Clinical coding guidelines: COVID-19

ICD-10-AM/ ACHI/ ACS Eleventh Edition
WA Clinical Coding Authority
Purchasing and System Performance Division
June 2020
Introduction

This document contains guidelines for code assignment once an admission has been deemed appropriate and the care type has been determined. Appropriateness of admission and determination of care type should be made following instructions in the Admission Policy (MP 0058/17).

These guidelines are a supplement to IHPA’s How to classify COVID-19, Supplementary guidance for classifying admitted care (effective 1 January 2020) and will be updated as necessary to address the evolving nature of the COVID-19 pandemic. Changes will be listed in the Version History.

Polymerase chain reaction (PCR) virology swab tests are currently the primary diagnostic tool for COVID-19, and are considered more clinically sensitive than serology antibody tests.¹

Abstraction and clinical coding process

Does the episode involve a suspected COVID-19 presentation?

- Yes
  - e.g. clinical manifestations or symptoms; or exposure.

- No
  - Only results from laboratory tests performed in the current episode are required for coding purposes.
  - COVID-19 is not suspected i.e. routine testing performed prior to patient transfer or elective surgery. Code in accordance with Table 4 of this document.

  - Results from laboratory tests performed during the episode, or recently prior to admission, must be obtained for coding purposes.
  - COVID-19 is suspected. Code in accordance with IHPA’s How to classify COVID-19, Supplementary guidance for classifying admitted care; and Tables 1, 2, 3 & 5 of this document.

### Table 1: Laboratory confirmed cases (tested positive)

**U07.1 Emergency use of U07.1 [COVID-19, virus identified]**

<table>
<thead>
<tr>
<th>Virology swab test HAS been performed</th>
<th>Virology swab test HAS NOT been performed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test result</strong></td>
<td><strong>Details</strong></td>
</tr>
<tr>
<td>Positive</td>
<td>• Positive virology swab result. <a href="#">Example 2</a> <a href="#">Example 5</a> <a href="#">Example 6</a></td>
</tr>
<tr>
<td>Negative</td>
<td>• Negative virology swab result but clinician diagnoses COVID-19 based on positive antibody serology test. <a href="#">Example 12</a></td>
</tr>
</tbody>
</table>

### Table 2: Clinically diagnosed or probable cases (testing is inconclusive, unavailable or not specified)

**U07.2 Emergency use of U07.2 [COVID-19, virus not identified]**

<table>
<thead>
<tr>
<th>Virology swab test HAS been performed</th>
<th>Virology swab test HAS NOT been performed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test result</strong></td>
<td><strong>Details</strong></td>
</tr>
<tr>
<td>Inconclusive or false negative</td>
<td>• Clinically diagnosed/probable COVID-19, which has taken into account the virology swab result. <a href="#">Example 13</a></td>
</tr>
</tbody>
</table>
### Table 3: Ruled out cases (tested negative)

**U06.0 Emergency use of U06.0 [COVID-19, ruled out]**

<table>
<thead>
<tr>
<th>Virology swab test HAS been performed</th>
<th>Virology swab test HAS NOT been performed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test result</strong></td>
<td><strong>Details</strong></td>
</tr>
</tbody>
</table>
| Negative | • COVID-19 suspected (e.g. symptoms and/or exposure) but subsequently ruled out with negative virology swab result (including when COVID-19 is a differential diagnosis or needs to be ruled out for other reasons). [Example 1](#) [Example 3](#) [Example 4](#) | n/a | n/a | • U06.0 can only be assigned if a virology swab test has been performed.  
• Do not assign U06.0 where COVID-19 is clinically ruled out alone. |

### Table 4: Routine testing (patient without clinical manifestation/symptom/exposure)

<table>
<thead>
<tr>
<th>Test result</th>
<th>Details</th>
<th>Code assignment</th>
<th>Coding tips</th>
</tr>
</thead>
</table>
| Negative | • Routine testing or screening with negative virology swab result . [Example 10](#) [Example 11](#) | Code first: Condition which occasioned the episode.  
Code also:  
Z29.0 Isolation (if applicable)  
U06.0 Emergency use of U06.0 [COVID-19, ruled out] | • Do not assign additional diagnosis Z11.5 *Special screening examination for other viral diseases* for routine screening during an episode, as per IHPA’s COVID-19 Frequently asked questions – admitted care (Part 1) and subsequent IHPA clarification.  
• U06.0 assigned alone will trigger a HMDS edit. Coder will need to explain that screening was performed and there are no symptoms or exposure. |

### Table 5: Pregnant patients

<table>
<thead>
<tr>
<th>Coding tips</th>
<th>Neonates</th>
</tr>
</thead>
</table>
| • If two or more criteria in ACS 1521 are met (i.e. ‘O’ code(s) from Chapter 15 are to be assigned) assign O98.5 *Other viral diseases complicating pregnancy, childbirth and the puerperium* and sequence it immediately prior to B97.2 or B34.2.  
A HMDS edit will be triggered if U07.1 is assigned without O98.5, when other “O” code(s) are present.  
When criteria in ACS 1521 are not met (i.e. ‘O’ code(s) from Chapter 15 are not assigned), assign Z33 *Pregnancy state, incidental* as additional diagnosis; O98.5 is not assigned.  
See also IHPA’s COVID-19 Frequently asked questions – admitted care (Part 2): COVID-19 complicating pregnancy. | • Where suspected COVID-19 is documented with symptoms, but is ruled out, assign Z03.71 *Observation of newborn for suspected infectious condition, for newborns (infants less than 28 days old)* in lieu of Z03.8. |
**Coding tips**

**Suspected**

- ACS 0012 *Suspected conditions* categorises “probable” and “suspected” as synonymous terms. However, for the purposes of COVID-19 classification, these terms are NOT synonymous.
- “*Suspected*” COVID-19 is any individual who undergoes laboratory testing due to:
  - Clinical manifestation(s), with or without exposure.
  - Symptom(s), with or without exposure.
  - Asymptomatic with exposure.
The suspicion will either be ruled out (negative result U06.0) or proven (positive result U07.1).
- “*Probable*” COVID-19 is where the suspicion is deemed likely/probable, based on clinical diagnosis, and:
  - no test has been performed.
  - a test has been performed with equivocal/inconclusive result (i.e. test result taken into account as part of clinical determination/diagnosis).
  - a test has been performed and the result is considered to be a false negative (i.e. test result taken into account as part of clinical determination/diagnosis).

**B97.2 Coronavirus as the cause of diseases classified to other chapters**

- Assigned for **symptomatic** COVID-19 patients.
- Sequenced following the condition(s) or symptom(s) code(s).
- B97.2 is not acceptable as a principal diagnosis.
- B97.2 and B34.2 are mutually exclusive and should not be assigned together.
- B97.2 should not be assigned with U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*.
- B97.2 should not be assigned with Z03.8 *Observation for other suspected diseases and conditions*.

**B34.2 Coronavirus infection, unspecified site**

- Assigned for **asymptomatic** COVID-19 patients.
- B34.2 may be assigned as a principal diagnosis.
- B97.2 and B34.2 are mutually exclusive and should not be assigned together.
- B34.2 should not be assigned with U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*.
- B34.2 should not be assigned with Z03.8 *Observation for other suspected diseases and conditions*.
Z20.8 Contact with and exposure to other communicable diseases

- Exposure must be determined and documented by a clinician, as opposed to patient reported exposure alone.
- **Do not** assign Z20.8 Contact with and exposure to other communicable diseases where:
  - COVID-19 is confirmed and either U07.1 Emergency use of U07.1 [COVID-19, virus identified] or U07.2 Emergency use of U07.2 [COVID-19, virus not identified] is assigned. Exposure is inherent.
  - patient alone reports exposure.
  - there is only documentation of recent overseas travel, or contact with individuals that have recently travelled overseas.

Screening

- As at 18 June 2020, **symptomatic** individuals meet laboratory testing criteria in WA.
- There is special allowance for screening of **asymptomatic** individuals undergoing specific aerodigestive procedures.\(^2\)
- IHPA’s COVID-19 Frequently asked questions – admitted care (Part 1) states Z11.5 Special screening examination for other viral diseases should only be assigned when screening is the only reason for admission. This circumstance would not meet the criteria for admission in WA.
- A query has been answered by IHPA clarifying that Z11.5 should not be assigned as additional diagnosis in elective surgery episodes where screening has been performed prior to conducting surgery. In these cases, where surgery goes ahead due to a negative result, U06.0 Emergency use of U06.0 (COVID-19, ruled out] is assigned alone. Note: where elective surgery does not go ahead due to positive result, refer to Admission Policy (MP 0058/17) to determine reporting requirement for cancelled procedures.

Isolation

- **Coders should** ascertain the protocols at their specific hospital regarding isolation of patients in order to permit the accurate assignment of Z29.0 Isolation.
- Z29.0 Isolation is appropriate for documentation such as “isolation” or placement of patient on “COVID ward”.
- Documented “PPE” (personal protective equipment) or “droplet precautions” alone does not justify assignment of Z29.0 Isolation.

Abstraction

- A test result in isolation should not be used to assign U06.0 Emergency use of U06.0 [COVID-19, ruled out]. The significance of the test result should be verified in the documentation. IHPA **Query 1**.

- Where a negative result is reported after discharge and a clinical diagnosis of COVID-19 is made and documented without taking into account the test result, a query should be generated to clarify whether the episode should be coded as a false negative. **Table 2**.

Exceptions to regular coding practice

- An exception has been made to ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions.*

Usually, codes for symptoms and signs are not assigned as principal diagnosis when a related definitive diagnosis has been established. However, for positive cases with principal diagnosis “COVID-19” or similar (without clinical manifestation such as pneumonia or LRTI) the symptoms are coded, even though inherent in the definitive diagnosis “COVID-19”. This is because COVID-19 classification is based on the patient’s presentation: clinical manifestation(s), symptomatic or asymptomatic.

### Regular coding practice

| Patient presents with cough and fever. Diagnosed with lower respiratory tract infection. | Patient presents with cough and fever. Diagnosed with COVID-19 with positive virology swab result. |
| Principal diagnosis: LRTI | Principal diagnosis: COVID-19 |

| J22 Unspecified acute lower respiratory tract infection | R05 Cough  
|---|---|
| As per ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions* the symptoms are not coded as they are inherent in the diagnosis LRTI. | R50.9 Fever, unspecified  
| B97.2 Coronavirus as the cause of diseases classified to other chapters  
| U07.1 Emergency use of U07.1 [COVID-19, virus identified] |

- An exception has been made to ACS 0012 *Suspected conditions* whereby Z03.8 *Observation for other suspected diseases and conditions* can be assigned in addition to codes for symptom(s) or condition(s) where COVID-19 was suspected but subsequently excluded on laboratory testing (and in whom a clinical diagnosis has not been made).

- Please note that in IHPA’s *COVID-19 Frequently asked questions – admitted care (Part 1) Transfer for suspected COVID-19*, Z03.8 is not assigned for Hospital B in Examples 1 and 2, however these have been flagged with IHPA as possible errors.
<table>
<thead>
<tr>
<th>Regular coding practice</th>
<th>COVID-19 exception to regular coding practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation following suspected ingestion of pills, patient is asymptomatic.</td>
<td>Respiratory symptoms with COVID-19 excluded on virology swab. After study, patient diagnosed with staphylococcal pneumonia.</td>
</tr>
<tr>
<td>Z03.6 Observation for suspected toxic effect from ingested substance</td>
<td>J15.2 Pneumonia due to staphylococcus</td>
</tr>
<tr>
<td>As per ACS 0012 Suspected conditions, codes from Z03 are only assigned where there are no symptoms related to the suspected condition.</td>
<td>Z03.8 Observation for other suspected diseases and conditions</td>
</tr>
<tr>
<td></td>
<td>U06.0 Emergency use of U06.0 [COVID-19, ruled out]</td>
</tr>
<tr>
<td></td>
<td>As per IHPA's How to classify COVID-19 instructions, Z03.8 is assigned even in a symptomatic presentation.</td>
</tr>
</tbody>
</table>

- O98.5 is usually only assigned in conjunction with code range B25-B34. An exception has been made to allow O98.5 to be assigned with B97.2 *Coronavirus as the cause of diseases classified to other chapters*.

**Coding Examples**

**Example 1: Symptomatic presentation with diagnosis, COVID-19 negative**


Principal diagnosis: Viral asthma

J45.9 Asthma, unspecified

B97.8 Other viral agents as the cause of diseases classified to other chapters

Z20.8 Contact with and exposure to other communicable diseases

Z03.8 Observation for other suspected diseases and conditions

U06.0 Emergency use of U06.0 [COVID-19, ruled out]

As there is a diagnosis (viral asthma) established after study to be chiefly responsible for the presenting symptoms, do not assign codes for the symptoms. Z03.8 and U06.0 are assigned as COVID-19 was suspected and ruled out. Z20.8 *Contact with and exposure to other communicable diseases* is assigned because exposure has been determined and documented by a clinician.
**Example 2: Symptomatic presentation with diagnosis, COVID-19 positive**

Patient admitted with cough, fever and sore throat. Close contact of confirmed COVID-19 case. Virology swab test returned positive result.

Principal diagnosis: COVID-19 + Upper Respiratory Tract Infection (URTI)

- **J06.9 Acute upper respiratory infection, unspecified**
- **B97.2 Coronavirus as the cause of diseases classified to other chapters**
- **U07.1 Emergency use of U07.1 [COVID-19, virus identified]**

As there is a clinical manifestation (URTI) related to COVID-19, URTI is coded and the symptoms are not. A code for exposure is not assigned as it is inherent in U07.1.

**Example 3: Symptomatic presentation with diagnosis, COVID-19 negative**

Patient presents with pneumonia. Nil overseas travel nor contacts with COVID-19 cases. Catches public transport to work. COVID-19 swabs sent and a negative result is returned.

Principal diagnosis: Pneumonia

- **J18.9 Pneumonia unspecified**
- **Z03.8 Observation for other suspected diseases and conditions**
- **U06.0 Emergency use of U06.0 [COVID-19, ruled out]**

As there is a diagnosis (pneumonia), do not assign codes for the symptoms. Z03.8 and U06.0 are assigned as COVID-19 was suspected and ruled out. The clinical documentation does not meet the requirements to assign a code for exposure.
Example 4: Symptomatic presentation, without diagnosis, COVID-19 negative

Returned overseas traveller admitted with cough, fever and myalgia. Virology testing returns a negative result.

Principal diagnosis: COVID-19 negative

R05 Cough
R50.9 Fever, unspecified
M79.19 Myalgia, site unspecified
Z03.8 Observation for other suspected diseases and conditions
U06.0 Emergency use of U06.0 [COVID-19, ruled out]

As no clinical manifestation related to COVID-19 has been diagnosed, the symptoms are coded. Z03.8 and U06.0 are assigned as COVID-19 was suspected and ruled out. Documentation of overseas travel does not meet the requirements to assign a code for exposure.

Example 5: COVID-19 complicating pregnancy

Symptomatic presentation, with diagnosis, COVID-19 positive

Pregnant patient presents with fever, dyspnoea and myalgia. Patient reports currently at day 10 of 14 isolation after returning from overseas. Seen by Obstetrician. CTG and virology swab test for COVID-19 performed. Patient develops acute respiratory distress syndrome. Virology testing returns a positive result and the patient is placed in isolation.

Principal diagnosis: Acute Respiratory Distress Syndrome due to COVID-19

O99.5 Diseases of the respiratory system in pregnancy, childbirth and the puerperium
J80.0 Acute respiratory distress syndrome
O98.5 Other viral diseases in pregnancy, childbirth and the puerperium
B97.2 Coronavirus as the cause of diseases classified to other chapters
U07.1 Emergency use of U07.1 [COVID-19, virus identified]
Z29.0 Isolation

COVID-19 is complicating pregnancy because criteria 2 and 3 in ACS 1521 Conditions and injuries in pregnancy are met. As there is a clinical manifestation (ARDS) related to COVID-19, ARDS is coded and the symptoms are not. Documentation of overseas travel does not meet the requirements to assign a code for exposure.
Example 6: COVID-19 not complicating pregnancy

Symptomatic presentation, with diagnosis, COVID-19 positive

Pregnant patient presents with upper respiratory tract infection (URTI). Patient reports partner and self are in self isolation following contact with a confirmed case of COVID-19. Virology swab test ordered; patient placed in isolation. Symptoms remain mild and patient is discharged home to continue isolation. Virology swab test returns positive result and the patient is informed to return if symptoms worsen.

Principal diagnosis: Coronavirus URTI

J06.9 Acute upper respiratory infection, unspecified
B97.2 Coronavirus as the cause of diseases classified to other chapters
U07.1 Emergency use of U07.1 [COVID-19, virus identified]
Z29.0 Isolation
Z33 Pregnant state, incidental

COVID-19 is not complicating pregnancy as it does not meet criteria in ACS 1521 Conditions and injuries in pregnancy, therefore Z33 is assigned and O98.5 is not required with B97.2. As there is a clinical manifestation (URTI) related to COVID-19, URTI is coded and the symptoms are not. Exposure is inherent in U07.1 therefore Z20.8 Contact with and exposure to other communicable diseases is not assigned.

Example 7: Transfer to another hospital, tested and awaiting result, COVID-19 positive

Patient presents to remote hospital (Hospital A) with shortness of breath and cough. Close contact of confirmed COVID-19 case. COVID-19 virology swab test performed. Patient deteriorates rapidly and is transferred to Hospital B (with an intensive care facility). The virology test returns a positive result and is reported after the patient is discharged from Hospital A.

Hospital A principal diagnosis: ?COVID-19
Hospital B principal diagnosis: COVID-19

<table>
<thead>
<tr>
<th>Hospital A</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>R06.0 Dyspnoea</td>
<td>R06.0 Dyspnoea</td>
</tr>
<tr>
<td>R05 Cough</td>
<td>R05 Cough</td>
</tr>
<tr>
<td>B97.2 Coronavirus as the cause of diseases classified to other chapters</td>
<td>B97.2 Coronavirus as the cause of diseases classified to other chapters</td>
</tr>
<tr>
<td>U07.1 Emergency use of U07.1 [COVID-19, virus identified]</td>
<td>U07.1 Emergency use of U07.1 [COVID-19, virus identified]</td>
</tr>
<tr>
<td></td>
<td>U07.1 is assigned in Hospital B, even though the test was performed prior to the episode.</td>
</tr>
</tbody>
</table>
Example 8: Transfer to another hospital, untested, COVID-19 positive

Patient presents to remote hospital (Hospital A) with shortness of breath and cough. Close contact of confirmed COVID-19 case. Patient deteriorates rapidly and is transferred to Hospital B (with an intensive care facility). Hospital B performs a virology swab test and it returns a positive result.

Hospital A principal diagnosis: ?COVID-19
Hospital B principal diagnosis: COVID-19

<table>
<thead>
<tr>
<th>Hospital A</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>R06.0 Dyspnoea</td>
<td>R06.0 Dyspnoea</td>
</tr>
<tr>
<td>R05 Cough</td>
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</tr>
<tr>
<td>B97.2 Coronavirus as the cause of diseases classified to other chapters</td>
<td>B97.2 Coronavirus as the cause of diseases classified to other chapters</td>
</tr>
<tr>
<td>Z20.8 Contact with and exposure to other communicable diseases</td>
<td>Z20.8 Contact with and exposure to other communicable diseases</td>
</tr>
<tr>
<td>Z75.6 Transfer for suspected condition</td>
<td></td>
</tr>
</tbody>
</table>

As the virology test was not performed in this episode, a U code is not assigned. This episode is coded in accordance with ACS 0012 Suspected conditions.

Z20.8 Contact with and exposure to other communicable diseases is not assigned, as history of exposure is inherent in the assignment of U07.1 or U07.2.

Because the patient was symptomatic, the symptoms are coded with B97.2, rather than B34.2 Coronavirus infection, unspecified site.
Example 9: Transfer to another hospital, untested, COVID-19 negative

Patient is admitted to Hospital A with shortness of breath and fever after returning from overseas. COVID-19, influenza, other viral infection. Patient is transferred to Hospital B for laboratory testing to exclude a diagnosis of COVID-19.

Patient is received from Hospital A for investigation of COVID-19, influenza, other viral infection. Laboratory testing is performed to exclude a diagnosis of COVID-19. Test results were negative for SARS-CoV-2. COVID-19 is documented as negative and the patient is diagnosed with influenza.

Hospital A principal diagnosis: COVID-19, influenza, other viral infection

Hospital B principal diagnosis: Influenza

<table>
<thead>
<tr>
<th>Hospital A</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>R06.0 Dyspnoea</td>
<td>J11.1 Influenza with other respiratory manifestations, virus not identified</td>
</tr>
<tr>
<td>R50.9 Fever, unspecified</td>
<td>Z03.8 Observation for other suspected diseases and conditions</td>
</tr>
<tr>
<td>Z03.8 Observation for other suspected diseases and conditions</td>
<td>U06.0 Emergency use of U06.0 [COVID-19, ruled out]</td>
</tr>
<tr>
<td>Z75.6 Transfer for suspected condition</td>
<td>Note: Examples 1 and 2 in IHPA’s COVID-19 Frequently asked questions – admitted care (Part 1) Transfer for suspected COVID-19 do not assign Z03.8 for Hospital B, these have been flagged with IHPA as possible errors.</td>
</tr>
</tbody>
</table>

As the virology test was not performed in this episode, a U code is not assigned. This episode is coded in accordance with ACS 0012 Suspected conditions and IHPA’s COVID-19 FAQ-admitted care (Part 1).

Example 10: Routine testing pre-procedure, COVID-19 negative

Patient admitted for excision of lesion of larynx. Rapid PCR test for COVID-19 performed prior to surgery. Results returned negative result and elective surgery proceeded as planned.

Condition which occasioned the episode
Other condition(s) meeting criteria for coding
U06.0 Emergency use of U06.0 [COVID-19, ruled out]

As patient is asymptomatic and no known exposure is documented U06.0 is assigned alone. Z11.5 is not assigned as patient was not admitted specifically for screening of COVID-19. A HMDS edit will be raised for U06.0 assigned alone. Coder will need to explain that screening was performed and there are no symptoms or exposure.
Example 11: Testing prior to transfer for unrelated condition, COVID-19 negative

Patient admitted to Hospital A with laceration of hand. Patient for transfer to Hospital B for surgery. Rapid PCR test for COVID-19 performed and patient given all clear for transfer due to negative result.

Condition which occasioned the episode
External causes codes
Other condition(s) meeting criteria for code assignment
U06.0 Emergency use of U06.0 [COVID-19, ruled out]

As patient is asymptomatic and no known exposure is documented, U06.0 is assigned alone. Testing is performed for clearance for transfer. A HMDS edit will be raised for U06.0 assigned alone. Coder will need to explain that screening was performed and there are no symptoms or exposure.

Example 12: Symptomatic presentation, without diagnosis, COVID-19 negative virology, positive serology

Patient presents with fever and cough. Recently returned from overseas. Two negative PCR results for COVID-19 this episode, however treated as positive given symptoms and high risk factors. Serology test ordered, result reviewed by infectious diseases consultant who confirmed patient should be treated as COVID-19 positive.

Principal diagnosis: Coronavirus infection

R50.9 Fever, unspecified
R05 Cough
B97.2 Coronavirus as the cause of diseases classified to other chapters
U07.1 Emergency use of U07.1 [COVID-19, virus identified]

As no clinical manifestation related to COVID-19 has been diagnosed, the symptoms are coded. In accordance with IHPA’s COVID-19 FAQs – admitted care (Part 2), documentation of COVID-19 with confirmation from antibody serology test can be used to assign U07.1.
Example 13: Symptomatic presentation, without diagnosis, COVID-19 clinically diagnosed
Patient developed fever and cough in quarantine hotel. Returned from travel 6 days ago. Two negative PCR results for COVID-19 this episode. Treated as positive COVID-19 given symptoms and high risk factors.

Principal diagnosis: COVID-19

R50.9 *Fever, unspecified*
R05 *Cough*
B97.2 *Coronavirus as the cause of diseases classified to other chapters*
U07.2 *Emergency use of U07.2 [COVID-19, virus not identified]*

As no clinical manifestation related to COVID-19 has been diagnosed, the symptoms are coded. The clinician has made a clinical diagnosis, taking into account the negative virology result.

Example 14: Symptomatic presentation, without diagnosis, test result unknown
Patient developed flu-like illness in quarantine hotel. Returned from travel 6 days ago. COVID-19 swab taken earlier today, prior to presenting to hospital. Patient assessed as stable. Nil need for COVID-19 swab this episode as already swabbed today. For discharge back to quarantine hotel.

Principal diagnosis: Probable COVID-19

In this case, the clinician had not received the COVID-19 laboratory test result during the episode or prior to writing the discharge summary (completed on day of discharge). As this is a suspected COVID-19 presentation, the result of the test performed recently prior to admission needs to be obtained for coding purposes. If the result is positive, U07.1 should be assigned. If the result is negative or equivocal, clinician clarification is required to allow the clinician to determine the final diagnosis (U07.2 or U06.0) after taking into account the laboratory test result.
Queries submitted to IHPA pending response

Query 1: Clarification FAQ Part 2 Application of U06.0 Emergency use of U06.0 [COVID-19, ruled out] for admitted patients with a negative test result for SARS-CoV-2 (COVID-19).

Recently published IHPA COVID-19 Frequently Asked Questions Part 2,

U06.0 Emergency use of U06.0 [COVID-19, ruled out] for admitted patients with a negative test result for SARS-CoV-2 (COVID-19) states U06.0 should only be assigned when there is clinical documentation stating that COVID-19 has been ruled out.

In the absence of documented COVID-19 “ruled out”, we consider documentation of a request for a test as adequate for classification purposes in line with ACS 0010 Clinical documentation and general abstraction guidelines/ Test results and medication charts to “not use test result values, descriptions, medication charts, symbols and abbreviations in isolation to inform code assignment. Is this correct?

Clinicians are unlikely to record such documentation in the body of the record and therefore this instruction as it stands is highly restrictive. WA believe that documentation indicating COVID-19 testing has been performed is sufficient for the test result to be used.

Query 2: Definition of “unspecified” at U07.2

In the document COVID-19 Response/ Rules for coding and reporting COVID-19 episodes of care/ 4. Admitted care classification, the following description appears:

U07.2 Emergency use of U07.2 [COVID-19, virus not identified] is to be assigned when COVID-19 has been documented as clinically diagnosed COVID-19, including evidence supported by radiological imaging (ie where a clinical determination of COVID-19 is made but laboratory testing is inconclusive, not available or unspecified).

We understand inconclusive as: inconclusive swab test result, as reported by the laboratory.

We understand not available as: referring to where swab testing is unable to be performed.

Could you please provide clarification on how unspecified is to be interpreted and which circumstances would be representative of this concept for classification purposes?

The WA Clinical Coding Authority have been providing the following instruction to coders and we seek your confirmation or otherwise as to whether our instruction and interpretation is correct.

For episodes where:

- A patient has had a COVID-19 swab performed in the admission; or
- A patient has had a COVID-19 swab performed recently prior to admission,

the swab result must be obtained for coding purposes to ensure accurate assignment of U07.1 versus U07.2 versus U06.0.
Queries submitted to IHPA pending response (continued)

Query 3: COVID-19 result obtained prior to classification

U07.2 Emergency use of U07.2 [COVID-19, virus not identified] is not to be assigned for swab result not available, which might be the case when:

- patients are discharged prior to swabs being processed; or
- patients are swabbed by Health Service A, recently prior to admission at Health Service B and the results are not readily available to coders at health service B.
  - For instance, a patient is swabbed in a public, non-admitted COVID-19 clinic (Health Service A) on 15.4.20. The patient is admitted to a private health service (Health Service B) on 17.4.20 for treatment of worsening lower respiratory tract infection symptoms.

We're instructing WA coders they must obtain the swab results prior to classifying the episode.

Our interpretation is that, 'not available' referred to within the U07.2 definition, refers to COVID-19 testing 'not available,' not the testing being recently performed with the swab result 'not available' to the coder.

Query 4: Assignment of Z03.8 when COVID-19 ruled out with symptoms due to other condition

In COVID-19 FAQs Part 1 (published 1 May 2020) Transfer for suspected COVID-19 examples 1 & 2 Z03.8 observation for other suspected disease and conditions is not assigned at hospital B as the symptoms were confirmed to be due to other conditions (influenza / viral pneumonia).

However, Coding Rule TN1530 – Coronavirus disease (COVID-19) (effective 1 January 2020; Updated 27 March 2020) and IHPA Supplementary guidance for classifying admitted care (updated 9 April 2020) advise to code Z03.8 in addition to the condition / symptoms.

Can you please clarify under what circumstances additional codes for observation for suspected conditions or exposure to communicable diseases would be assigned?

Can you please clarify whether Z03.8 should be assigned when the symptoms are determined to be due to another condition?

Version History:
- Version 1.1 June 2020.
References


Western Australian Department of Health. (2020, April 7). COVID-19 Activity Data Recording.