Fourth Quarter highlights include mechanical ventilation, principal procedure sequencing

by Sharme Brodie, RN, CCDS

The AHA wrapped up its Coding Clinic for ICD-10-CM/PCS advice for 2014 by answering a lot of questions regarding the coding of surgical procedures/interventions—a trend we’ve seen over the last several issues of the publication. Let’s take a look at some of the most interesting areas discussed.

Counting the hours

To start things off, Coding Clinic offered clarification regarding the duration of time a patient is on mechanical ventilation. ICD-10 gives us more options to describe the time frame than ICD-9, including:

- Less than 24 hours
- 24–96 hours
- Greater than 96 hours

The counting of hours starts with one of the following;

- Endotracheal intubation (and subsequent initiation of mechanical ventilation)
- Initiation of mechanical ventilation through a tracheostomy
- Admission of a previously intubated patient or a patient with a tracheostomy who is on mechanical ventilation

Ventilator support provided to a patient during a surgery is considered an integral part of the surgical procedure and is not coded separately, Coding Clinic states.

If, however, the patient remains on mechanical ventilation for an extended period (several days) postsurgery, the mechanical ventilation should be reported. The removal and immediate replacement of an endotracheal tube (in situations such as mechanical problems, like leaking of the cuff) should be counted as part of the initial duration.

When a patient is being weaned from the mechanical ventilation, the entire duration of the weaning process is counted. This process may take several attempts and includes the time a patient is on the ventilator, the actual weaning, and the ending, when the patient is extubated and the mechanical ventilation is turned off (after the weaning period).

Not all patients require a weaning period and there are times, depending on the method used for weaning, that the mechanical ventilator will not be in use but is still considered part of the weaning process.

For example, Coding Clinic explains that for a patient admitted to a long-term acute care facility on a T-piece or tracheostomy collar the day of transfer, and is placed on mechanical ventilation that evening, the clock would start at the time of admission, because all the time during the weaning period gets counted.

Internal facility policies cannot be used to extend the weaning process, Coding Clinic states, and once mechanical ventilation is shut off, it would be inappropriate to continue to count ventilator hours, even if the patient is continuously being monitored per facility protocol.

Coding Clinic also addressed the timing associated with the use of continuous positive airway pressure via a tracheostomy, which would be coded to respiratory ventilation and the exact code determined by the number of hours. The coding of bilevel positive airway pressure (BiPAP), per Coding Clinic, depends on the method of delivery—i.e., whether it is invasive (tracheostomy) or noninvasive (a patient that is not intubated).

If the patient receives treatment via a tracheostomy or T-tube, the coder can assign a code for mechanical ventilation and the number of hours in use. If noninvasive, then the coder would assign a code for ventilation support, assistance, and again the number of hours would determine the exact code.

Should the patient require subsequent ventilation during the same hospital stay, then each episode of continuous
mechanical ventilation would be coded separately, and the clock restarted from the beginning of each period of intubation. Physicians should document whether an endotracheal tube is placed orally or nasally for coders to properly code the procedure, so tube placement could be an area where a CDI specialist reviewing the record concurrently could assist.

**Sequencing of procedures**

This issue of *Coding Clinic* describes new rules governing sequencing of the principal procedure per the ICD-10-PCS *Official Guidelines for Coding and Reporting*, which states:

- When there is a procedure performed for definitive treatment of both a principal and secondary diagnosis, sequence the procedure performed for definitive treatment most related to the principal diagnosis as the principal procedure.
- When a diagnostic procedure is performed for the principal diagnosis and a procedure for definitive treatment of a secondary diagnosis, sequence the diagnostic procedure as the principal procedure because the procedure most related to the principal diagnosis takes precedence.
- When there are no procedures (definitive or non-definitive) performed related to the principal diagnosis, sequence the procedure performed for definitive treatment of a secondary diagnosis as the principal procedure.
- If more than one procedure is performed and documentation is unclear as to which one is more significant, query the provider.

Most of this *Coding Clinic* explored the coding of specific procedures, and is less relevant, but it offered some general information helpful to understanding PCS code. This includes the following:

- Guideline B4.1 which states that when a body part is prefixed with “peri,” the procedure should be coded to the body part named—i.e., “perirenal” is coded to kidney body part. This guideline only applies when a more specific body part value is unavailable.
- An accidental retention of a foreign body following surgery is classified as a complication even when there is no immediate problem resulting from the retained foreign body.
- When debridement is performed along with a surgical procedure, the physician should be queried to determine whether the debridement should be coded separately or if it is part of the original surgical procedure.
- “Radical” procedures can have different meanings depending on the procedure. In ICD-10-PCS, Guideline B3.2a states that if during the same operative session the same root operation is repeated at different body sites that are defined by distinct values of the body part character, multiple procedures should be coded.
- Guideline B3.1b clarifies that procedural steps necessary to close the operative site, including anastomosis of a tubular body part, are not coded separately. This guideline would apply regardless of whether the procedure is an end-to-end or a side-to-side anastomosis.
- The root operation “control” is only used when the intent of the procedure is to stop postprocedural bleeding. The root operation “control” is only available in the general anatomic regions.
- When a combination of drugs is administered during a single injection and the facility desires to collect this information, the introduction of both substances may be coded.

**Sepsis revisited**

*Coding Clinic* also revisited advice regarding non-Candida albicans sepsis, stating that if Candida sepsis of any type is present, coders should assign code B37.7, Candidal sepsis. If the causal organism is not Candida at all, assign code B48.8, other specified mycoses. 🍅

**Editor’s note:** Brodie is a CDI education specialist for HCPro in Danvers, Massachusetts. Contact her at sbrodie@hcpro.com. For information regarding CDI Boot Camps offered by HCPro, visit [www.hcprobootcamps.com](http://www.hcprobootcamps.com).