Pulmonary insufficiency
continued from p. 5

prevent a coder from using this code when the respiratory failure is due to other conditions besides trauma or surgery.

Never forget that the Index trumps the Table; thus, if the physician links the respiratory failure to the surgery or trauma, a coder should report 518.5, even though “respiratory failure” is not in the description.

In summary, based on the current Index to Diseases and previous Coding Clinic advice:

» Given that the ICD-9-CM Index supersedes the table, 518.5 is the appropriate code when the physician explicitly links acute respiratory failure to the surgery.

» However, if all the physician documents is “postoperative respiratory failure” without explicit linkage to the procedure, either the advice in Coding Clinic, Fourth Quarter, 1987, pp. 1–3, may be followed, or a query may be rendered to determine what disease entities, drugs, and/or procedures led to the condition. The code assignment would then be based on the physician’s answer.

Please note that this advice will likely change when new ICD-9-CM codes are implemented on October 1.

This issue was discussed at the March 10 meeting of the ICD-9-CM Coordination and Maintenance Committee; an excellent description of the relevant issues is available in its handout available at the CDC website: www.cdc.gov/nchs/data/icd9/TopicpacketforMarch2011_HA1.pdf.

New codes that are likely to be effective on October 1 include the following:

» 518.5, Pulmonary insufficiency following trauma and surgery

» New code 518.51, Acute respiratory failure following trauma and surgery

Respiratory failure, not otherwise specified, following trauma and surgery

Excludes:

Acute respiratory failure in other conditions (518.81)

» New code 518.52, Other pulmonary insufficiency, not elsewhere classified, following trauma and surgery

Adult respiratory distress syndrome

Pulmonary insufficiency following:

surgery

trauma

Shock lung related to trauma and surgery

Excludes: adult respiratory distress syndrome associated with other conditions (518.82)

pneumonia:

aspiration (507.0)

hypostatic (514)

shock lung, not related to trauma or surgery (518.82)

» New code 518.53, Acute and chronic respiratory failure following trauma and surgery

Editor’s note: James S. Kennedy, MD, CCS, managing editor of FTI Healthcare in Brentwood, TN, answered this question with input from 3M. He can be reached at james.kennedy@ftihealthcare.com.

Take a closer look when reviewing lung cancer charts

by Helen Walker, MD

Lung cancer is the principal diagnosis in about 150,000 hospital admissions per year and a secondary diagnosis for roughly 386,000 admissions. Patients admitted with lung cancer either as a primary or secondary diagnosis require a longer length of stay than an average admission (source: Healthcare Cost and Utilization Project website, http://hcup-us.ahrq.gov). CDI specialists should know what to look for when reviewing cancer admissions in order to capture the true severity of these patients’ illnesses.

Cancer coding

The ICD-9 codes related to lung cancer are assigned based on the following factors:

» Documentation of a lung malignancy

» Type of cancer

» What part of the lung is involved

» Whether the cancer is primary or secondary

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Often patients are discharged with the diagnosis of “possible” or “probable” cancer when the pathology report is still pending. Although “probable,” “suspected,” “likely,” “possible,” and “still to be ruled out” diagnoses can still be coded as a malignancy, it is best to have the attending physician provide documentation. The department in charge of the post-discharge query process (typically CDI or HIM) should query the physician if the pathology report returns after discharge.

The majority of lung cancers are non-small-cell carcinomas. These include the following:
» Adenocarcinoma
» Squamous cell carcinoma
» Large-cell carcinomas
» Non-small-cell/non-large-cell carcinomas

Thirteen percent of all lung cancers are small-cell carcinomas.

Look for documentation to establish whether the lung cancer is primary or secondary. Many cancers metastasize to the lungs, including breast cancer, gastrointestinal tumors, kidney cancer, melanoma, sarcomas, lymphomas and leukemias, germ cell tumors, and ovarian cancer. So if there is a question whether a tumor is metastatic to the lung, or from the lung, query the physician.

Complications from lung cancer

Patients with lung cancer often have complications that prolong their stay. Many of these conditions are CCs and a few are MCCs. Here are a few:
» CCs: Cardiac tamponade; acute pericarditis; malignant pleural effusion; cachexia; hemoptysis; deep vein thrombosis; syndrome of inappropriate antidiuretic hormone hypersecretion (aka SIADH); superior vena cava syndrome; Pancoast’s syndrome; metastases to the bone, adrenal gland, brain, and liver
» MCCs: Acute respiratory failure, postobstructive pneumonia, and tracheoesophageal fistula

Complicating the case

Physicians sometimes document symptoms or findings instead of diagnoses. Look to the following places in the record for CC/MCC or other clues of secondary diagnoses:
» History and physical. For example, a patient noted to cough up blood may indicate hemoptysis, a patient who presents with shoulder pain may indicate Horner’s syndrome, and weakness of the hand muscles may indicate Pancoast’s syndrome.
» Laboratory findings and physician orders. A patient with small-cell lung cancer and a low sodium level treated with

Sample query: Pathology results clarification request

Dear Dr. Jones,

Codes may not be assigned based on abnormal results from diagnostic studies without physician documentation of the significance of the findings. This patient was admitted with a lung mass and had a lung biopsy. The final pathology report, which is now available, documents adenocarcinoma. Please document the significance of these results in the patient’s medical record.

Sample query: Clarification of time on ventilator

Dear Dr. Jones,

The medical record documentation requires clarification for accurate coding. The patient with lung cancer had an open lung biopsy and was on a ventilator for four days postoperatively. Please document whether this was an expected or a longer-than-expected period of time on the ventilator.

❐ The patient was on the ventilator postoperatively an expected length of time
❐ The patient was on the ventilator postoperatively longer than expected
❐ Unable to determine
❐ Other: _____________________
fluid restriction, salt administration, and demeclocycline may indicate SIADH.

» Diagnostic testing. A liver mass found on a CT scan may be a metastasis.

Sequencing rules

Be familiar with cancer sequencing rules. Code the cancer as principal in the following instances:

» When treatment (except radiotherapy or chemotherapy) is directed at the malignancy
» When the patient was admitted to stage the malignancy
» If the patient is admitted for symptoms related to the malignancy
» If the admission is for surgery followed by adjunct chemotherapy or radiotherapy

Code the lung cancer as a secondary diagnosis in the following instances:

» When the admission is for inpatient chemotherapy or radiotherapy
» The admission is for complications of the malignancy or toxic effects of drugs
» The primary malignancy was eradicated and no treatment was directed toward it (use V code)
» The treatment is directed at metastases only (code secondary tumor as principal)

Capture all procedures

Consider the following examples of opportunities to capture additional documentation:

1. Was the patient on the ventilator for an extended period of time postoperatively?
   a. If the patient is ventilated more than two days postoperatively, the coder may be able to code the ventilator procedure. Query the physician to determine whether the patient was on the mechanical ventilator for an unexpected extended period of time.

2. Did the transbronchial needle aspiration include lung tissue?
   a. This can move the DRG to 166–168 (Other respiratory system operating room procedures).
   b. If so, a coder may report both codes: 34.24, Pleural biopsy, and 34.21, Transpleural thoracoscopy, according to Coding Clinic, Third Quarter 2002, p. 27. This also can move the DRG to 166–168 (Other respiratory system operating room procedures).

Opportunities to query

Any number of situations may make it necessary to query the provider regarding the care of a lung cancer patient. Consider querying when:

» The pathology report is back after the patient is discharged
» It is not clear whether the thoracoscopy involved more than the surgical approach
» There is uncertainty whether the patient was on the ventilator longer than expected
» There are orders not linked to a diagnosis
» Test results have not been interpreted

Editor’s note: Walker is vice president of clinical quality at FairCode Associates, LLC, in Towson, MD, a healthcare consulting firm specializing in DRG and coding audits. A former RN, she graduated from the University of Maryland School of Medicine and has been board-certified in internal medicine since 1987. Contact her at 410/825-6178 or by e-mail at hwalker@faircode.com.