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COVID-19's continued impact on CDI and coding across care settings

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3M quality webinar
Q&A responses

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If the documentation clearly states pulmonary embolism is secondary to COVID-19 and the patient completed Eliquis 6 months ago, but the current inpatient encounter includes "acute pulmonary embolism," should the physician be queried to clarify if the pulmonary embolism is a current condition or a history of condition?
Without all of the clinical information specific to this case it is hard to determine. Know that PTS may be predisposed to developing any clots due to inherent conditions such as Factor V Leiden, but COVID-19 also causes hypercoagulability (evidenced by elevated D-dimer) so it would be appropriate to determine if COVID-19 is a co-contributor. In the absence of risk due to inherent conditions, it is very appropriate. Remember that radiologically, the chronicity can be assessed.

On first example are you stating that sepsis if due to COVID would not be the PDX?
No. If sepsis is due to COVID-19, then per COVID-19 chapter guidelines, sepsis would be sequenced as PDX. In the example, the PDX would be determined by the provider response.

What are the incubation times for Della and Omicron?
Our understanding that Delta was six days and Omicron three, but recommend you research official sources.

Can we note that if the Physician doesn't specifically state that the patient acquired the infection in the Hospital, that they did not?
No. When test was not performed on admission and patient has no symptoms on admission, we cannot make assumptions. As the POA guidelines note, provider must determine POA.

If a patient tested positive while in SFN but two days later test two days later Rapid real time (PCR) is negative, do you still code the U07 code?
This would need to be clarified with the provider to confirm if the patient has an active COVID-19 infection or if the COVID-19 infection was ruled out.

What if the person is already has a history… do we need to code the exposure when test was done?
When we perform a test on this encounter, we should report the exposure. If the patient also has a history of COVID-19, it is appropriate to assign code Z86.16. Codes Z20.822 and Z86.16 may be assigned together in the same encounter.

Have you heard of any discussion regarding codes for reactions specifically from the COVID vaccine? Thank you.
We refer you to the AHA FAQs and Coding Clinic 2021 first quarter on code assignment for reaction to vaccines.

CS modifier assigned to Medicare Mananged care or just straight Medicare?
I have seen some managed care payors accept the CS modifier (Anthem). Best to check with your payors.

What do you do for nursing that go into patient homes? This is a thing that we are starting to see as well. Can we charge for this?
Not clear what services the nurses are providing in the patient's homes. There is a fact sheet for administering COVID vaccines in the patient's home.
(https://www.cms.gov/files/document/vaccine-home.pdf)

Do you have the reference or web link for the exclusion for the U07.1 from qualities?
It is in the CMS final rule FY 2022 on the final rule homepage

Would it be best practice if patient presents with a HX of COVID to query whether the patients symptoms could be related to COVID?
It is dependent on the individual presentation and symptoms. If there are common conditions known to be caused by active infection and/or sequelae, it may be appropriate to query relationship.

For the new COVID codes affective April 1, do we pull the COVID injection documentation from the MD documentation or from other clinical note? (i.e. nurses notes regarding COVID vaccine status.)
Because there is not a specific guideline stating that the vaccination status could be reported by others (the SDOH codes and BMI have specific guidelines that state the diagnosis doesn't have to be documented by the provider) we should follow the general guideline that a diagnosis must be documented by a qualified healthcare provider.

Asymptomatic positive COVID patient presents to Ambulatory Surgery 6 days later, after test. Physician documents risks of patient having surgery with the COVID complications, documented in linked H&P. Do you assign U07.1 for this patient?
I believe it would be best to query for clarification in this instance. The patient was asymptomatic and the CDC guidelines on asymptomatic positive patients have changed over time. The provider needs to clarify if this is an active COVID infection or a history of or to clarify what the COVID complications are.

COVID-19 excluded from HAC reduction programs what about PSIS?
No. AHRQ cannot exclude COVID-19 from PSI methodology as the base comparative years did not have COVID-19 patients in them (currently base performance years are 2017-201×8)

Could you put a POA of U?
U is only to be used when there is no information and should be used in extreme rare circumstances. Best practice is to query and assign, Y, N or W (clinically unable to determine) based on provider response.

Aren't we going to code the symptom if provider's are unsure of diagnoses?
There is a guideline within the COVID coding guidelines which states to assign the signs and symptoms associated with COVID-19 when a definitive diagnosis has not been established. However, there has been subsequent advice published in Coding Clinic (2021 4Q, pp. 101-111), which states, "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."

What would the code be if provider documented positive COVID infection in discharge summary? There is positive COVID-19 test result.
Current coding guidelines for COVID state that it is appropriate to assign a code for COVID (U07.1) based on the positive test alone. Therefore, it would be appropriate to assign code U07.1 when there is a positive COVID test result as a part of the current medical record encounter even if the provider is documenting possible COVID-19. However, if there is concern in the final diagnosis, it is appropriate to query for confirmation.

Patient admitted for stroke . COVID test positive (POA) but no need to treatment. What is the PDX?
If CVA is not due to COVID-19 and the circumstances of admission as documented by the provider is CVA, then CVA is PDX. If however, provider notes the CVA is due to an active COVID-19 infection, COVID-19 is PDX. If CVA is a sequelae of previous infection, CVA is PDX with post-COVID condition assigned as SDX.

Question related to COVID/PE. Physician documents patient reports one out of two genetic mutations for Factor V. COVID pneumonia with hospitalization 12/21-1/22. Strong family history of PE/DVT. Placed on heparin drip. Is this where we are to query PE related to recent history of COVID-19? Would you query Acute PE due to recent history of COVID-19 verses Acute PE due to genetic predisposition ? If the physician responds as acute PE related to history of recent COVID -19, What is the PDX?
Would need to discuss with provider intended meaning of "history of recent COVID-19." If the PE is a sequelae of a previous recent infection, the PE is PDX with a post-COVID condition code (U09.9) reported as SDX. If COVID-19 is a co-contributor with an active COVID-19 infection, U07.1 would be reported as the PDX.

Was the CS modifier just for Medicare B only? I just caught the end of the slide.
I have seen some commercial payors that do accept the CS modifier, but the FFCRA lets the states determine if they will cover these costs for the uninsured. Best to check with your state Medicaid dept and with each commercial payor.

In an asymptomatic COVID positive case what does being active mean? How long does it last?
It is extremely variable. A basic rule of thumb is the CDC guideline requirement for quarantine.

W is a choice for POA... wouldn't we just use that when provider is unable to determine whether condition was POA or not?
You must use W when the provider cannot determine POA and it is appropriate to use in this type of situation based on the provider response.