Physician advisors
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look poor on paper, as well as on Web sites such as www.hospitalcompare.com, which compares expected versus observed rates of mortality. “What hit the physicians was when we saw that you could go to the Internet and pull up various Web sites, and compared to other physicians in the same community, we didn’t look very good, when in fact we knew they were darned good physicians,” Pappas says.

Serving as a champion

Loma Linda is a four-hospital system, so Pappas placed a physician champion in each hospital, including two in the university hospital. Each champion, referred to as a multidisciplinary quality committee chair, attended a daylong training session that included coding and documentation education.

Part of Pappas’ role is to follow up with reluctant ordering physicians who don’t respond to queries. “It can be a yes or a no response, but what you don’t want is a nonresponse,” he says. For those departments whose physicians don’t respond to queries, Pappas develops solutions to increase their response rate. For example, surgery hasn’t had nearly as much success as medicine, and Pappas is currently working to help educate that group.

“We had to do that [additional work] with surgery because surgery didn’t get their residents to the education sessions,” he says, noting that Loma Linda’s residents issue 90% of the orders. Pappas says the hospital also employs a large group of residents who began their residency in July. Newly employed residents can pose a challenge, he says, because they are unfamiliar with the CDI program. “Any place with teaching residents is going to have to reteach that group every year,” he says.

Pappas says a physician champion should be someone who is respected, influential, and well-known in the institution. “It’s not necessarily any particular specialty, it’s more person-dependent,” he says. “That’s what works here really well.”

Pappas says his role as physician advisor was initially time-consuming due to several kickoff meetings when the program began. However, he opened a clinical documentation section within the quality improvement department and has since received assistance from a clinical documentation nurse specialist who provides most of the physician education.

“[The time commitment] varies, based on the size of your institution and how well-functioning your CDI department is,” Pappas says. “At first, it was a sizable chunk of my day, but now, it’s starting to take off on its own.”

Pappas is salaried by the hospital as its vice president of quality and patient safety, a position that includes his duties as a physician champion. The other four hospital-specific physician champions are paid 40 hours per month of their particular specialty’s hourly pay.

Loma Linda’s three CDI specialists review 60%–70% of all Medicare claims. The hospital has also given approval for the addition of a fourth specialist due to the early successes. “The financial benefits have been profound in the short-term,” Pappas says, noting that the cost of the consulting firm has already been paid for.

Respiratory failure: Recognize clinical indicators and query opportunities to capture this difficult diagnosis

by William E. Haik, MD

Respiratory insufficiency. Hypoxemia. Respiratory distress. Its names are numerous and, unfortunately, often result in nonspecific codes and inaccurate DRG assignment. The offender: respiratory failure.

Respiratory failure is problematic for CDI specialists and coders for several reasons, including the following:

» Definition (confusion about what constitutes respiratory failure)
» Sequencing (when to sequence respiratory failure as a principal diagnosis)
» Documentation (how to combat insufficient or nonspecific documentation that includes terms such as respiratory insufficiency, hypoxemia, and respiratory distress)
Define respiratory failure carefully

Respiratory failure confuses specialists and coders because the term originally appeared in Chapter 16 (“Symptoms, Signs, and Ill-Defined Conditions”) of the ICD-9-CM Manual. This placement meant that the condition was viewed as a symptom, and coders could not report it as a principal diagnosis. In 1987, the National Centers for Health Statistics assigned a new code for acute respiratory failure, 518.81, which resulted in the movement of the diagnosis from Chapter 16 of the ICD-9-CM Manual to Chapter 8 (“Diseases of the Respiratory System”).

Subsequent to this change, the confusion centered on how to define respiratory failure and in what circumstances coders could report it as the principal diagnosis. In an effort to qualify all remaining questions regarding respiratory failure, multiple articles appeared in the AHA’s Coding Clinic for ICD-9-CM.

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Sequence acute respiratory failure correctly

Properly sequencing acute respiratory failure has gotten considerably easier over the years; however, there are several Coding Clinic references of which CDI specialists and coders should be aware. The ICD-9-CM Official Guidelines define a principal diagnosis as “that condition established after study as being chiefly responsible for occasioning the admission of the patient to the hospital for care.” Report acute respiratory failure as a principal diagnosis under the following circumstances:

- When the cause of the respiratory failure is not identified. This might occur when the patient expires or is transferred shortly after admission. Do not report acute respiratory failure as the principal diagnosis when there is a chapter-specific coding guideline (e.g., sepsis, obstetrics, poisoning, HIV, newborn) or an alphabetic index or tabular directive that takes precedence over the general respiratory failure guidelines and examples. For example:
  - Acute respiratory failure secondary to Pneumocystis carinii pneumonia in a patient with HIV. Report HIV (code 042) as the principal diagnosis.
  - A patient is admitted with acute respiratory failure secondary to Valium overdose. Report the Valium overdose as the principal diagnosis.
  - A patient is admitted with aspiration pneumonia with associated sepsis and acute respiratory failure. Report the sepsis as the principal diagnosis.

Coders and CDI specialists typically choose respiratory failure as a principal diagnosis when it is associated with another acute condition that is equally responsible for occasioning the patient’s admission to the hospital. However, certain underlying respiratory conditions have a higher weight than respiratory failure (e.g., aspiration pneumonia) and would likely be sequenced first.

Respiratory failure
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In summary, Coding Clinic articles state that you can suspect respiratory failure based on the following facts:

» Respiratory failure is a condition categorized by inadequate exchange of oxygen and/or carbon dioxide by the lungs.

» Respiratory failure is a life-threatening disorder that requires close patient monitoring and evaluation with aggressive management. To treat it, physicians place the patient in a monitored bed and initiate aggressive respiratory therapy and/or mechanical ventilation. Treatments can include frequent oxygen level checks, nebulization of bronchodilators, antibiotic treatment, and intubation.

» A patient with acute respiratory failure usually presents with evidence of increased work of breathing. Typical symptoms include a rapid respiratory rate and use of accessory respiration muscles (e.g., intercostal muscle retraction, paradoxical breathing, or cyanosis).

Note that patients do not have to be intubated or on mechanical ventilation to have respiratory failure. Physicians can treat respiratory failure using noninvasive methods such as continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP). These treatments involve a face mask strapped to the patient’s mouth to provide oxygen, keep the lungs open, and prevent lung collapse. Neither CPAP nor BiPAP require the patient to be intubated; however, both can indicate respiratory failure. Of course, patients who are on mechanical ventilation are in respiratory failure.

Don’t forget to look at lab values

CDI specialists should review laboratory notes for evidence of respiratory failure.

For example, the following arterial blood gas determinations (a process whereby a needle is inserted into the artery to measure oxygen and carbon dioxide levels, as well as the alkalinity/acidity of the blood) are helpful in determining acute respiratory failure.

Note that lab values for respiratory failure differ between a patient whose lungs were previously normal versus one whose lungs were previously abnormal, such as a patient who is suffering from chronic obstructive lung disease.

Specialists can identify respiratory failure in a patient whose lungs were previously normal (i.e., no preexisting lung disease) by using the following criteria:

» \( P_{O2} < 60 \text{ mmHg} \)

» \( P_{CO2} > 50 \text{ mmHg} \)

However, most patients who present to the hospital in acute respiratory failure do not have normal lungs. These patients typically have a chronic disease of the lung with an acute insult (e.g., pneumonia or bronchitis) that leads to respiratory failure.

Specialists can identify acute respiratory failure in a patient with previously abnormal lungs using either of the following criteria:

» \( \text{pH} < 7.35 \text{ with a } P_{CO2} > 50 \text{ mmHg} \)

» A change in the \( P_{O2} < 60 \text{ mmHg} \) representing a drop of 15 mmHg from the previous normal \( P_{O2} \)

The arterial blood pH (rather than the \( P_{CO2} \)) is generally more useful for determining respiratory failure for patients who have chronic lung disease. Patients with chronic lung disease...
typically always have slightly elevated $P_{CO_2}$ levels and low $P_{O_2}$ levels; however, they have acclimated to the low oxygen level.

Specialists can use $P_{O_2}$ levels for determining the possible presence of respiratory failure, but it’s not an easy parameter to measure, since they must first know the patient’s baseline. For example, when a specialist knows that the patient’s baseline $P_{O_2}$ is 60, a drop of 15 mmHg to 45 mmHg could constitute respiratory failure.

Note that physicians are responsible for final documentation in the medical record. However, it’s the responsibility of the CDI specialist and/or the coder to validate the diagnoses.

**Watch for indefinite documentation**

Respiratory failure documentation problems are typically twofold.

Many physicians don’t document “acute respiratory failure” when the patient has acute respiratory failure, and many physicians document terminology that they think is synonymous with acute respiratory failure, although ICD-9-CM doesn’t define the condition using those terms.

For example, a physician may document pneumonia with severe hypoxemia when he or she actually meant to document respiratory failure in the medical record. However, the coder must code hypoxemia. Although this condition has its own ICD-9-CM code (799.02), it doesn’t qualify as a CC or MCC. Another common scenario is when the physician documents acute respiratory insufficiency or acute respiratory distress, which have their own codes, when in fact the patient might be in acute respiratory failure. Terminology such as this should always prompt a query by the CDI specialist or coder.

Editor’s note: Haik, a former editorial advisory board member for Coding Clinic, wrote the guidelines defining respiratory failure in that publication. He is the director of DRG Review, Inc., in Fort Walton Beach, FL, where he has practiced medicine since 1980. He has received board certification in internal, pulmonary, and critical care medicine.

Haik served on the editorial advisory board of AHA Coding Clinic for ICD-9-CM from 1988–1992 and subsequently on the expert advisory panel. Presently, he serves on the Hospital Payment Monitoring Program of the Florida Quality Improvement Organization. You can reach him via e-mail at DRGreview@aol.com.