



ACUTE RESPIRATORY FAILURE

Acute respiratory failure documentation and coding has long presented a challenge for coders. Unfortunately, there is not a simple, single answer on when to query, when to code, what clinical factors to look for, or instructions on how to sequence.

The following information should all be considered when coding respiratory failure.

CHART DOCUMENTATION

What does the chart documentation tell us?

CLINICAL INDICATORS

Look for evidence the patient is working to breathe:

- Circumoral cyanosis
- Nasal Flaring
- Pursed Lip Breathing
- Unable to Speak in Full Sentences
- Accessory Muscle Use
- Tripod Position
- Impending Sense of Doom/Anxiety
- Altered Mental Status
- Audible, Diminished or Absent Breath Sounds

DIAGNOSTIC VALUES

Keep in mind that anyone with asthma, COPD, CHF or pneumonia...may have abnormal arterial blood gases (ABGs) on a normal day.

Some diagnostic values to be aware of:

Respiration rate

pH <7.35

pH >7.35

pCO₂

pO₂

O₂ saturation

P/F Ratio

<300 = acute lung injury, mild ARDS acute respiratory failure

<250 = severe respiratory failure

<200 = moderate ARDS, extreme respiratory failure

<100 = severe ARDS

ACP Hospitalist

Acute respiratory failure is defined by any one of the following:

- pO₂ <60 mm Hg or SpO₂ (pulse oximetry) <91% breathing room air
- pCO₂ >50 and pH <7.35
- P/F ratio (pO₂ / FIO₂) <300
- pO₂ decrease or pCO₂ increase by 10 mm Hg from baseline (if known)

TREATMENT:

Look for:

O₂ Support including Delivery System

CPAP

BiPAP

Airway/Ambu Bag

Intubation/Mechanical Ventilation

Other: _____

2021 ICD-10-CM ACUTE RESPIRATORY FAILURE GUIDELINES

Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis

A code from subcategory J96.0, Acute respiratory failure, or subcategory J96.2, Acute and chronic 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. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

When considering acute respiratory failure as principal diagnosis, be sure to think of the acronym SOAP. With the SOAP acronym situations, respiratory failure will “never” be the principal diagnosis.

S – sepsis

O – obstetrics

A – AIDS/HIV disease

P - poisoning

2) Acute respiratory failure as 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.

3) Sequencing of acute respiratory failure and another acute condition

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 nonrespiratory 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.

2021 ICD-10-CM SELECTION OF THE PRINCIPAL DIAGNOSIS GUIDELINES

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as ***“that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”***

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time, the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.). The UHDDS definitions also apply to hospice services (all levels of care).

In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines.

(See Section I.A., Conventions for the ICD-10-CM)

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

CODING CHALLENGE: Is the acute respiratory failure POA and the principal diagnosis?

CHART DOCUMENTATION:

ED Day 1 – COPD exacerbation.

On CPAP, speaking in full sentences, no accessory muscle use noted, tachypneic, diminished breath sounds at the bases with wheezes diffusely.

Only ABGs done in ED:

pCO₂: 41. mmHg, pH: 7.38, pO₂: 73 mmHg

H&P Day 2 – acute and chronic COPD exacerbation, chronic respiratory failure

Vitals & Measurements T: 36.6 °C (Temporal Artery) TMIN: 36.6 °C (Temporal Artery) TMAX: 36.8 °C (Temporal Artery) HR: 103(Monitored) RR: 18 BP: 135/80 SpO₂: 99%

Pulmonary Consult -Day 2

	<u>Vital Signs (Time)</u>
Temperature	37 (14:30)
Systolic Blood Pressure	126 (14:30)
Diastolic Blood Pressure	72 (14:30)
Pulse	110 (14:30)
SpO ₂	99 (10:25)
Respiratory Rate	18 (10:26)

Assessment:

1. Acute on chronic hypoxic respiratory failure with increased need of O₂ supplementation.
2. Acute COPD exacerbation/asthma exacerbation [acute allergic bronchitis], with acute bronchitis

Plan:

1. Respiratory treatments and oxygen supplementation to maintain a saturation above 92%.

CLINICAL INDICATORS

Evidence the patient is working to breathe: **PATIENT DOES NOT HAVE ANY OF THE CLINICAL INDICATORS. ONLY HAS SHORTNESS OF BREATH (SOB).**

DIAGNOSTIC VALUES:

ABGs done X 1 IN ED

Resp rate: 18

pH <7.35: _____

pH >7.35: 7.38

pCO2: 41 mmHg

pO2: 73 mmHg

O2 sat: _____

P/F Ratio: _____

TREATMENT:

Patient received:

- **Metered dose bronchodilator inhaler treatment**
- **aerosol treatment**
- **IV steroids**
- **O2 therapy**
- **antibiotics**

POA INDICATORS

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

If a single code identifies both an acute and chronic condition, see the POA guidelines for codes that contain multiple clinical concepts.

Codes That Contain Multiple Clinical Concepts

Assign “N” if at least one of the clinical concepts included in the code was not present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).

Assign “Y” if all of the clinical concepts included in the code were present on admission (e.g., duodenal ulcer that perforates prior to admission).

Query

A query was sent out to the attending. The query response was acute on chronic respiratory failure with increased need of O2 supplementation – **POA Y**.

It appears that this patient has the co-equal diagnoses of acute COPD exacerbation and acute on chronic respiratory failure present on admission. So, either can be the principal dx.

A/C resp failure	DRG 189	wght 1.2248
COPD exac	DRG 190	wght 1.1239

Payer review of COPD/asthma cases is common as those patients tend to be readmitted regularly.

REFERENCES

Optum 360* ICD-10-CM Professional for Hospitals

[Revisiting respiratory failure | ACP Hospitalist](#)

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