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By Nina Youngstrom

With the pandemic in its second year, coding and documentation of long-haul COVID-19 patients who are admitted or readmitted to the hospital may be a sleeper risk. They pose coding challenges because long-haul COVID-19 patients don't have active infections and documentation may be murky, an expert said. At the same time, hospitals have seen denials for other COVID-19 claims, including patient status and sequencing.

Admissions for long-haul COVID-19 usually aren't coded with a principal diagnosis of COVID-19 (U07.1), said Garnette McLaughlin, senior consultant and compliance officer at Intersect Healthcare + AppealMasters in Towson, Maryland. "If people aren't actively infected with COVID, you don't assign the COVID code. You would assign a sequela code," which captures the residual effects of an acute illness or injury. The problem is "the documentation gets real muddy in terms of the current acute infection due to COVID or a sequela," said McLaughlin, who is also a contract coder and has seen a lack of clarity in documentation for long-haulers. For example, if patients need a lung transplant because of severe lung damage caused by COVID-19, the coder wouldn't code active lung infection. "You code fibrosis of the lung. It can't absorb oxygen anymore because of COVID," McLaughlin said. "You don't code active COVID. You code a sequela of COVID. The COVID itself is gone, but you are dealing with the leftovers."

Here's how the coding plays out (in the correct order): (1) the diagnosis code for the fibrosis (or whatever the leftovers are) and (2) B94.8 (sequelae of other specified infectious and parasitic diseases).[1]

Hospitals should brace for other coding challenges and claim denials. Denise Wilson, senior vice president of Intersect Healthcare + AppealMasters, heard from a coder who said an auditor removed COVID-19 as a secondary diagnosis from a claim even though the patient had a positive COVID-19 test during admission. The auditor said the physician documented that the test must be a false positive because the patient wasn't infected on admission, and therefore the positive test was an artifact of a previous COVID-19 infection. Wilson told the coder to appeal the denial because COVID-19 can be coded based on a positive test, and conversely, COVID-19 can be coded when the test is negative if the physician documents the diagnosis. "We are making this too difficult," Wilson said. "The CDC wants to capture more information in their surveillance data, and that's why I think they want you to code every positive test as COVID."

She has also been asked whether to code U07.1 when patients come to the hospital for pre-op testing. The answer is no. "There have been a ton of denials" because of this misapprehension, Wilson said. According to 40 answers to questions from the American Health Information Management Association (AHIMA) and the American Hospital Association (AHA),[2] which were updated on March 24, 2021, "For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (code Z20.828 for encounters prior to January 1, 2021 or code Z20.822, Contact with and (suspected) exposure to COVID-19, for encounters after January 1, 2021."

Some Level of Care Denials Are Coming In

McLaughlin has started to see commercial payer denials for COVID-19 inpatient admissions in terms of patient status and the level of care. One payer denied a claim for a vented patient on the grounds that the patient didn't

need to be in the intensive care unit. "It has to be on my top 10 list of most ridiculous denials I have seen," she said. "Are we looking at the same patient?" The payers don't explain why they think an inpatient admission wasn't medically necessary in the initial denial. If they don't elaborate, hospitals "waste a level of appeal" arguing why it was appropriate in a vacuum, she said. In the next round of appeals, payers might point to something clinical and provide more details about their rationale, but "they're trying to get you to go away."

Some coding denials are coming in for sequencing of COVID-19 complications, McLaughlin said. The denials stem from hospital documentation that doesn't adequately link COVID-19 to the consequences of the complication or auditors misunderstanding or being unaware of the coding rules for COVID-19. Hospitals are now advised to code COVID-19 as the principal diagnosis when patients are admitted with conditions associated with COVID-19, with some exceptions (sepsis, obstetrics and transplant complications). When other conditions are the chief condition occasioning the admission to the hospital, which is the definition of a principal diagnosis, and the other condition is related to COVID-19, coders are advised to put COVID-19 in the top spot and report COVID-19-associated conditions as secondary diagnoses, according to AHIMA and AHA.

The sequencing rules, which are a departure from the norm, have become clear in AHIMA/AHA answers to multiple questions. For example, in response to a question about how to code for continued treatment of acute hypoxic respiratory failure due to COVID-19 when a patient is transferred from a short-term acute-care hospital to a long-term acute-care hospital, AHIMA and AHA advised coders to "assign code U07.1, COVID-19, as the principal diagnosis, and code [J96.01, acute] respiratory failure with hypoxia, as a secondary diagnosis."

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1 American Health Information Management Association and the American Hospital Association, "Frequently Asked Questions Regarding ICD-10-CM/PCS Coding for COVID-19," revised March 24, 2021, https://bit.ly/3vmzdB8.
2 American Health Information Management Association and the American Hospital Association, "AHIMA and AHA FAQ: ICD-10-CM/PCS Coding for COVID-19," *Journal of AHIMA*, updated March 24, 2021, https://bit.ly/2x4J6eh.