



COPD and Respiratory Failure: Documentation and Coding

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
AHIMA ICD-10-CM/PCS Trainer



About the Presenter



Gloryanne Bryant, RHIA, CDIP, CCS, CCDS AHIMA ICD-10-CM/PCS Trainer

- Ms. Bryant has over 40 years of experience in HIM Coding, CDI and Compliance.
- Gloryanne is the Past-President and Director of CHIA having been an HIM volunteer on local, state and national levels and served on and led many CHIA, AHIMA, HFMA and ACDIS workgroups and committees. Gloryanne served two years on the AHA Coding Clinic EAB.
- She is a sought-after advisor, mentor, national educator, speaker and author on clinical coding compliance and ethics, reimbursement, CDI, physician querying, coding regulations (ICD-10-CM/PCS, CPT, MS-DRGs, and HCCs).
- Over the past four years she was an Expert Witness and Consultant for clinical coding, documentation, charging and MS-DRGs. Currently, she works part-time as an Independent HIM Coding & CDI Compliance Consultant.



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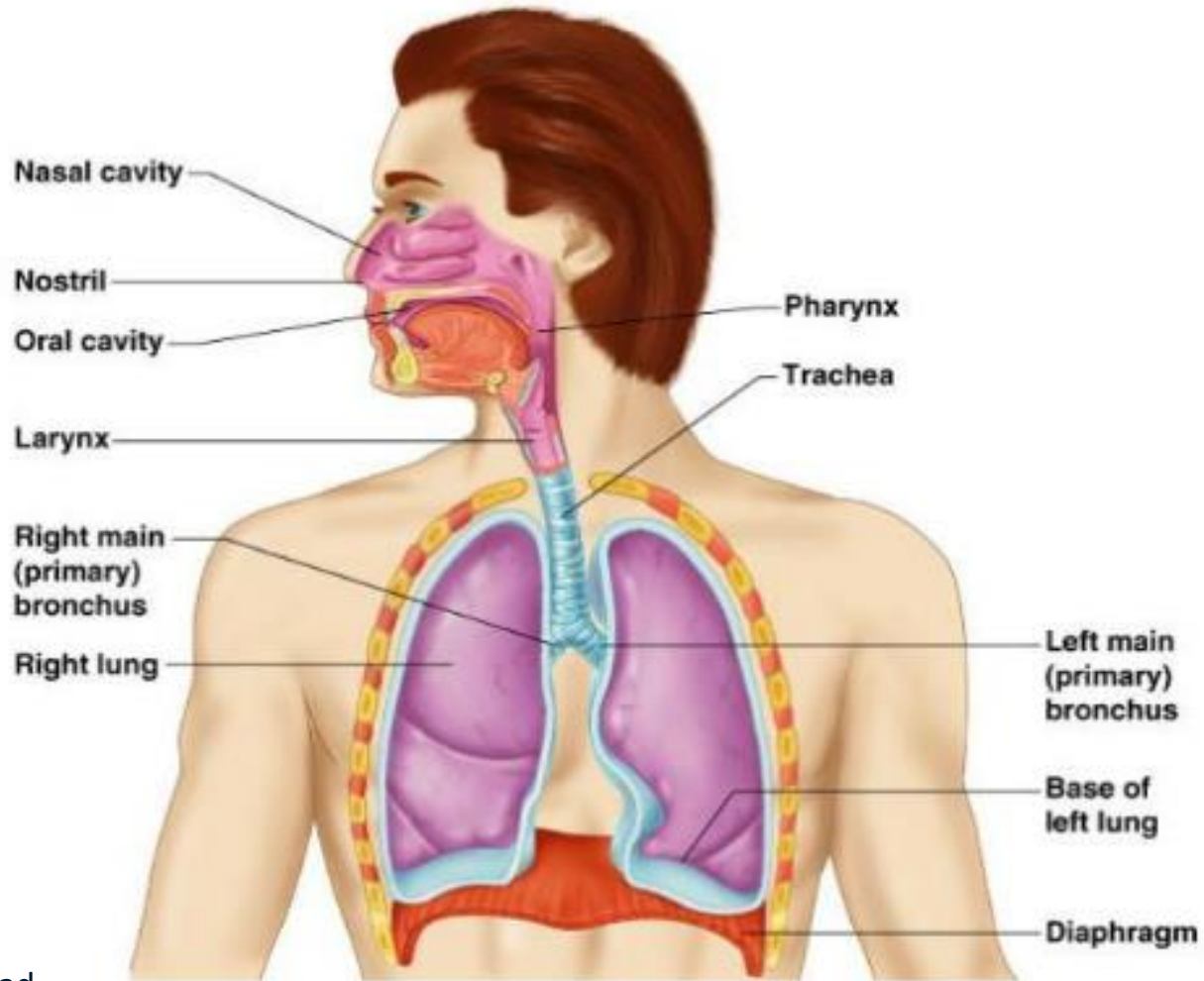
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Goals/Objectives

1. Review key clinical indicators for COPD and Respiratory Failure;
2. Understand the ICD-10-CM guidelines for coding COPD and Respiratory Failure;
3. Gain a better understanding of payer denials for COPD & Respiratory Failure;
4. Enhance knowledge through review of case scenarios;
5. Improve coding accuracy and compliance.

Respiratory System Anatomy



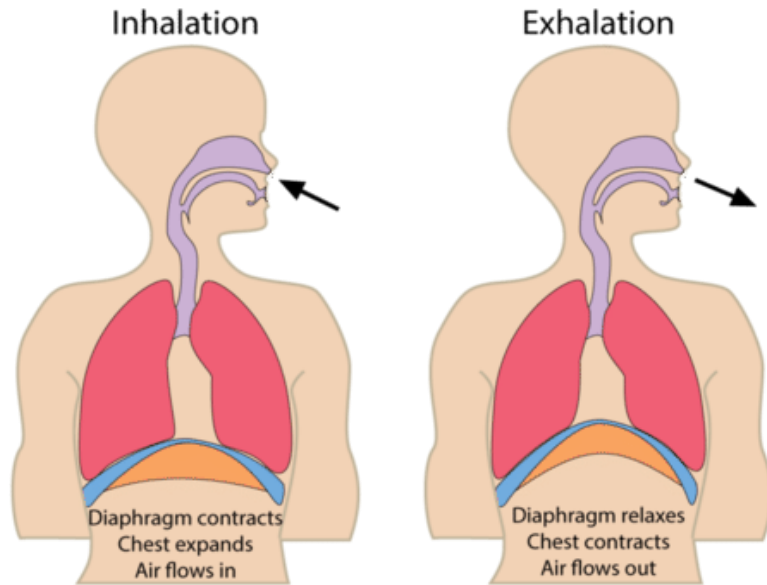
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Respiratory System: Anatomy & Physiology (cont.)

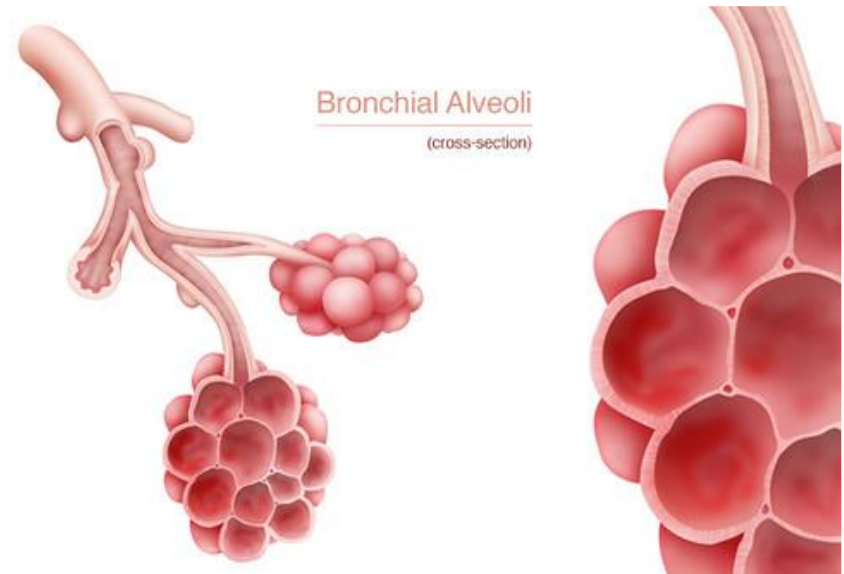


- The functions of the respiratory system are:
 - 1. Oxygen supplier. The job of the respiratory system is to keep the body constantly supplied with oxygen.
 - 2. Elimination. Elimination of carbon dioxide.
 - 3. Gas exchange. The respiratory system organs oversee the gas exchanges that occur between the blood, tissue cells and the lungs.
- **Pulmonary ventilation.** Air must move into and out of the lungs so that gasses in the air sacs are continuously refreshed, and this process is commonly called breathing.
- **External respiration.** Gas exchange between the pulmonary blood and alveoli must take place.
- **Respiratory gas transport.** Oxygen and carbon dioxide must be transported to and from the lungs and tissue cells of the body via the bloodstream.
- **Internal respiration.** At systemic capillaries, gas exchanges must be made between the blood and tissue cells.

Respiratory System (cont.)



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NOTE: The inner surface of the bronchi, and bronchioles are lined by ciliated epithelium.

Exhalation is a passive process and starts when the expiratory muscles relax. During exhalation, elastic properties of the lung help to expel deoxygenated air



What is Respiration?

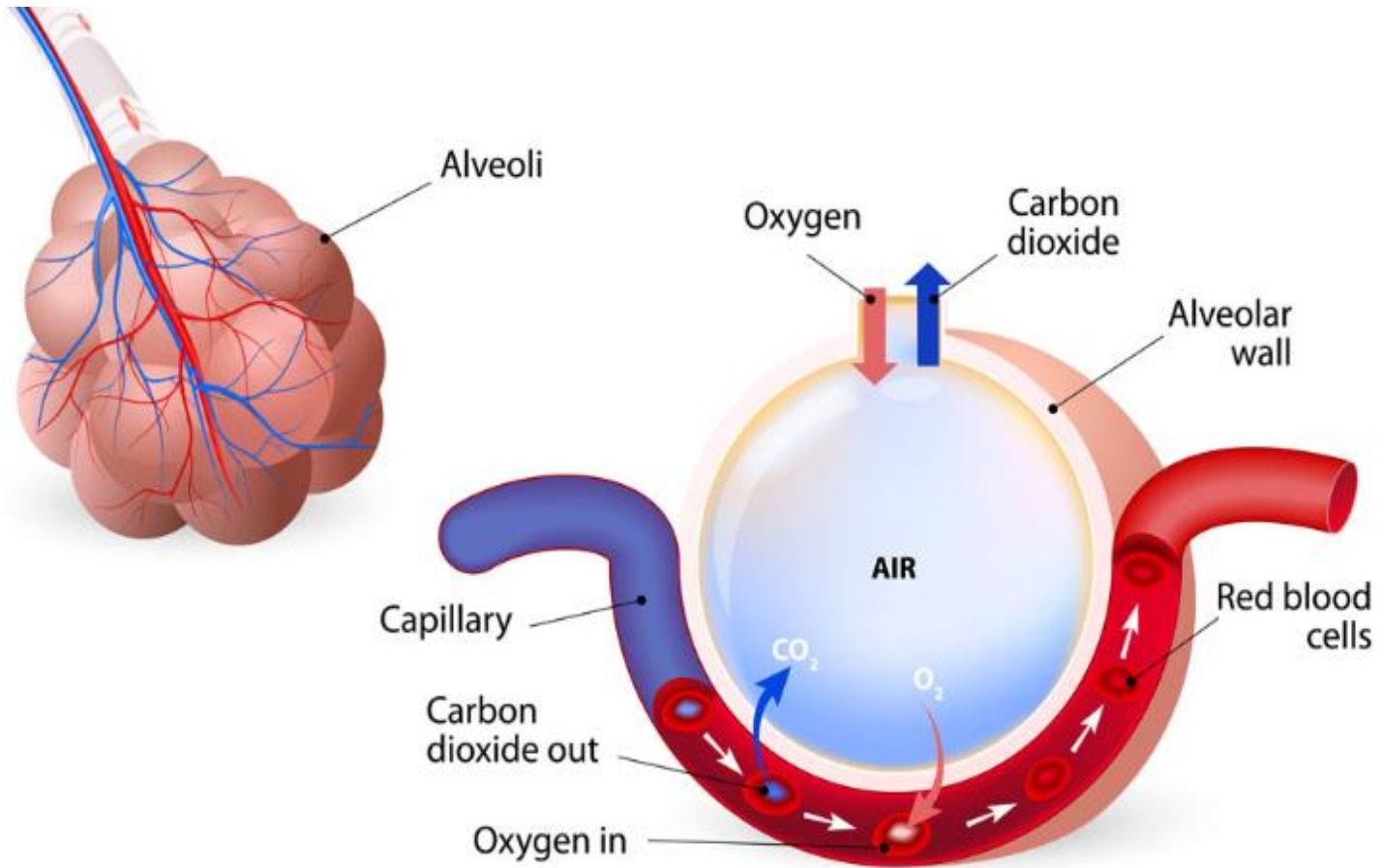


Image source: <https://www.pedilung.com/wp-content/uploads/2015/12/Alveolus.-gas-exchange.-Pulmonary-alveolus.jpg>

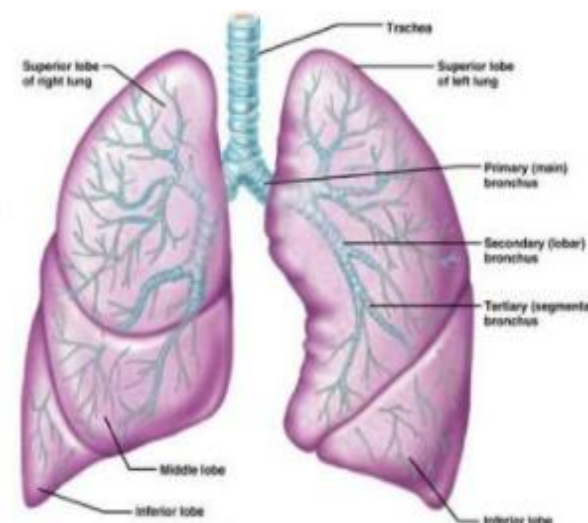
https://www.youtube.com/watch?v=hc1YtXc_84A (3:28)



Anatomy of the Lung

Respiratory Sounds:

- Bronchial sounds. Bronchial sounds are produced by air rushing through the large respiratory passageways (trachea and bronchi)
- Vesicular breathing sounds. Vesicular breathing sounds occur as air fills the alveoli, and they are soft and resemble a muffled breeze.



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The right lung has three lobes and the left has two. (Paired air exchange organs)



Some Key Definitions (not an all-inclusive list)

- **Respiratory failure:** The inability of the lungs to perform the task of “gas exchange”; the transfer of oxygen from inhaled air into the blood and the transfer of carbon dioxide from the blood into exhaled air.
- **Emphysema:** A chronic lung disease caused by damage to the alveoli, the tiny air sacs within the lung where the exchange of oxygen and carbon dioxide takes place.
- **Chronic Obstructive Pulmonary Disease (COPD):** A disorder that persistently obstructs bronchial airflow.
- **Bronchitis:** An inflammation of the lining of the bronchial tubes, which carry air to and from the lungs.
- **Hypoxia:** A deficiency in the amount of oxygen in the blood reaching the tissues.
- **Hypercapnia:** An excessive or elevated carbon dioxide in the blood.



Some Key Definitions (cont.)

- **Arterial Blood Gases:** A blood test, in which blood is taken from an artery and a measurement of oxygen and carbon dioxide in the arteries is done versus the venous blood.
- **Gas Exchange:** The function between inhaled air and blood which is external respiration.
- **Pulse Oximetry:** An oximeter that measures the proportion of oxygenated hemoglobin in the blood in pulsating vessels, especially the capillaries of the finger or ear.
- **Total lung capacity:** The maximum volume of air contained in the lung by a full forced inhalation.
- **Vital capacity:** The maximum volume of air that can be released from the lungs by forceful expiration after deepest inspiration.
- **Spirometry:** A simple breathing test administered by a health care professional that measures how much air you breathe out and how fast you can blow air out.



Physiology of COPD

- Increased airway resistance
- Decreased elastic recoil and fibrotic changes in the lung parenchyma
- Luminal obstruction of the airways by secretions
- Limited expiratory flow which promotes hyperinflation.
- COPD is the evolution of adverse functional changes associated with the airways.

Chronic Obstructive Pulmonary Disease (cont.)



- Chronic obstructive pulmonary disease, or COPD is a progressive lung disease, which gets worse over time.
- In COPD there is an obstruction in the flow of air that disturbs the normal breathing pattern; it includes pathologies such as emphysema or chronic bronchitis, or both.
- Common symptoms:
 - Cough, Shortness of breath, Wheezing, Chest tightness
- The stages of COPD are based on the forced expiratory volume or FEV1. This is the maximal amount of air someone can forcefully exhale in one second. The lower the FEV1, the more severe the disease.
- Approximately 1 in 17 American adults have COPD. Roughly 16 million Americans are diagnosed with COPD, but millions more may have COPD and not know it.

NOTE: Often see "Chronic Respiratory Failure" with COPD patients, on home oxygen.

NOTE: COPD patients can exacerbate and go into Acute Respiratory Failure quickly.



COPD Common Treatment

Treatment for COPD:

- Bronchodilators to open airways — Most come in the form of inhalers. Both short- and long-acting bronchodilators are available.
- Steroids — These reduce inflammation, swelling and mucus production. Less swelling allows more space through which air can travel. Steroids can be inhaled, taken orally or injected.
- Immunization — Centers for Disease Control and Prevention recommends that individuals with COPD get flu and pneumococcal vaccinations to help protect against complications of COPD.
- Oxygen therapy — Because COPD can lower blood oxygen levels, this treatment provides the body with the extra oxygen it needs. Home and portable oxygen can be used.

- (Source: https://www.bcbsm.com/content/dam/microsites/corpcomm/provider/the_record/2019/aug/Record_0819v.shtml)



Disease Process: COPD & Asthma

- Acute exacerbation of chronic obstructive bronchitis and asthma
- The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation.
- An acute exacerbation is a worsening or decompensation of a chronic condition.
- An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.



Physiology: Respiratory Failure

Acute

- Develops in minutes to hours
- Life-threatening
- Correlates to abnormal blood gas measurements
 - Hypoxemic
 - Lower than normal arterial O₂-deprivation
 - Lung diseases
 - Hypercapnic
 - Higher than normal PaCO₂
 - Drug overdoses
 - Severe airway disorders
 - Neuromuscular diseases

Chronic or long-term

- Develops over a period of days or longer
- Worsens over time
- Triggers need to be identified
- Correlates to superimposed infection
- Often caused by
 - Various types of COPD
 - Neuromuscular diseases
 - CF
 - Morbid obesity

Acute on Chronic

- Rapid deterioration of patients with chronic RF
- Typically
 - COPD patients
 - Neuromuscular diseases
 - Chest wall disorders
- May require long-term mechanical ventilation

Post-operative/post procedural

- Defined by need for ventilation for more than 48 hr. after surgery or intubation with mechanical ventilation post-extubation
- Comorbid risk factors:
 - Sleep apnea
 - COPD
 - CHF
 - Advanced age
 - ASA class > or = to 2
 - Pulmonary hypertension



Respiratory Failure Clinical Indicators

Acute RF

- Clinical Indicators:
 - Moderate to severe respiratory distress
 - Elevated RR (>32)
 - Use of accessory muscles
 - labored
- Breathing at rest
 - Need for intubation, continuous nebs, BIPAP, or CPAP
- Control Ventilation
 - In patients without preexisting lung disease
 - $pCO_2 > 50$ or $PO_2 < 60$ on ABG
 - Inpatients with preexisting lung
 - pCO_2 markedly elevated from baseline
 - pO_2 markedly lower than baseline

Acute Distress/Insufficiency

- Clinical Indicators
 - Mild to moderate respiratory distress
 - Elevated RR(>26)
 - use of accessory muscles
 - labored
- Breathing at rest
 - Need for continuous high flow O₂ (3-4L NC in patient without known lung disease or hypoxia)

Chronic RF

- Persistent decrease in respiratory function prior to admission
- Clinical Indicators
 - Chronic continuous home O₂
 - Chronic hypercapnia due to respiratory condition (ie: $pCO_2 > 40$)
 - Use of chronic steroids for underlying lung pathology



Clinical Background: Signs & Symptoms of Hypoxemia & Hypercapnia

Signs & Symptoms of Hypoxemia (abnormal level of oxygen – blood oxygen level)

- Dyspnea, irritability
- Confusion, somnolence, fits
- Tachycardia, arrhythmia
- Tachypnea
- Cyanosis

Signs & Symptoms of Hypercapnia (higher than normal level of carbon dioxide in the blood)

- Headache
- Change of behavior
- Coma
- Asterixis
- Papilloedema
- Warm extremities

Review the clinical documentation carefully, especially in the ED or the ICD upon admission.



Respiratory Acidosis?

Respiratory vs. Metabolic Acidosis

- The difference between respiratory and metabolic acidosis stems from which body system causes the acidosis. Respiratory acidosis happens when the PaCO_2 of the respiratory system is acidic and causes the body's pH to become acidic. Metabolic acidosis is when the HCO_3 of the metabolic system is acidic and causes the body's pH to become acidic.

Respiratory Acidosis vs. Alkalosis

- The difference between respiratory acidosis and alkalosis is how acidic or alkaline (basic) the blood is. Respiratory acidosis happens when the PaCO_2 of the respiratory system is acidic and causes the body's pH to become acidic. Respiratory alkalosis happens when the PaCO_2 levels are basic and cause the body's pH to become basic.

Source: Level Up RN

ABG's?



- **Arterial Blood Gases or “ ABGs”:**

Arterial blood gas determinations are “helpful” in determining acute respiratory failure.

- Although having ABGs is often a medical standard, a patient can meet medical criteria for Respiratory Failure without an arterial blood gas if an oxygen saturation less than or equal to 90% is identified and documented.
- In most cases, if there is a documented oxygen saturation less than or equal to 90% on room air with a physical exam showing signs of respiratory distress, the provider will often determine the diagnosis of acute respiratory failure. This will negate the need to always have an ABG.
- NOTE HOWEVER: A patient with a chronic lung disease such as COPD may have an abnormal ABG level that could actually be considered that particular patient’s baseline. ALSO NOTE: What is normal for one patient could be abnormal for another.

Coding professionals must not use ABGs solely in the diagnosis coding of acute respiratory failure, but it may help with when to query.

ICD-10-CM Official Guidelines for Coding & Reporting



ICD-10-CM Official Guidelines for Coding and Reporting FY 2023 -- UPDATED April 1, 2023 (October 1, 2022 - September 30, 2023)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2022 version
Italics are used to indicate revisions to heading changes

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

Conventions of the ICD-10-CM



1. The Alphabetic Index and Tabular List
2. Format and Structure
3. Use of codes for reporting purposes
4. Placeholder character
5. 7th Characters
6. Abbreviations
 - a. Alphabetic Index abbreviations
 - b. Tabular List abbreviations
7. Punctuation
8. Use of “and”
9. Other and Unspecified codes
 - a. “Other” codes
 - b. “Unspecified” codes
10. Includes Notes
11. Inclusion terms
12. Excludes Notes
 - a. Excludes1
 - b. Excludes2
13. Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)
14. “And”
15. “With”
16. “See” and “See Also”
17. “Code also” note
18. Default codes
19. Code assignment and Clinical Criteria



General Guidelines: Acute and Chronic Conditions

- Acute and Chronic Conditions are classified within ICD-10-CM
- If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

ICD-10-CM Chapter: Respiratory System (J00-J99)



- At the beginning of this Chapter in the tabular there are instructional notes to be followed.
- Note: When a respiratory condition is described as occurring in more than one site and is not specifically indexed, it should be classified to the lower anatomic site (e.g. tracheobronchitis to bronchitis in J40).
- Use additional code, where applicable, to identify:
 - exposure to environmental tobacco smoke (Z77.22)
 - exposure to tobacco smoke in the perinatal period (P96.81)
 - history of tobacco dependence (Z87.891)
 - occupational exposure to environmental tobacco smoke (Z57.31)
 - tobacco dependence (F17.-)
 - tobacco use (Z72.0)

Chapter 10 Respiratory System - Tabular (cont.)



- Excludes2:
- Certain conditions originating in the perinatal period (P04-P96)
- Certain infectious and parasitic diseases (A00-B99)
- Complications of pregnancy, childbirth and the puerperium (O00-O9A)
- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- Endocrine, nutritional and metabolic diseases (E00-E88)
- Injury, poisoning and certain other consequences of external causes (S00-T88)
- Neoplasms (C00-D49)
- Smoke inhalation (T59.81-)
- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)



Chapter 10

Chapter 10 of ICD-10-CM is divided into the following subsections:

- J00-J06, acute upper respiratory infections
- J09-J18, influenza and pneumonia
- J20-J22, other acute lower respiratory infections
- J30-J39, other diseases of upper respiratory tract
- **J40-J47, chronic lower respiratory diseases** ←
- J60-J70, lung diseases due to external agents
- J80-J84, other respiratory diseases principally affecting the interstitium
- J85-J86, suppurative and necrotic conditions of the lower respiratory tract
- J90-J94, other diseases of the pleura
- J95, intraoperative and postprocedural complications and disorders of the respiratory system, not elsewhere classified
- **J96-J99, other diseases of the respiratory system** ←



ICD-10-CM Tabular COPD

- J44.0 Chronic obstructive pulmonary disease with lower respiratory infection
- J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
- J44.9 Chronic obstructive pulmonary disease, unspecified

Acute care inpatient hospital MS-DRGs: Principal diagnosis code J44.9 COPD, unspecified (without a procedure), will group to any of the following three MS-DRGs (ver. 37.0):

- 190 Chronic obstructive pulmonary disease with MCC
- 191 Chronic obstructive pulmonary disease with CC
- 192 Chronic obstructive pulmonary disease without CC/MCC



ICD-10-CM Respiratory Failure

- J95.8 Other intraoperative and postprocedural complications and disorders of the respiratory system, not elsewhere classified
 - J95.81 Postprocedural pneumothorax and air leak
 - J95.811 Postprocedural pneumothorax
 - J95.812 Postprocedural air leak
 - J95.82 Postprocedural respiratory failure
 - Excludes1: Respiratory failure in other conditions (J96.-)
 - J95.821 Acute postprocedural respiratory failure Postprocedural respiratory failure NOS
 - J95.822 Acute and chronic postprocedural respiratory failure

DX DATA FREQUENCY REPORT

ICD-10-CM Respiratory Failure (cont.)



- Other diseases of the respiratory system (J96-J99)
- J96 Respiratory failure, not elsewhere classified
- Excludes1: acute respiratory distress syndrome (J80) cardiorespiratory failure (R09.2)
- Newborn respiratory distress syndrome (P22.0)
- Postprocedural respiratory failure (J95.82-)
- Respiratory arrest (R09.2) respiratory arrest of newborn (P28.81)
- Respiratory failure of newborn (P28.5)
- J96.0 Acute respiratory failure
- J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
- J96.01 Acute respiratory failure with hypoxia
- J96.02 Acute respiratory failure with hypercapnia
- Acute respiratory acidosis

There are 4 severity subclassifications

ICD-10-CM Respiratory Failure (cont.)



- J96.1 Chronic respiratory failure
- **J96.10** Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- **J96.11** Chronic respiratory failure with hypoxia
- **J96.12** Chronic respiratory failure with hypercapnia Chronic respiratory acidosis
- J96.2 Acute and chronic respiratory failure Acute on chronic respiratory failure
- **J96.20** Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- **J96.21** Acute and chronic respiratory failure with hypoxia
- **J96.22** Acute and chronic respiratory failure with hypercapnia
- J96.9 Respiratory failure, unspecified
- **J96.90** Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
- **J96.91** Respiratory failure, unspecified with hypoxia
- **J96.92** Respiratory failure, unspecified with hypercapnia

There are 4 severity subclassifications

ICD-10-CM Tabular: Respiratory Failure (cont.)



J96 Respiratory failure, not elsewhere classified

J96.0 Acute respiratory failure

- J96.00 unspecified whether with hypoxia or hypercapnia (MCC, HCC)
- J96.01 with hypoxia (MCC, HCC)
- J96.02 with hypercapnia (MCC, HCC)

J96.1 Chronic respiratory failure

- J96.10..... unspecified whether with hypoxia or hypercapnia (CC, HCC)
- J96.11 with hypoxia (CC, HCC)
- J96.12 with hypercapnia (CC, HCC)

Four primary/main ICD-10-CM classifications of Respiratory Failure: Acute, Chronic, Acute and Chronic, and Unspecified.

ICD-10-CM Tabular: Respiratory Failure (cont.)



J96 Respiratory failure, not elsewhere classified

J96.2 Acute and chronic respiratory failure

- J96.20 unspecified whether with hypoxia or hypercapnia (MCC, HCC)
- J96.21 with hypoxia (MCC, HCC)
- J96.22 with hypercapnia (MCC, HCC)

J96.9 Respiratory failure, unspecified

- J96.90..... unspecified whether with hypoxia or hypercapnia (MCC, HCC)
- J96.91 with hypoxia (MCC, HCC)
- J96.92 with hypercapnia (MCC, HCC)

Four primary/main ICD-10-CM classifications of Respiratory Failure: Acute, Chronic, Acute and Chronic, and Unspecified.



Official Guidelines: Respiratory Failure

Section I.C.10.b.3

- When a patient is admitted with Respiratory Failure and another acute condition (e.g., Myocardial Infarction, Cerebrovascular Accident, Aspiration Pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or non-respiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the Respiratory Failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (Section II.C) may be applied in these situations.
- If the documentation is not clear as to whether Acute Respiratory Failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.



Secondary Diagnosis Guidelines: Inpatient

- For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
 - clinical evaluation;
 - or therapeutic treatment;
 - or diagnostic procedures;
 - or extended length of hospital stay;
 - or increased nursing care and/or monitoring.

Only one of the criteria needs to be met in order to report/code the condition.



AHA Coding Clinic

- Numerous AHA Coding Clinic on Respiratory conditions
- Note that AHA Coding Clinic is an official resource for coding guidance
 - PER AHA: The American Hospital Association's Central Office serves as the official U.S. Clearinghouse on medical coding for the proper use of ICD-10-CM and ICD-10-PCS (formerly ICD-9-CM) coding systems and Level I HCPCS (CPT-4 codes) for hospital providers and certain Level II HCPCS codes for hospitals, physicians and other health professionals.
- NOTE: Acute respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List.

AHA Coding Clinic Guidance (cont.)



IS RESPIRATORY FAILURE THE PRINCIPAL DIAGNOSIS?

- Circumstances of admission
- Condition found after study to be chiefly responsible . . . Chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence
- If for any reason there is doubt due to a lack of clinical indicators/criteria, then that physician should be queried for clarification.

IS RESPIRATORY FAILURE A SECONDARY DIAGNOSIS?

- Secondary diagnosis: Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.
- Follow UHDDS guidance for secondary diagnosis/condition to be reported.
- If for any reason there is doubt due to a lack of clinical indicators/criteria, then that physician should be queried for clarification.

Official Guidelines ICD-10-CM Coding & Reporting



Complication

16. Documentation of Complications of Care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure unless otherwise instructed by the classification. **The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and the documentation must support that the condition is clinically significant.** It is not necessary for the provider to explicitly document the term "complication." For example, if the condition alters the course of the surgery as documented in the operative report, then it would be appropriate to report a complication code.

Query the provider for clarification if the documentation is not clear as to the relationship between the condition and the care or procedure.



AHA Coding Clinic (cont.)

- 1st Q 2017 says: “If however the patient remains on mechanical ventilation for an extended period” ...
 - What is an extended period?
 - NOTE: Mechanical ventilation is a process in which the patient’s own effort to breathe is augmented or replaced using a mechanical device.
- Extended period: the timeframe should be established by the Medical Staff Surgical Committee and may be a different timeframe for different surgeries (conditions).
 - Beyond 48 hours?
 - Beyond 36 hours
 - Beyond 14 hours?
 - Specific to certain major surgeries? (need to call this out)

AHA ICD-10-CM/PCS Coding Handbook



Some information:

- There must be a cause-and-effect relation between the complication and the procedure in the clinical documentation of the provider, in order to assign the postprocedural complication code(s).
- The coding professional cannot make the cause-and-effect determination, the physician/provider must do that.
- Query the provider for clarification when a postprocedural complication is not documented clearly.
- Was the complication (being documented) exceeding routine expectations for the surgical procedure or medical care?
- The term “complication used in ICD-10-CM does not imply that improper or inadequate care is responsible for the problem.



Integral Dx to the Surgery & Expected Postop Dx

- Ask the question regarding the respiratory failure being integral to the surgery, especially major surgery in which the patient was vented during the surgery and continued at the end of the procedure.
- Postoperative condition, is not the same as a postoperative complication.
- The documentation (wording) “postoperative” can simply mean the timeframe of the diagnosis or event, not that it is a complication.
 - On the other hand, review documentation carefully for any significant clinical indicators that may warrant a query for clarification.

WATCH: extubated in a shorter timeframe or staying on the vent for 28-30 hours, which was expected.



Integral Dx to the Surgery & Expected Postop Dx (cont.)

Trying to differentiate the 'expected' from a true “postoperative respiratory failure” complication diagnosis is difficult.

Ask the surgeon how long did they plan on the patient being vented post operatively? Think about this:

- With many neuro procedures providers want to keep the patient sedated and quiet-
 - Thus, if the patient remains on the vent greater than 48 hours but that was the plan this is not postop respiratory failure.
 - But if the plan was immediate extubation and we are now at 24 hours postop and still on the vent, you need to ask the question is WHY?*

WATCH: extubated in a shorter timeframe or staying on the vent for 28-30 hours, which was expected.



Complication of Care or Procedure

- For a true complication of care or procedure there must be a true “Cause and Effect relationship” – documented
 - Is there conflicting documentation?
- Terms such as "due to," "associated with," or "secondary to" help clarify this relationship.
- Educate your providers
- CDI and Coding staff look for specific documentation of the cause and effect – A query often is needed.

Query (Yes)



It's important to query the provider for clarification and concurrent is the best practice (conflicting information).

Example of a query you might develop or have available for both CDI and Coding staff.

Dr. XX,

DOCUMENTATION Query:

On DATE of xx/2022 documentation in the [NOTE TYPE section] of the medical record indicates the patient has [CURRENT DIAGNOSIS] and is status post SURGICAL [PROCEDURE, ie CABG, etc.].

Based on your medical judgment and review of the clinical indicators, please clarify the relationship between the DIAGNOSIS and the SURGICAL PROCEDURE.

You may answer this Query by marking the checkbox(es) below or using free text at the (*) if appropriate. Provider Query Response:*

- Incidental occurrence inherent to the surgical procedure
- Expected recovery phase diagnosis
- This SHOULD be considered a complication of the procedure
- This is NOT a complication of the procedure
- Unable to determine
- Other (please specify)* _____

The purpose of this query is to ensure accurate coding, severity of illness and risk of mortality compilation. When responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected.



You Should Query When...

- It is not clear whether Acute RF was POA;
- It is not clear what condition was responsible for occasioning the admission;
- It is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator;
- When the diagnosis of ARF drops off the chart because it is resolved - especially when there is a change in the Attending Physician;
- When the clinical indicators do not support the documented Dx.



Clinical Coding

- Black and White = yes most of the time
- Gray = yes at times
- Yes, Confusing at times
- Lots of rules and lots of exceptions to the rules
- Challenging, yes!
- Mistakes and misunderstandings and misinterpretations do happen.
- Always learning . . . Always improving!
- Coding professionals want to and strive to be exact!

IT'S ABOUT CLINICAL DOCUMENTATION AND GUIDELINES!



Coding Challenges

- ICD-10-CM Official Guidelines – clear understanding
- AHA Coding Clinic guidance – review often and discuss with Coding Staff
- ICD-10-CM Alpha and Tabular – check for inclusion terminology and instructional notes
- Documentation – need to query
- PSI (Quality)
- Audit results – rationale for findings
- Education
- CDI collaboration, cooperation and communication

IT'S ABOUT CLINICAL DOCUMENTATION AND GUIDELINES!



Denials: Respiratory Failure

- The diagnosis of Respiratory Failure, Acute has been increasing as a denial focus for payers.
- Create a grid for the clinical indicators AND key elements that should be present in the health record.
 - It's about the clinical documentation
- Writing your appeal should be clear and concise
 - Include clinical indicators within the health record
 - Include industry references, Official Guidelines, AHA Coding Clinic, NIH and CDC, etc.
- Track and trend your denials – always
 - Which payers and which diagnoses
 - % of appeals, % of won appeals



PSI 11 & MS-DRG Impact

- Patient Safety Initiative: PSI 11 Postoperative Respiratory Failure – elective surgery (ie., CABG) see - https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/v2020/TechSpecs/PSI_11_Postoperative_Respiratory_Failure_Rate.pdf
 - Dx included: Postoperative respiratory failure (secondary diagnosis), prolonged mechanical ventilation, or reintubation cases per 1,000 elective surgical discharges for patients ages 18 years and older
 - Acute respiratory failure diagnosis codes: ICD-10-CM J95.821 Acute postprocedural respiratory failure Or ICD-10-CM J95.822 Acute and chronic postprocedural respiratory failure
- MS-DRG reimbursement impact with an MCC from “Postoperative Respiratory Failure” Dx – single MCC.
 - Relative weight increases with MCC
 - OIG is focusing on a single MCC for an MS-DRG encounter



Selecting the Principal Diagnosis

Try to determine whether the condition/disease should be assigned as the principal diagnosis or not, look for:

- All signs and symptoms at the time of admission or the **circumstances of admission**
- Clinical indicators
- Supporting physician documentation
- MD Orders
- Treatment plans
- Impression (not just the condition listed first in the documentation)

NOTE: A diagnosis of COPD may be assigned as a principal diagnosis and one should review carefully the circumstances of admission for a hospital inpatient encounter. Also apply the definition of a principal diagnosis, “when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List”. However, chapter specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

Selecting the Principal Diagnosis (cont.)



- **Apply the definition of Pr Dx: *The condition found after study to be chiefly responsible for the admission to the hospital for care.***
 - *Circumstances of admission!*
 - *Documentation!*
- **Keep in mind that because a condition may be present on admission does not necessarily mean it qualifies for principal diagnosis.** Elderly patients can often have multiple conditions active at the same time, especially when they have “Respiratory Failure”.
- **As a Coding and/or CDI Professional ask yourself these questions:**
 - What were the circumstances of admission?
 - After the study, is this the condition that was chiefly responsible for admission?
 - How aggressive was the work-up and treatment?
 - Is there another condition that equally meets the criteria for principal diagnosis?
 - Are there any chapter specific guidelines to consider?
 - Could this condition have been treated as an outpatient i.e. observation or via office visits?
 - Repeat these questions after you’ve selected the Princ Diagnosis, double check and confirm.



What is “Circumstances of Admission?”

- At the time in which the patient is being ordered to be admitted or is being admitted review closely the physician orders, the plan of care, intensity of services and treatment being provided.
 - Look closely at the Emergency Room documentation and clinical indicators, and check the timeline closely, as the patients condition can rapidly change.
 - Look over the intensivists or consultant documentation upon admission to the ICU
- Ask yourself what is the thrust of care and main focus?



Case Scenario #1

- 70 year old male significant past medical history of COPD with multiple intubations in the past for exacerbations who presents today with shortness of breath.
- Upon arrival in ER general assessment noted: Pulmonary/Chest: Accessory muscle usage present. No apnea, no tachypnea and no bradypnea. He is in respiratory distress. He has decreased breath sounds. Venous Blood Gases: pH 7.33, pCO₂ 52 and pO₂ 46. Patient required methylPREDNISolone PF (Solu-MEDROL) injection 40 mg and BiPAP. Respiratory therapy. Temp is 99.6.
- Documentation on H&P and first progress note: COPD w acute exacerbation and hypoxia.
- LOS 2 days.

WHAT WOULD YOU CODE AS THE PRINC DX?



Case Scenario #2

A 78-year-old male patient with known COPD and uses a nebulizer regularly who was experiencing increased SOB and came to the ER. In the ER the patient was found to be wheezing, SOB and hypoxic and has a history of smoking for 30 years, none now.

Due to the respiratory status, ABGs were drawn and were abnormal. RT came and treated the patient at bedside with slight improvement, orders for a 2nd RT treatment ordered. Re-evaluation was performed and the patient was still wheezing and having difficulty breathing. The patient was needing inpatient care. The decision was made to admit the patient to the ICU with respiratory failure due to severe exacerbation of COPD.

A pulmonary consultant is involved. Hospital treatment includes IV antibiotics, steroids, oxygen, pulse oximetry, and aggressive respiratory therapy modalities. Two days in ICU, then to the floor for 2 days and ready for discharge to Home Health.

The physician lists COPD with acute exacerbation with respiratory failure in the discharge summary together.

What is the principal diagnosis?



Next Steps...

- Coding and CDI collaboration, cooperation and communication (the 3 C's)
- Coding compliance and accuracy is not an aspiration, it must be a reality
- Assess your clinical documentation
- Track and trend your denials, esp. for Respiratory Failure Dx
- Know what your PSI 11 data looks like; discuss with quality
- Awareness and education to providers is vital to provide
- Ongoing and continuous education for Coding and CDI is also pivotal
- Review your queries (at least annually, but more often may be necessary)
- Conduct reviews/audits



Summary

- Knowledge of A&P and disease processes are a continuous process for Coding and CDI
 - Enhance your clinical knowledge
- Review the Official Guidelines closely
- Review carefully the AHA Coding Clinic
- Respiratory Failure and associated conditions should be documented clearly and accurately
- Cause and Effect relationship within the clinical documentation must be obtained – a query is often needed



Common Respiratory Abbreviations

- ABG Arterial blood gas
- A/C A mechanical ventilation mode, assist/control
- AMV Assisted mechanical ventilation
- APRV Airway pressure release ventilation
- ARDS Acute Respiratory Distress Syndrome
- ARF Acute Respiratory Failure
- BiPAP Bi-Level positive airway pressure
- CaO₂ Arterial oxygen content
- CC Closing capacity
- CMV Continuous mechanical ventilation (specific rate for apneic patients)
- CO Carbon Monoxide
- CO₂ Carbon Dioxide
- CPAP Continuous positive airway pressure
- ECMO Extracorporeal membrane oxygenation
- EPAP End positive airway pressure

Common Respiratory Abbreviations (cont.)



- ETS Endotracheal suction
- FEF Forced expiratory flowrate
- FVC Forced vital capacity
- IPPB Intermittent positive pressure breathing
- IMV Intermittent mandatory ventilation (vent breaths delivered between the patient's spontaneous breaths)
- IPS Inspiratory pressure support
- NPPV Noninvasive positive pressure ventilation
- PA Alveolar pressure, Pulmonary artery, Posterior-anterior
- PaACO₂ Arterial-alveolar carbon dioxide partial pressure difference
- PAaO₂ Alveolar-arterial oxygen partial pressure difference
- PAO₂ Is obtained from alveolar gas equation
- PaO₂ Is obtained from the ABGs
- PAP Pulmonary artery pressure, Positive airway pressure

Common Respiratory Abbreviations (cont.)



- Peak expiratory flow: Measurement of the ability to blow air out of the lungs that is used to diagnose asthma
- PEEP Positive end expiratory pressure (delivered at end of exhalation) (ARDS patients)
- PEP Positive expiratory pressure, Peak expiratory pressure
- PIMV Pressure intermittent mandatory ventilation
- PRVC Pressure Regulated Volume Control (Mechanical ventilation)
 - Pressure-limited
 - Time cycled – Adaptive Pressure Ventilation (Galileo) – Autoflow (Evita 4)
 - Automatically adjusts pressure support level to the minimum needed to maintain constant set TV.
- PO2 Oxygen partial pressure
- PSV Pressure Support Ventilation
- SaO2 Arterial oxygen saturation
- SIMV Synchronized intermittent lung ventilation (mechanical ventilation)



References

- *Just Coding* HCPro, Coding *Clinic*, Official Coding Guidelines 2017, Robert Stein, MD, CCDS and Shannon Newell, RIA, CCS, *Briefings on Coding Compliance Strategies*
- [ICD-10-CM Guidelines FY 2023 \(cms.gov\)](#)
- [Q&A: Respiratory documentation FAQs | ACDIS: https://acdis.org/articles/qa-respiratory-documentation-faqs](#)
- AHA ICd-10-CM Coding Clinic
- <https://theecmconsultant.com/what-is-collaboration/>
- [ABG Interpretation for Nurses - Respiratory Acidosis – LevelUpRN](#)
- Acute Respiratory Failure - All There Is To Know | Read more (pinsonandtang.com)



Thank You!

If you have any questions, please contact: connect@mrahis.com