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Don’t Take the COVID-19 Codes for Granted

When money goes to a healthcare provider from the federal or state government, there is always the risk of audit and/or investigation. There are a variety of auditing agencies known by their acronyms — OIG, DOJ, CMS, MAC, RAC, ZPIC — and each has its own interpretation of what the regulations require. The post-COVID-19 world is no exception.

In fact, regulatory activity has already been initiated on several fronts. The speed with which money has been disbursed, along with the flurry of new codes, waivers and regulations, has opened the door to fraudsters — but also created possibilities for innocent mistakes and unintentional misreporting.

Inpatient claims account for much of the money potentially at risk. To capture COVID-19-related data in a consistent fashion, several new ICD-10-CM diagnosis codes have been created, most of which are off cycle from the customary October 1st effective date. New guidelines have been introduced as well, and many will affect payment in some way. For example, the assignment of certain COVID-related diagnosis codes can result in a 20% upward adjustment on top of the typical inpatient MS-DRG payment from Medicare. Therefore, the ever-watchful eye of the regulators will be closely examining submissions. Compliance officers, coding and billing leaders, revenue integrity leaders and counsel should take note of the following important COVID-related ICD-10 coding rules, including the time period that each coding change went into effect.

EFFECTIVE DATE	DIAGNOSIS CODES	CODING RULE DESCRIPTION
01/27 - 03/31/20	B97.29	The ICD-10-CM diagnosis code for COVID-19 infection, U07.1, became effective April 1, 2020. For discharges occurring January 27, 2020 through March 31, 2020, coders were instructed to report B97.29, Other Coronavirus as the cause of diseases classified elsewhere. ICD-10-CM coding conventions precluded B97.29 from being the principal diagnosis, so the MS-DRG was always based on the manifestation of COVID-19, which could range from an acute bronchitis to an acute respiratory distress syndrome. Regardless of MS-DRG assignment, a 20% upward adjustment was made to the hospital MS-DRG payment if the B97.29 code was assigned.[1]
4/1/2020	U07.1	On April 1, 2020, a new code, U07.1, COVID-19, was provided for COVID-19 reporting. This code can be used in the principal diagnosis position. However, the medical record documentation must support the definition of principal diagnosis, which is the reason, after study, for the hospital admission. If the U07.1 code is supported as principal diagnosis, the MS-DRG assigned can be MS-DRG 177, Respiratory Infections and Inflammations with MCC; MS-DRG 178, Respiratory Infections and Inflammation with CC; MS-DRG 179, Respiratory Infections and Inflammations without MCC or CC; MS-DRG 208, Respiratory System Diagnosis with Ventilator Support <= 96 hours; or MS-DRG 207, Respiratory System Diagnosis with Ventilator Support > 96 hours. If U07.1 is not supported as principal diagnosis, the MS-DRG assigned, in most cases, is driven by the principal diagnosis with COVID-19 serving as an MCC. The exception to this would be if the principal diagnosis is a respiratory system diagnosis AND the patient was on mechanical ventilation, in which case the MS-DRG would be either MS-DRG 208, Respiratory System Diagnosis with Ventilator Support <=96 hours or MS-DRG 207, Respiratory System Diagnosis with Ventilator Support >96 hours, as the procedure drives MS-DRG assignment. If U07.1 is present on the claim, the 20% upward adjustment to the MS-DRG is made.[2]
9/1/2020	Positive Lab Test	Additionally, as published in SE 20015 released September 11, 2020, for admissions (rather than the customary discharges) occurring on or after September 1, 2020 to be eligible for the 20% payment adjustment, the medical record will be required to have a positive COVID-19 laboratory test documented in the patient's chart. Positive tests must be demonstrated using only the results of viral testing (*i.e.*, molecular or antigen), consistent with CDC guidelines. The test may be performed either during or prior to the hospital admission. For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. If the hospital does not have evidence of a positive test result, the 20% adjustment should be declined at the time of claim submission. To notify the MAC, the provider should enter a Billing Note NTE02 "No Pos Test" on the electronic claim 837I or a remark "No Pos Test" on a paper claim.[3]
1/1/2021	Z20.822 Z11.52 Z86.16 M35.81 M35.89 J12.82	Effective January 1, 2021, there were six new COVID-19-related diagnosis codes issued in another off-cycle release:[4] Z20.822: Contact with and (suspected) exposure to COVID-19 Z11.52: Encounter for screening for COVID-19 Z86.16: Personal history of COVID-19 M35.81: Multisystem inflammatory syndrome M35.89: Other specified systemic involvement of connective tissue J12.82: Pneumonia due to coronavirus disease 2019

[1] CDC interim advice for cornavirus feb 20 2020.pdf

[2] New ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19), April 1, 2020: https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-3-18-2020.pdf

[3] CMS (September 11, 2020): https://www.cms.gov/files/document/se20015.pdf

[4] https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-19-508.pdf

It is evident that the turmoil created in the healthcare provider network, coupled with the dynamic and constantly changing codes and guidance, is a recipe for coding and billing errors. It is incumbent upon providers to look back to identify patterns of behavior that may have resulted in overpayments. Don't wait for the regulators to show up at the door.

ABOUT FTI CONSULTING

FTI Consulting's Health Solutions Practice has been built to include the full range of skills and backgrounds required in healthcare investigations, litigation, compliance, auditing, risk management and regulatory oversight. Our team includes healthcare professionals with coding, operations, compliance, clinical, reimbursement, data mining and other specialized expertise.

We have assisted healthcare clients and counsel with proactive compliance auditing and monitoring efforts and have been involved across numerous federal, state, and internally initiated investigations, self-disclosures and litigation matters, including a significant number in which provider coding practices, billing practices, financial relationships with referral sources, and the medical necessity of services provided are in question. Our work on these matters often involves data analysis, developing appropriate sampling plans, conducting reviews of documentation, coding and billing, evaluating root causes and identifying necessary corrective actions.

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