for Coding and Reporting, the provider's documentation that the individual has COVID-19 is sufficient for coding purposes.

38. *Question: How should an encounter for screening for COVID-19 be coded, such as a patient being tested for COVID-19 as part of preoperative testing? Should code Z11.59, Encounter for screening for other viral diseases be assigned? (8/5/2020)*

Answer: During the COVID-19 pandemic, a screening code is generally not appropriate. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (code Z20.828).

For an encounter for COVID-19 testing being performed as part of preoperative testing, assign code Z01.812, Encounter for preprocedural laboratory examination, as the first-listed diagnosis and assign code Z20.828 as an additional diagnosis.

 Note: This advice is consistent with the updated *ICD-10-CM Official Guidelines for Coding and Reporting* that become effective October 1, 2020. During these unprecedented times, AHA and AHIMA concluded it was necessary to clarify the appropriate codes for COVID-19 testing in advance of the effective date for the revised official coding guidelines.

39. *Question: What ICD-10-CM code should be assigned for an encounter for COVID-19 testing? (8/5/2020)*

Answer: For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

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

If COVID-19 is confirmed, assign code U07.1 instead of code Z20.828.

Note: This advice is consistent with the updated *ICD-10-CM Official Guidelines for Coding and Reporting* that become effective October 1, 2020. During these unprecedented times, AHA and AHIMA concluded it was necessary to clarify the appropriate codes for COVID-19 testing in advance of the effective date for the revised official coding guidelines.

ICD-10-PCS Questions

1. *Question: Will new ICD-10-PCS procedure codes be created to identify the use of specific drugs and other therapeutic substances for treatment of COVID-19 in the hospital inpatient setting? (7/30/2020)*

    Answer: In response to the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) implemented 12 new ICD-10-PCS procedure codes to describe the introduction or infusion of therapeutics for the treatment of COVID-19, effective with discharges on or after August 1, 2020.

    The Code Tables, Index and related Addenda files for the 12 new procedure codes are available at: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS.

2. *Question: What ICD-10-PCS procedure codes should be assigned to identify the administration of specific drugs, such as remdesivir, to treat COVID-19 in the hospital inpatient setting? (7/30/2020)*

    Answer: Effective with discharges on or after August 1, 2020, new ICD-10-PCS codes have been implemented for the administration of three different drugs when used to treat COVID-19:

    XW033E5, Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5

    XW043E5, Introduction of Remdesivir Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 5

    XW033G5, Introduction of Sarilumab into Peripheral Vein, Percutaneous Approach, New Technology Group 5

    XW043G5, Introduction of Sarilumab into Central Vein, Percutaneous Approach, New Technology Group 5

XW033H5, Introduction of Tocilizumab into Peripheral Vein, Percutaneous Approach, New Technology Group 5

XW043H5, Introduction of Tocilizumab into Central Vein, Percutaneous Approach, New Technology Group 5

These codes should only be assigned when these drugs are administered to treat COVID-19.

3. *Question: What ICD-10-PCS procedure code should be assigned to identify the use of convalescent plasma to treat COVID-19 in the hospital inpatient setting? (7/30/2020)*

Answer: Effective with discharges on or after August 1, 2020, assign ICD-10-PCS code XW13325, Transfusion of Convalescent Plasma (Nonautologous) into Peripheral Vein, Percutaneous Approach, New Technology Group 5, or code XW14325, Transfusion of Convalescent Plasma (Nonautologous) into Central Vein, Percutaneous Approach, New Technology Group 5.

4. *Question: What ICD-10-PCS procedure code should be assigned for a new drug or other therapeutic substance administered in the hospital inpatient setting to treat COVID-19 when there is no unique code for the administration of the specific substance? (7/30/2020; revised 8/5/2020)*

Answer: Effective with discharges on or after August 1, 2020, the following ICD-10-PCS codes should be used for administration of a new therapeutic substance to treat COVID-19 when the substance is not classified elsewhere in ICD-10-PCS:

XW013F5, Introduction of Other New Technology Therapeutic Substance into Subcutaneous Tissue, Percutaneous Approach, New Technology Group 5

XW033F5, Introduction of Other New Technology Therapeutic Substance into Peripheral Vein, Percutaneous Approach, New Technology Group 5

XW043F5, Introduction of Other New Technology Therapeutic Substance into Central Vein, Percutaneous Approach, New Technology Group 5

XW0DXF5, Introduction of Other New Technology Therapeutic Substance into Mouth and Pharynx, External Approach, New Technology Group 5

These codes should only be assigned for therapeutic substances being used to treat COVID-19. For administration of "other therapeutic substances" that are being used

to treat medical conditions other than COVID-19, see ICD-10-PCS table 3E0. For example, code 3E033GC describes "Introduction of Other Therapeutic Substance into Peripheral Vein, Percutaneous Approach."

5. *Question: Do the new ICD-10-PCS procedure codes for COVID-19 treatment that became effective August 1, 2020 impact MS-DRG assignment? (7/30/2020)*

Answer: No, the 12 new ICD-10-PCS codes describing the use of therapeutic substances to treat COVID-19 do not impact MS-DRG assignment. However, hospitals are encouraged to report these codes when applicable, as they will be useful in evaluating the effectiveness of different therapeutic substances used to treat COVID-19 and for tracking patient outcomes.

6. *Question: If an ICD-10-PCS code or value already exists for introduction or infusion of a therapeutic substance (e.g., stem cell transfusion), should that code be used when the substance is being administered to treat COVID-19 or one of the new codes for "introduction of other new technology therapeutic substance" that became effective on August 1, 2020? (8/5/2020)*

Answer: When a more specific ICD-10-PCS code exists, such as stem cell transfusion, assign that code rather than one of the less specific new technology codes. The new codes for "introduction of other new technology therapeutic substance" are only intended for new substances that are not classified elsewhere in ICD-10-PCS.

7. *Question: If remdesivir, sarilumab, or tocilizumab is administered for treatment of a clinical condition other than COVID-19, should one of the new ICD-10-PCS codes in table XW0 be assigned? (8/5/2020)*

Answer: No, these new codes are only intended for use when these drugs are being administered to treat COVID-19.

8. *Question: Should the administration of remdesivir, sarilumab, or tocilizumab be coded each time it is administered during a hospitalization or just coded once? (9/1/2020)*

Answer: Only assign the drug administration code once.

9. *Question: What ICD-10-PCS code should be assigned for the administration of Dexamethasone (either orally or intravenously) when it is being used to treat COVID-19? (9/1/2020)*

> Answer: If your facility wishes to capture this information, you may assign the appropriate code from table 3E0 for introduction of an anti-inflammatory drug. Do not assign a code from table XW0 for Introduction of Other New Technology Therapeutic Substance.