ICD-10 Documentation Training for Pulmonology
Objectives

At the completion of this lesson the learner will be able to:

• Identify frequently utilized pulmonology diagnoses and procedures

• Identify the ICD-10 changes associated with frequently utilized pulmonology diagnoses and procedures

• Define documentation recommendations for each diagnosis and procedure
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ICD-10 Diagnosis Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Diagnostic and Procedure Documentation Overview

- While the actual number of pulmonology diagnoses and procedure codes has increased from ICD-9 to ICD-10
- The structure and function of coding has improved to better represent the diagnosis and acuity of patients with respiratory illness and procedures performed
- This training is not inclusive of every diagnosis and procedure but the major themes across pulmonology documentation are included
Pulmonology Documentation Themes

- Document social factors that influence pulmonary diagnoses—BMI, smoking exposure/history, non-compliance with treatment regimen including over/under-dosing
- Document the clinical findings/indicators to support the diagnosis documented
- Document location with as much specificity as possible
- Document the condition as acute or chronic
- Document related, secondary or causal illness whenever appropriate
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis
- Recall the procedure code axes and ensure documentation required to support the required specificity
ICD-10 Diagnosis Documentation

Recommendations

ICD-10 Diagnosis Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Documenting Post-Operative Complications

Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Most Common Pulmonary Diagnosis

This module is focused on the most frequently documented diagnoses that will have the greatest impact on the provider including:

- COPD
- Asthma
- Respiratory insufficiency/distress
- Pulmonary insufficiency
- Emphysema
- Pneumonia
- Pulmonary Embolus
- Respiratory Failure
- Neoplasms
- Bronchitis
- CHF
- Under-dosing
- Emphasis of tobacco use abuse documentation

*Note: This training module is not intended to be an all-inclusive training tool to teach the provider every coding nuance within ICD-10*
Common Documentation for Respiratory Related Conditions

• Identify the severity, acute or chronic
• Document the site e.g. frontal sinusitis
• Document any cause e.g. pneumonia due to streptococcus pneumonia
• Document any secondary diseases e.g. COPD with respiratory failure
• Document any lung disease due to external agents e.g. Pneumonia due to chemical fumes
Chronic Obstructive Pulmonary Disease

- Roughly the same number of codes in both systems coding but documentation requirements are streamlined
- “Decompensated” has been eliminated and the required documentation points follow the severity of illness:

**Chronic Obstructive Pulmonary Disease**

- Involves:
  - Chronic Obstructive Bronchitis
  - Chronic bronchitis with airway obstruction
  - Chronic bronchitis with emphysema
  - Chronic Obstructive Tracheobronchitis
  - Asthma with COPD
  - Asthma is classified as: Mild intermittent, mild persistent, moderate persistent and severe persistent

**COPD with Acute Lower Respiratory Infection**

- Document the type of infection

**COPD with Exacerbation**

- Coding will include any documentation of “decompensated COPD”
- Indicate if with respiratory failure and its severity
- Document if oxygen dependent
- Document any Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
Asthma

Documentation for asthma includes the following components:

1. Severity
2. Frequency
3. Episode
4. Episode or level of exacerbation
5. Other conditions such as allergic rhinitis, allergic bronchitis, etc.
6. External forces to establish a cause and effect relationship e.g. asthma due to dusts.
7. Document exposure to tobacco or smoking, etc.

Examples:

*Mild intermittent asthma with acute exacerbation*

*Severe persistent asthma with status asthmaticus*

*Moderate persistent asthma, uncomplicated*
Pneumonia and Respiratory Tract Infections

Documenting pneumonia / other respiratory tract infections on this information:
1. Causal agent or organism
2. Any related or underlying disease that would be complicated by pneumonia
3. Any procedural or post-procedural complication e.g. Ventilator Associated Pneumonia. Document the relationship between the condition and the procedure and the associated organism(s)

NOTE: Sinusitis must be documented as **acute, recurrent, or acute recurrent**

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**Documentation for Pneumonia**

- **Define Type of Pneumonia:**
  - Examples:
    - Viral
    - Bacterial
    - Aspiration

- **Document Causal Agent:**
  - Examples:
    - Streptococcus, group B
    - H. Influenzae
    - RSV
    - Klebsiella

- **Document Related Disease:**
  - Examples
    - Rheumatic Fever
    - Measles
    - Rubella
    - Salmonella
    - Whooping Cough

- **Complication Related:**
  - Examples:
    - VAP
    - Aspiration
Pulmonary Embolus

Documentation for pulmonary embolus requires two components:

1. Indicate Type:
   - Septic pulmonary embolus
   - Saddle embolus

2. Document *presence of acute cor pulmonale* where appropriate

3. Document Cor Pulmonale if present - Cor Pulmonale is a separate set of diagnoses codes that require acute or chronic designation and should include causal conditions e.g. COPD, pulmonary HTN, or sleep apnea

4. Specify if chronic (still present), healed/old

5. Note: History of Pulmonary embolism is ambiguous, therefore more specificity is needed.

Examples:

- *Saddle embolus of pulmonary artery without acute cor pulmonale*
- *Septic pulmonary embolism with acute cor pulmonale*
Respiratory Failure

- Respiratory Failure never a single diagnosis—always an associated cause
- Documentation of cause and sequence of events vital to assigning the correct codes:
  - Is respiratory failure the reason the patient was admitted secondary to another cause?
    - Patient with myasthenia gravis presents to the ED with acute exacerbation and respiratory failure
  - Did the patient present with a problem that after the admission resulted in respiratory failure?
    - Patient with acute on chronic combined heart failure required mechanical ventilation following hospitalization for sepsis and aggressive fluid resuscitation that resulted in respiratory failure

Documenting Respiratory Failure:

1. Diagnosis **does not** require mechanical ventilation
2. Must document as **acute, chronic, or acute and chronic**
3. Must be defined as **hypercapnic** or **hypoxic**
4. If respiratory failure is **post-procedural**, specify if this is a **complication** or an **expected outcome** of the surgery and specify the **etiology** (aspiration, radiation, pneumonia, etc.)
5. Document any **tobacco use, dependence, past history, or exposure** (second hand, occupational, etc.)
Respiratory Failure

• Pulmonary inefficiency:
  – Document the severity (acute or chronic)
  – Document the cause e.g. shock, trauma, surgery, etc.

• Respiratory insufficiency/distress:
  – Insufficiency and distress are symptomatic of an underlying condition, therefore more specificity is needed. If there is no underlying condition, then specify the severity and cause

• Emphysema:
  – Document the cause if known e.g. trauma, gas, etc.
  – Document the type and location e.g. interstitial, compensatory, congenital, etc.
  – Document if presence of COPD or other infectious disease
  – Document tobacco use and exposure to 2nd hand smoking
Neoplasms

Neoplasms will be defined location and behavior - Location specificity should include:

- Laterality
- Specificity
- Any overlapping sites
- Document site, state morphology e.g. benign, in situ, malignant, uncertain behavior, document the stage and any metastatic sites.
- Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
- Reason for the patient’s current admission/encounter, or when the patient is admitted for a specific treatment related to the neoplasm, e.g. chemo, surgical removal, radiation therapy

Examples:

- Malignant neoplasm of overlapping sites of bone and cartilage of right limb
- Malignant melanoma of nose
- Merkel cell of the left eyelid, including canthus
Neoplasms

Primary vs. Metastatic Sites
Coding for treatment of primary sites differs from that of treatment directed at secondary or other sites
- Document primary site
- Document malignancies
- Identification of direction of treatment

Documenting Histology of Neoplasms
- The documentation of a specific histology helps to direct coding of neoplasm diagnosis
- Document that a neoplasm cannot be determined after histology study to be Malignant, benign, or uncertain behavior.
- Clinical information by acknowledging the cytology, pathology or histology findings in the notes
- When histology is known, document clearly
- Neoplasm complication:
  - These are conditions that complicates the neoplasm, they are either adverse reaction to neoplastic treatment or the progression of neoplastic disease e.g. neoplastic anemia, pathological fracture due to a neoplastic process, vomiting secondary to chemo.
- Clearly document the reason for the encounter, the conditions that requires treatment e.g. dehydration, anemia
- Specify any drug causing adverse effects and the adverse effects of treatments e.g. anemia secondary to anemia
Procedure Documentation Recommendations

ICD-10 Diagnosis Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts coders capture rather than memorize every detail

- Procedure documentation can be thought of on multiple axes
- Each axis captures an increased amount of provider documentation in respect to the service or procedure provided
### Axis 1: Section

**Axis 1: Starting point for coding procedures.**

Provides the coder with the initial criteria to class information and narrows available codes

**Pulmonology procedures are located in all of these highlighted sections.**

**Examples include:**

Medical and Surgical—Bronchoscopy

Extracorporeal Assistance and Performance—Mechanical Ventilation Placement—Chest Tube Placement

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**Other Procedures**
Axis 2: Body System

**Body System:** is the next axis for understand ICD-10 coding. As the Axes increase so does the specificity of documentation AND coding.

**Depending on the section identified the axis may be:**
- Body System
- Physiologic System
- Anatomic Region

**Examples of Axis 2:**
- Heart and Great Vessels
- Upper Veins
- Lower Veins
- Upper Arteries
- Lower Arteries
- Central Nervous System
- Upper Extremities
- Lower Extremities
Axis 3: Root Operation

Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a **body part**
2. Procedures that take out **solids/fluids/gases** from a body part
3. Procedures involving **cutting or separating** only
4. Procedures that **put in/put back** or **move** some/all of a body part
5. Procedures that **alter the diameter/route of a tubular body part** - can be performed only on tubular body parts
6. Procedures that always involve a **device**
7. Procedures involving **examination only**
8. Procedures that **define other repairs**
9. Procedures that **define other objectives**
Axis 3: Root Operation

Pulmonology Examples of Axis 3-Root Operation:
- Drainage—Drainage of right lower lobe via chest tube placement
- Dilation—dilation of trachea with intraluminal device
- Inspection—Bronchoscopy

Documenting for Axis 3:
- Don’t attempt to memorize the coding verbiage for each root operation
- Ensure that documentation of the procedure has a clear objective/purpose
- Ensure that one of the 9 groupings of operations can be identified

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Axis 4: Very specific and detailed, procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or On a body Part
- Conduction mechanism (brain or heart)

Respiratory Examples of Axis 4:

- Bilateral Lungs
- Right Lung
- Right Upper Lobe
- Right Middle Lobe
- Right Lower Lobe

INCREASING SPECIFICITY
Axis 4: Body Part

Documenting for Axis 4:

• Be as specific as the body part and procedure allow
• If there is laterality capture right, left or bilateral
• If there is distance capture proximal and distal
• Multiple procedures in the same organ or vessel need to have clear documentation
Axis 5: Approach

Axis 5: Based on access **location**, **method** and types of **instrumentation** used:
- Open

Axis 5: Defined based on access **location**, **method** and types of **instrumentation** used:
- **Open**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site
- **Percutaneous**—Entry, by puncture or incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach procedure site
- **Percutaneous endoscopic**—Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach and visualize procedure site
- **Via natural or artificial opening**—Entry of instrumentation through natural or artificial external opening to reach procedure site
- **Via natural or artificial opening endoscopic**—Entry of instrumentation through natural or artificial external opening to reach and visualize procedure site
- **Open with percutaneous endoscopic assistance**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site, and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to aid in performance of the procedure.
- **External**—Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane
  - Percutaneous
  - Percutaneous Endoscopic
  - Via Natural or Artificial Opening
  - Via Natural or Artificial Opening Endoscopic
  - Via Natural or Artificial Opening Endoscopic with Percutaneous Endoscopic Assistance
  - External
Axis 6: Devices left in place at the completion of a procedure require a code.

Examples include:

- Endotrachial Tube
- Radioactive Element
- Swan-Ganz Catheter

Respiratory Assistance vs. Respiratory Performance:

**Assistance** is respiratory support delivered via mask or non-invasive device (CPAP, BiPAP)

**Performance** is respiratory support delivered via invasive ETT device (nasal, oral, trach)
Axis 7: Qualifier

Axis 7: Defines “qualifier” or an additional attribute of the procedure when appropriate.

- Not all procedure codes require qualifiers
- Data adds specific, clarifying information that is not contained in another axis

Examples of Pulmonary Qualifiers:

- Manual measurement of pulmonary artery wedge pressure
- Procedures including biopsy for diagnostic purposes
Mechanical Ventilation

New Concepts for Mechanical Ventilation in ICD-10:

1. Respiratory Assistance vs. Respiratory Performance
   - Assistance is respiratory support delivered via mask or non-invasive device (CPAP, BiPAP)
   - Performance is respiratory support delivered via invasive ETT device (nasal, oral, trach)

2. Duration of Ventilator support
   - less than 24 hours
   - 24-96 hours
   - more than 96 hours

3. Capture of detail of support
   - Continuous Positive Airway Pressure
   - Intermittent Positive Airway Pressure
   - Continuous Negative Airway Pressure
   - Intermittent Negative Airway Pressure

Respiratory Arrest:
- Is not a diagnosis
- Is a clinical finding for which a more definitive diagnosis should be determined
- Is appropriate to describe an initial finding
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non-Autologous

Important Note:
The receipt of transfusions has to be acknowledged by the provider
Lymph Node Removal

• Document how many lymph nodes were removed
• Document location, laterality
• Document approach
Biopsy and Bronchoscopy

• Biopsy
  – Document the root operation e.g. excision, resection, etc
  – Document specific site and laterality (if applicable)
  – Document approach e.g. open, percutaneous endoscopic, etc.

• Bronchoscopy
  – Document the root operation
  – Document site/location
  – Document whether diagnostic or not
Putting It All Together

**Code Descriptions for Removal of Pleura:**

**Pleura, Right >**

- **0BDN0 Open >**
  - 0BDN0ZX Extraction of Right Pleura, Open Approach, Diagnostic
  - 0BDN0ZZ Extraction of Right Pleura, Open Approach

- **0BDN3 Percutaneous >**
  - 0BDN3ZX Extraction of Right Pleura, Percutaneous Approach, Diagnostic
  - 0BDN3ZZ Extraction of Right Pleura, Percutaneous Approach

- **0BDN4 Percutaneous Endoscopic >**
  - 0BDN4ZX Extraction of Right Pleura, Percutaneous Endoscopic Approach, Diagnostic
  - 0BDN4ZZ Extraction of Right Pleura, Percutaneous Endoscopic Approach

**Pleura, Left >**

- **0BDP0 Open >**
  - 0BDP0ZX Extraction of Left Pleura, Open Approach, Diagnostic
  - 0BDP0ZZ Extraction of Left Pleura, Open Approach

- **0BDP3 Percutaneous >**
  - 0BDP3ZX Extraction of Left Pleura, Percutaneous Approach, Diagnostic
  - 0BDP3ZZ Extraction of Left Pleura, Percutaneous Approach

- **0BDP4 Percutaneous Endoscopic >**
  - 0BDP4ZX Extraction of Left Pleura, Percutaneous Endoscopic Approach, Diagnostic
  - 0BDP4ZZ Extraction of Left Pleura, Percutaneous Endoscopic Approach
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