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Pulmonology Coding Alert

ICD-10 Update: ICD-10 Pulmonology Coding Mistakes You Cannot Afford To Make

Don't just correct, perfect your respiratory failure and seventh character coding.

You have now entered the era of hard-core ICD-10 coding. No more grace period luxuries you need to tighten your seatbelt and focus let specificity guide your path. Take a lesson from last year's most common coding mistakes to chart your way to a denial-free 2017.

Learn from Other's Mistakes

The most common challenge when tackling ICD-10-CM coding lies in not factoring in all of the available information before you make your code choice, says **Carol Pohlig, BSN, RN, CPC, ACS,** senior coding and education specialist at the Hospital of the University of Pennsylvania. You'll need to consider all the details and the associated complications in order to choose the correct code.

Confusion and misunderstanding lead to recurrent mistakes in respiratory failure and seventh character coding, amongst several other areas, according to **Tammy Ree, BS, RHIT, CCS-P, CHC, CPC**, manager, internal monitoring and coding compliance at CIOX Health, Alpharetta, GA. He shared the following ICD-10 coding areas with AHIMA (http://bok.ahima.org/doc?oid=301549#.WAnkdPkrLIU):

1. Fight Respiratory Failure Coding Blues with CMS's 2017 Coding Guidelines

One common mistake coders made in 2017 was inappropriately reporting respiratory failure as a principal diagnosis, Ree said. Fortunately, the new 2017 ICD-10-CM coding guidelines for pulmonology offer some clarity on how and when to report respiratory failure.

According to ICD-10 guidelines, if acute respiratory failure (ARF) is the primary reason for the patient's visit to the provider, then you may choose an appropriate code from subcategory J96.0- (Acute respiratory failure...), or subcategory J96.2-, (Acute and chronic respiratory failure...) as the primary diagnosis.

But if the ARF occurs after admission or even if it exists at the time of admission but doesn't meet the definition of principal diagnosis above, you will report it as the secondary diagnosis.

When ARF is coexistent with another acute condition, (such as myocardial infarction [I21.-, I22.-], cerebrovascular accident [I63.-], aspiration pneumonia J69.- [Pneumonitis due to solids and liquids...]), the selection of principal diagnosis will be different according to the situation.

In this situation, selecting the correct code can be a little tricky, depending on whether the other existing pathology is respiratory or non-respiratory in nature, and also on the circumstances of admission. Here's how to make your decision:

- If both ARF and the other acute condition are equally responsible for patient's admission, check for any chapter specific sequencing rules or any chapter specific guidelines that lead you to zero in on the primary diagnosis.
- If the documentation does not make it clear whether ARF and the other condition were equally instrumental in effecting the patient's admission, you may have to ask the provider for further clarification.

2. Solve 7th Character Conundrums In Reporting Trauma Cases:

You may have dig deep into the documentation, so as not to miss coding up to the seventh character, especially in

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thoracic trauma cases.

Example: Suppose a patient has an accident, and faces blunt trauma to the right front wall of thorax. Based on the provider's documentation, you will code S20.211A (Contusion of right front wall of thorax, initial encounter), as the patient sees the provider for the first time. If the provider does strapping of the thorax to treat muscle strain, you may choose to report CPT® code 29200 (Strapping; thorax).

The bottom line: "The changes in ICD-10 coding are so radically different from ICD-9, a practice must diligently take the time to learn how to appropriately and correctly code, or else the practice's cash flow will be significantly impacted," says **Jeff Berman, MD, FCCP,** executive director of the Florida Pulmonary Society.

For best results, take time to identify and proactively work on your ICD-10 coding pain points. Contact your payers if you are not sure about any specific requirements based the payer may have for on accepting a claim.

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