CORONAVIRUS DISEASE 2019
(COVID-19)

Death Certifications and Coding of Diagnoses May Differ

Trinity Health
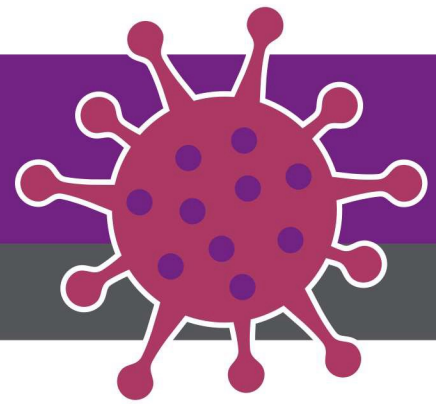
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Differences between Death Certification and Coding

Coding of the principal diagnosis might not be the same as the Part 1, Line A listing of the immediate cause of death on the death certificate. The following is coding guidance and CDC guidance regarding certifying COVID-19 related deaths.

CDC Guidance – How to Certify Deaths Due to the Coronavirus Disease 2019

Part 1 of the death certificate is for reporting the sequence of conditions that led directly to the patient's death. The immediate cause of death is the disease or condition that directly preceded death and is not necessarily the underlying cause of death (UCOD). The conditions that led to the immediate cause of death should be reported in a logical sequence in terms of time and etiology.

Coding Guidance

Coding for patients should follow the guidance provided in the AHA Official Coding Guidelines. When the patient is admitted with a condition thought to be caused by COVID-19, such as pneumonia, the U07.1 – Covid-19 would be the principal diagnosis code and pneumonia would be secondary.

For Sepsis, we would follow the sepsis and sepsis POA guidelines. If the patient has been admitted with COVID-19 sepsis, Sepsis would be principal diagnosis with COVID-19 code secondary. If admitted with COVID-19 pneumonia that progresses to sepsis—i.e. sepsis not POA, the COVID-19 code would be principal diagnosis with pneumonia and Sepsis secondary.

Example

A patient is diagnosed with COVID19 and is admitted with moderate respiratory distress, and then moved to the ICU for worsening respiratory acidosis and then has a cardiac arrest. On the death certificate acute respiratory acidosis would be listed on Part 1 Line A, followed by COVID19 on Part 1 Line B.

COVID19 would be the principal diagnosis and acute respiratory distress would be coded as a secondary diagnosis.