Assignment of symptoms in patients with COVID-19

The COVID-19 pandemic is unprecedented, unique and evolving. Similarly, the classification of COVID-19 is unprecedented, unique and evolving.

At the beginning of the pandemic a decision was made, in Australia, to distinguish the classification of symptomatic COVID-19 admitted episodes from asymptomatic admitted episodes as it was considered this information would be useful in understanding the disease in the future.

Symptoms are not normally coded when a condition has been definitively diagnosed and so the classification of COVID-19 is unique in this respect.

There are complexities in the symptomatic versus asymptomatic nature of COVID-19 presentations, as the type and onset of symptoms are variable and may be related to causes other than COVID-19.

The following principles apply to the classification of symptoms in COVID-19 admitted episodes of care:

Scenario	Classification
COVID-19 has been confirmed and symptoms are present that are attributable to a definitive condition not associated with COVID-19	Codes for symptoms are not assigned, in accordance with normal coding practice
COVID-19 has been confirmed and symptoms are present that are attributable to a definitive condition associated with COVID-19, such as pneumonia or a respiratory tract infection	Codes for symptoms are not assigned, in accordance with normal coding practice
COVID-19 has been confirmed and symptoms are present, that are not attributable to a definitive condition or any other cause	Codes for symptoms are assigned for the classification of COVID-19
COVID-19 has been confirmed and symptoms are present or develop during the episode of care that are not attributable to a definitive condition or any other cause	Codes for symptoms are assigned for the classification of COVID-19

Where a symptom arising during the admitted episode is assigned as a principal diagnosis, follow ACS 0048 *Condition onset flag* to assign a condition onset flag (COF) of 2 *Condition not noted as arising during the current episode of care*, in accordance with *Guide for use point 3*.

Where there is uncertainty as to whether symptoms are attributable to COVID-19, confirmation should be sought from the treating clinician.

Assignment of COVID-19 emergency use codes in admitted episodes of care for transferred patients

The assignment of the COVID-19 emergency use codes are guided by clinical documentation, and supported by the test results.

Each COVID-19 related admitted episode of care must be reviewed on a case by case basis.

Where COVID-19 is documented as a suspected condition before transfer, apply the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* to assign the relevant emergency use code in that episode:

- where the laboratory test confirms a negative COVID-19 result, assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*
- where the laboratory test confirms a positive COVID-19 result, assign U07.1 *Emergency use of U07.1 [COVID-19, virus identified]*

See also COVID-19 FAQ Part 3: *Clinical documentation to support assignment of U06.0 Emergency use of U06.0 [COVID-19, ruled out]*.

Clinical documentation to support assignment of U06.0 *Emergency use of U06.0 [COVID-19, ruled out]*

Australia enacted U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* to identify activity related to the testing of COVID-19 in accordance with the National Partnership on COVID-19 Response.

Assign U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* where clinical documentation indicates that testing for COVID-19 has occurred but the presence of COVID-19 has been ruled out by virtue of a negative test result for SARS-CoV-2. The specific terminology of 'ruled out' is not required in order to assign this code.

U06.0 *Emergency use of U06.0 [COVID-19, ruled out]* is only assigned in the episode where the laboratory test was performed.