Requirements for diagnostic bronchoscopic procedures

by William E. Haik, MD, FCCP

There has been a considerable amount of confusion regarding physician terminology, documentation requirements, and subsequent coding of various diagnostic bronchoscopic lung procedures. Because the current MS-DRG structure categorizes some of these as “operating room procedures,” each procedure carries with it different reimbursement; therefore, they are frequently the targets of third-party reviewers.

While CDI specialists do not typically clarify documentation for procedures, diagnostic bronchoscopic lung procedures are an exception. Following are thumbnail descriptions of these procedures to aid the CDI specialist when clarifying physician documentation for correct code assignment.

The most commonly documented diagnostic bronchoscopic procedures include the following:

1. Transbronchial biopsy of lung
2. Endobronchial bronchoscopic biopsy (bronchial biopsy)
3. Brush biopsy of lung or bronchus
4. Transbronchoscopic needle (Wang) biopsy of lung
5. Bronchoalveolar lavage
6. Transbronchoscopic (closed) needle aspiration of a mediastinal lymph node

As with all ICD-9-CM codes, the coding and reporting of a diagnostic bronchoscopic procedure completely depends on accurate and specific physician documentation. Let’s review a few possible documentation trouble spots for these procedures.

Transbronchial biopsy of lung (33.27)

A potential coding conflict occurs when the physician merely documents a transbronchial biopsy and does not specify it as being of the lung, rather than the bronchus. Because the 2012 ICD-9-CM Manual, Volume III Tabular Index separates a transbronchial biopsy of the lung (33.27) from that of the bronchus (33.24), an error commonly occurs when a hospital assigns 33.27 due to the fact the physician has not documented the specific structure biopsied (lung versus bronchus).

However, from a clinical perspective it is redundant for a physician to document both a transbronchial biopsy and a transbronchial lung biopsy, since lung tissue surrounds the bronchus and is the only structure that is obtainable via transbronchial biopsy. Although a second-level appeal to a physician reviewer will typically overturn the initial adverse determination, CDI specialists should query the attending physician regarding the specific pulmonary structure that was biopsied (lung versus bronchus) to avoid the burdensome appeal process.

Clinical elements that may be present in the health record to support a physician query for further specification of a transbronchial lung biopsy are as follows:

1. Use of fluoroscopy
2. Non-visualization of the biopsied lesion endobronchially via the bronchoscope
3. Pulmonary infiltrate or solitary peripheral lung nodule as the indication for the biopsy
4. Alveolar (lung) tissue on pathological examination
5. Resultant pneumothorax

Consider the following sample multiple-choice query format employing the above clinical information:

Dear Dr. Haik,

It is noted in the impression of the history and physical examination that the patient has a diffuse left lower lobe pulmonary infiltrate. The operative report notes that a transbronchoscopic biopsy was performed under fluoroscopy with the resultant pathology report revealing multiple granulomata with surrounding normal lung parenchyma.

Can you identify the tissue biopsied via the transbronchoscopic biopsy as being:

1. Lung
2. Bronchus
3. Some other tissue
4. Undetermined

Note that according to AHA’s Coding Clinic for ICD-9-CM, 3rd Quarter 2011, p. 6, it is not necessary for lung tissue to be present on a pathology report to substantiate the physician’s documentation of a transbronchial biopsy of the lung.
It is not uncommon for tissue samples to be inadequate or inconclusive; therefore, this does not mitigate the reporting of the extent of the procedure (even if failed).

Also, in a related issue, physicians may merely document a “bronchial biopsy of left lower lobe,” which may be incorrectly assumed to mean a transbronchial biopsy of the lung. When this documentation occurs, query the physician to determine the specific type of tissue biopsied (lung versus bronchus) so that a coder may assign the correct ICD-9-CM procedure code.

Endoscopic (bronchial) biopsy (33.24)

This biopsy is usually performed with forceps and occurs when a bronchial lesion is sited through the bronchoscope lying within the tracheobronchial tree. Therefore, the physician performs this procedure under direct visualization of the lesion. This is different from a transbronchial biopsy of the lung where the lesion is not sited directly through the bronchoscope.

When an endobronchial biopsy is performed in conjunction with a transbronchial lung biopsy, a coder assigns both 33.24 and 33.27, respectively.

Brush biopsy of lung or bronchus (33.24)

This type of biopsy is performed by inserting a firm bristled brush into a bronchus or extending the brush into the lung via a small bronchiole to collect cellular material. Regardless of the site of the transbronchial brush biopsy (lung and/or bronchus), a coder assigns ICD-9-CM code 33.24 based on the 2012 ICD-9-CM Manual, Volume III Tabular Index. Assigning 33.27 to represent this procedure is incorrect and will result in adverse determination by a third-party reviewer.

Transbronchoscopic needle (Wang) biopsy of lung (33.27) and bronchus (33.24)

Revisions to the 2012 ICD-9-CM Manual, Volume III, clarified the coding of a bronchoscopic needle biopsy. A bronchoscopic transbronchial needle biopsy of the lung is usually performed for sampling an isolated parenchymal lung lesion, providing a cellular sample for microscopic examination. This procedure is performed by passing a thin-walled needle out of the tip of the bronchoscope through the bronchus into the surrounding lung parenchyma.

Although the 2012 ICD-9-CM Manual revisions also listed a code for a transbronchial needle biopsy of the bronchus (33.24), this procedure is rarely performed as a transbronchial procedure and would result in going through the bronchus into the lung for sampling a lung lesion and not solely for sampling a bronchial lesion. However, a needle biopsy solely of a bronchial lesion may be performed, and in this instance, 33.24 would be appropriately assigned.

Bronchoalveolar lavage (33.24)

Also sometimes referred to as a “liquid biopsy,” this procedure is performed by infusing saline into a bronchial subsegment of the lung, which is subsequently suctioned to retrieve a cellular sample. This procedure is differentiated from a “whole-lung lavage” (33.29), which is usually performed therapeutically in the treatment of alveolar proteinosis.

Transbronchoscopic (closed) needle aspiration of a mediastinal lymph node (40.11)

Based on AHA’s Coding Clinic for ICD-9-CM, 1st Quarter 2010, p. 9, the appropriate code assignment for this procedure is 40.11. This new guidance resolves previous confusion surrounding the code assignment for this procedure. This procedure involves the insertion of a small gauged needle via the bronchoscope through the tracheobronchial tree into the mediastinum for the sampling of a mediastinal lymph node, which is usually enlarged and suspected of being invaded by a pathogenic process.

In general, all personnel involved in the documentation and coding of bronchoscopic procedures would find AHA’s Coding Clinic for ICD-9-CM, 3rd Quarter 2011, pp. 6–9 a useful clarification of previous Coding Clinic for ICD-9-CM publications. I recommend obtaining a copy of that publication and sharing it with your coding staff.

Editor’s note: Dr. Haik is the director of DRG Review, Inc., in Fort Walton Beach, FL. In addition to maintaining his own clinical practice, Dr. Haik has served on the AHA’s editorial advisory board and expert advisory panel of the AHA’s Coding Clinic for ICD-9-CM, and was a founding member of the ACDIS advisory board. Contact him at drgreview@aol.com.