Pulmonology Coding Alert

ICD-10: Avoid These 3 Pulmonology Diagnosis Coding Myths

Myths lead to misdiagnoses □ which can lead to chargebacks.

You know that assigning the correct ICD-10 code is essential to your claim, but it's possible that your pulmonology practice may still be falling prey to one of the many diagnosis coding myths that are circling the community. Check out the following three commonly-held myths so you can ensure that your diagnosis codes are submitted the right way every time.

Myth #1: You're limited to the pre-certified procedure and diagnosis.

Your pulmonologist pre-certifies a transbronchial lung biopsy (31628, Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy[s], single lobe) based on one diagnosis. But after the pulmonologist starts the procedure, he discovers other problems requiring surgical attention. Because you pre-certified only the original diagnosis, you can't report the additional procedures, right? Wrong.

Reality: If the diagnosis changes in the course of the procedure, you should report the final diagnosis and not the pre-surgical one, or if the patient is found to have multiple diagnoses, you should report them all.

Example: Suppose the pulmonologist preapproves thoracentesis (32554, Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance) for a patient with pleural effusion (J90).

After the pulmonologist begins the procedure, he aspirates a small amount of blood and pus from the patient's lung, leading him to believe that the patient has hemothorax (J94.2). The physician inserts a chest tube and performs thoracostomy to remove the fluid (32551, Tube thoracostomy, includes connection to drainage system [eg, water seal], when performed, open [separate procedure]). Because the insurer only pre-authorized the procedure based on the pleural effusion diagnosis, should the practice report both conditions?

Yes, if both exist at the time of surgery, you should report both. But if the patient only has the hemothorax, you should only report J94.2. According to the 2017 ICD-10-CM Official Guidelines for Coding and Reporting, "For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive."

Myth #2: You should expect denials if you report signs and symptoms as primary diagnoses.

When your pulmonologist confirms a diagnosis, you have to use that ICD-10 code, according to CMS and ICD-10 regulations. But when your physician doesn't specify a particular diagnosis, you should report the patient's signs and symptoms instead.

What to do: Suppose a patient's primary care physician requests that your pulmonologist examine the patient for suspected sarcoidosis (D86.0).

Your pulmonologist documents, "Rule out sarcoidosis" in the medical chart. ICD-10 coding guidelines state that you should not report "rule out" diagnoses.

But you can still assign other symptoms, such as fatigue (R53.83), cough (R05), and shortness of breath (R06.02) if documented, to describe the patient's symptoms in the absence of a sarcoidosis diagnosis.

And, if the pulmonologist ultimately concludes that a patient does not have the diagnosis the physician once suspected,

you can report only documented symptoms and secondary codes.

Myth #3: Forgetting Subsequent Characters Is OK

Coders have a right to worry about using ICD-10 codes that are missing crucial characters: To medically justify a procedure, the pulmonologist must supply the most specific ICD-10 code that describes the patient's condition, which means including any extra characters.

For example, you will forfeit deserved reimbursement if you bill for asthma treatments using the J45.9 ICD-10 code. To appropriately report other asthma, you'd haveto add fifth and sixth characters, such as J45.998 (Other asthma).

Protect yourself: If your physician selects an incomplete diagnosis code or if the documentation does not include the diagnosis that your physician has selected, you should alert your physician to the coding discrepancy. This way, you can educate the pulmonologist on selecting the most accurate codes in the future.