Internal Medicine Coding Alert

Reader Question: Reader Question

Question: A patient was admitted to the hospital with a principal diagnosis of acute pyelonephritis without lesion of renal medullary necrosis (590.10). On the third day of hospitalization, the patient had some right-sided pain, so the doctor did a thoracentesis using a diagnosis of pleurisy with effusion (511.1). This was denied by the insurance company saying it lacks information.

Anonymous Subscriber

Answer: There are a couple of potential problems with this claim, advises **Jeanne Fitzgerald, CPC.** There are also a couple of solutions.

First, the definition for the diagnosis code chosen for the pleural effusion specifies a bacterial cause and mentions three specific causes and one nonspecific tuberculosis bacterial cause. If the physician had a pathology report at the time the thoracentesis was performed or after the procedure was performed, then you might need to send that to the insurance company along with the operative or procedural note done for the thoracentesis to justify the appropriateness of the coding, Fitzgerald notes.

If the physician did not have the pathology report, the problem should probably have been coded with ICD-9 511.9 (unspecified pleural effusion).

When an insurance company says it lacks information, the best approach is to call them and ask what further information they would like you to supply, she adds. Perhaps the admitting diagnosis of pyelonephritis created a little interference in their computer when a pleural procedure was billed.

The physician progress notes and operative/procedural report should clear that up for them.

Note: When you are uncertain of the reason for a denial, it may be more productive to communicate directly with the payer before attempting to re-submit the bill.