Ask ACDIS

Parsing documentation for opportunities related to postoperative pneumonia and respiratory complications

Q: What is the correct code assignment for a diagnosis of postoperative aspiration pneumonia? ICD-9-CM's Tabular List under code 997.39 provides the following inclusion terms: “Pneumonia (aspiration) resulting from a procedure.” However, the instructional note under category 997 states, “Use additional code to identify complication.” Should we assign code 997.39, Respiratory complications, Other respiratory complications, along with code 507.0, Pneumonitis due to solids and liquids, due to inhalation of food or vomitus, to describe postsurgical aspiration pneumonia?

I am working on our anesthesiologist’s documentation template in the post-anesthesia care unit. Instead of using “respiratory event,” I had hoped we could identify acute respiratory failure and link the failure to the cause (i.e., chronic obstructive pulmonary disease, congestive heart failure, neuromuscular diseases) or complication of the surgery (i.e., accidental tear to pulmonary organ, pneumonitis due to the anesthesia). My rationale was that if the provider linked the acute respiratory failure to an underlying respiratory condition, it would not be considered a surgical complication.

However, my coding resource states the cause doesn’t matter and that it will still code to a complication due to the fact that the condition occurred in the postoperative period and the ICD-9 Tabular Index takes the coder to 518.51 instead of 518.81 (if linked to other actual cause). My fear is that if I revise the template and add more specific diagnoses, the coding will only reflect complications.

A: Complication codes are tricky. The coding guidelines require documentation of a cause and effect relationship as well as an “indication” of a complication before these codes can be used. Many people disagree about what constitutes an indication of a complication.

We have two possible codes to address the situation in ICD-9-CM. The most accurate code 997.32, post procedural aspiration pneumonia, which can also be described as “chemical pneumonitis resulting from a procedure.” An additional code to specify aspiration pneumonia would not be used. However, code 997.39, other respiratory complications would require another code to further specify the type of respiratory complication. ICD-10-CM has the ability to be more specific about the type of respiratory complication within the code itself. (Read more about this in a related article on p. 10.) It includes following codes:

- J95.1, Acute pulmonary insufficiency following thoracic surgery
- J95.2, Acute pulmonary insufficiency following nonthoracic surgery
- J95.3, Chronic pulmonary insufficiency following surgery
- J95.4, Chemical pneumonitis due to anesthesia (e.g., Mendelson’s syndrome, postprocedural aspiration pneumonia)

Coding Clinic may provide more guidance following ICD-10-CM implementation to ensure consistency across organizations. You may want to change your form to reflect the documentation needed to support ICD-10 coding, as it often takes a while for a new form to be approved and used. You don’t want to have to create another one once ICD-10 is implemented.

It sounds like your facility may have additional concerns here regarding the patient safety indicator of acute postoperative respiratory failure (PORF).

To avoid any negative implications, you need to know which codes trigger this quality metric, and why, to make sure these conditions are accurately reflected when they occur. Codes associated with this measure will become part of the Hospital Value Based Purchasing in fiscal year 2015.

The goal of this metric is to identify postoperative respiratory failure (as a secondary diagnosis), mechanical ventilation, or reintubation cases per 1,000 elective surgical discharges for patients ages 18 years and older and excludes...
the following:

» Cases with principal diagnosis for acute respiratory failure, cases with secondary diagnosis for acute respiratory failure present on admission

» Cases in which tracheostomy is the only operating room procedure or in which a tracheostomy occurs before the first operating room procedure

» Cases with neuromuscular disorders, laryngeal or pharyngeal surgery, craniofacial anomalies that had a procedure for the face, esophageal resection, lung cancer, or degenerative neurological disorders

» Cases with a procedure on the nose, mouth, or pharynx

» Cases with respiratory or circulatory diseases

» Obstetric discharges

CDI specialists should look to ensure the present on admission indicator is accurate on these cases. In the example you provide, for instance, the acute respiratory failure was present on admission so it would not trigger this quality metric.

Revise your query form to reflect diagnoses that can be coded accurately. “Respiratory event,” for example, is not a diagnosis and does not support the use of hospital resources.

Have the provider link the acute respiratory failure to its cause to capture data used in the National Surgical Quality Improvement Program (a surgical quality database) even though it may not be reflected in coding.

Elective surgical discharges are defined by specific DRG or MS-DRG codes with admission type recorded as elective. Often the assignment of a procedure as elective is arbitrarily done by registration so have a process that clearly identifies the type of surgery.

The numerator for this metric (e.g., the volume of cases which can be classified as a PORF) considers discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either:

» Any secondary ICD-9-CM diagnosis code for acute respiratory failure; or

» Any-listed ICD-9-CM procedure codes for a mechanical ventilation for less than 96 consecutive hours (or undetermined) that occurs two or more days after the first major operating room procedure code (based on days from admission to procedure); or

The denominator, or total population being measured, includes elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM procedure codes for an operating room procedure.

The reality is that none of these acute respiratory failure codes (518.*) are “complication codes,” as in ICD-9-CM the respiratory complication code is really 997.39, other respiratory complication, which should be reported if the acute respiratory failure is linked to the procedure or 997.32 as discussed above.

The quality metric of PORF is considered a “complication” by the Agency for Healthcare Research and Quality (AHRQ) but is not considered a “complication code,” which is why it is so confusing.

There are specific guidelines of when a complication code can be assigned—there has to be a cause-and-effect link between the condition and the medical intervention, and the provider has to consider it a complication. It cannot be assumed that everything that happens postoperatively is a complication.

The AHA’s Coding Clinic for ICD-9-CM, First Quarter 2011, addresses the matter, indicating that code 997.39 would be reported with the applicable acute respiratory failure code to specify the type of respiratory complication. This is a very complex topic, which will become even more relevant as time goes on.

EDITOR’S NOTE
Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director for HCPro, answered this question. Contact her at cericson@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit www.hcprobootcamps.com/courses/10040/overview.