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New ICD-10 Coding Guidance on COVID-19 Creates a Conflict; Some Hospitals Hold Claims

By Nina Youngstrom

Mixed messages about diagnosis coding in CMS's official coding guidelines have gummed up some of the hospital billing for the treatment of patients with COVID-19.

Different sections of the ICD-10 *Official Guidelines for Coding and Reporting*[1] have contradicting instructions on coding COVID-19, said Leslie Slater, specialist leader at Deloitte Advisory in New York City. As a result, some hospitals are holding claims until they get more clarity. "They're concerned because there isn't clear guidance on how to interpret these guidelines," she said.

Here's the conflict: Section B4 of the coding guidelines has long said that "abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added." On April 1, CMS added to the coding guidelines for COVID-19, which incorporate the brand-new diagnosis code (U07.1). The guidelines direct coders to "code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19" (see Chapter 1, Sec. g).[2]