Ask ACDIS

Know when to query for pulmonary insufficiency after trauma/surgery vs. postop acute respiratory failure

Are there any coding guidelines/definitions regarding code 518.5 (Pulmonary insufficiency following trauma and surgery) vs. the use of 518.81 (Acute respiratory failure postop)? If a physician documents postop respiratory failure, which code should we report? I looked in Coding Clinic and found a definition for acute respiratory failure, but I don’t see a definition/guideline for 518.5. Any help would be greatly appreciated.

As a general rule, any respiratory failure that occurs after surgery codes to 518.5 unless the physician specifies an underlying cause due to a medical condition (e.g., chronic obstructive pulmonary disease) or medication (e.g., morphine). This is based on advice in Coding Clinic, Fourth Quarter 1987, pp. 1–3, which states the following:

Respiratory failure, 518.81, may be designated as principal diagnosis if it led to hospital admission, or it may be listed as an associated condition if it occurs after admission.

Note from 3M: As of October 1, 1998, respiratory failure has been further specified to indicate acute respiratory failure (518.81), chronic respiratory failure (518.83), and acute and chronic respiratory failure (518.84).

Code 518.5 is assigned when respiratory failure occurs following surgery or trauma. (Emphasis added.)

Respiratory failure is a life-threatening condition. It is usually regarded as being acute in nature and may occur in the presence of either chronic lung disease or in previously normal lungs. Respiratory failure is severe derangement of the body’s exchange of oxygen or carbon dioxide or both. Detection requires the measurement of these gases in arterial blood. Common causes of respiratory failure are:

» Alveolar hypoventilation in normal lungs related to trauma, drug overdose, neurologic diseases (such as multiple sclerosis or nontraumatic intracranial hemorrhage or infarction), neuromuscular diseases, or respiratory muscle diseases (such as congenital chest abnormalities or muscular dystrophy), and direct chest trauma or other injuries indirectly affecting the lungs.

» Injury to small capillary and alveolar walls resulting in adult respiratory distress syndrome, and due to smoke inhalation, near-drowning, some pesticides, and previous infections.

» Chronic obstructive lung disease, which is most often seen with chronic emphysema and bronchitis.

» Chronic intrinsic restrictive lung disease (CIRLD) that is characterized by stiffness of the lung tissue resulting from changes in the lung’s intrinsic elastic properties. CIRLD encompasses more than 100 diseases that share the characteristics of stiffness and chronicity, such as hypersensitivity pneumonitis and pneumoconiosis.

» Acute major loss of pulmonary vascular bed associated with massive pulmonary embolism.

Note that codes 518.81 or 518.84, when not reported as present on admission, count as Patient Safety Indicators (PSI) for applicable surgeries under Agency for Healthcare Research and Quality (AHRQ) criteria (PSI 11). Code 518.5 is not included in PSI 11. (Learn more at the AHRQ website: www.tinyurl.com/ahrqpsi11.)

If the physician documents “postop respiratory failure,” the coder may assign 518.5, Pulmonary insufficiency following trauma and surgery, based on the Coding Clinic advice referenced above.

If explicitly linked to the surgery, this is supported by the ICD-9-CM Index, which states the following:

Failure
Respiratory
Due to trauma, surgery or shock — 518.5

Note that the title of 518.5, “Pulmonary insufficiency following trauma and surgery,” is a source of confusion. The title only includes “pulmonary insufficiency,” not “respiratory failure,” following trauma and surgery. In fact, respiratory failure is not listed as an inclusion note under code 518.5 at all. The only mention of it is in the exclusion, which states, “respiratory failure in other conditions (518.81, 518.83–518.84).”

This excludes note does not prevent a coder from using code 518.5 for respiratory failure due to surgery, but it does...
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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://hsup-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